Health System Accountability and Primary Health Care Delivery in Rural Kenya

An Analysis of the Structures, PROCESS and Outcomes

UNIVERSITY OF CAMBRIDGE

Thesis submitted for the Degree of Doctor of Philosophy
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ACRONYMS

AHPSR	Alliance for Health Policy and Systems Research
AIDS	Acquired Immune Deficiency Syndrome
APHRC	African Population and Health Research Centre
ARI	Acute Respiratory Illnesses
CBO	Community Based Organisation
CDF	Constituency Development Fund
95% CI	95% Confidence Interval
CIA	Central Intelligence Agency
DHC	Dispensary Health Committee
DHMT	District Health Management Team
DMOH	District Medical Officer of Health
FI	Facility In-Charge
FGD	Focus Group Discussion
GBP	British Sterling Pound
GDP	Gross Domestic Product
HCC	Health Centre Committee
HF	Health Facility
HFC	Health Facility Committee
HIV	Human Immunodeficiency Syndrome
HSA	Health System Accountability
HSSF	Health Sector Services Fund
IDI	In-depth Interview
IMCI	Integrated Management of Childhood Illnesses
IMF	International Monetary Fund
ITNS	Insecticide Treated Nets
KEMSA	Kenya Medical Supplies Agency
KEPH	Kenya Essential Package for Health
KES	Kenya Shillings
KI	Key Informant
KNBS	Kenya National Bureau of Statistics
LMIC	Low and Middle Income Countries
MDG	Millennium Development Goals

MOH	Ministry of Health
MP	Member of Parliament
NCAPD	National Coordination Agency for Population and Development
NCD	Non-Communicable Diseases
NCPD	National Council for Population and Development
NGO	Non-Governmental Organisation
NHSSP	National Health Services Strategic Plan
OR	Odds Ratio
PHC	Primary Health Care
PHO	Public Health Officer
PRC	Patients' Rights Charter
RA	Research Assistant
SAP	Structural Adjustment Programme
SB	Suggestion Box
SC	Facility Service Charter
SSA	Sub-Saharan Africa
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNICEF	United Nations Children Fund
VCT	Voluntary Counselling and Testing
VE	Village Elder
VHC	Village Health Committee
WB	World Bank
WHO	World Health Organization

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ABSTRACT

Globally, health systems accountability and engagement are increasingly claimed to be vital means to improve services by providing mechanisms for potential beneficiaries to contribute to the design, implementation, and evaluation of service delivery. In Kenya, these have taken the form of hospital boards, health facility committees, patient and facility service charters, and suggestion boxes. However, there is little information available on the factors that impact on the performance of such accountability mechanisms. This thesis addresses the shortfall, by investigating process issues that influence the performance of accountability initiatives.

Primary research was conducted in a rural district through a cross-sectional survey of households clustered around four public health facilities. Following a pilot study, data on accountability mechanisms supporting service delivery were collected through a mapping exercise involving in-depth interviews and facility audits. Data on the use of these were then collected through a large cross-sectional household survey, participant observation and focus group discussions. Analysis focused on accountability mechanisms within the health facilities and on issues around the relationship between those facilities and the local community. This was supplemented by user experiences of services where this was central to an understanding of accountability structures performance.

The research identified health facility committees and Service Charters as the main accountability mechanisms adopted. Further analysis showed that four main underlying factors - accessibility/proximity, trust, power and responsibility –influenced both of these. The context of the health system and cultural practices were also important determinants of performance, either constraining or enhancing their impact on service delivery.

These findings suggest that emphasis on the structure of accountability and engagement mechanisms, or adopting simple measures of outcome, are unlikely to account for how and why accountability mechanisms perform as they do. Processes that sustain and are sustained by accountability mechanisms need to be considered including the selection process of health facility committee members, the use of effective communication methods with the local community, and appropriate national regulation. In addition, these efforts should always take into account the health needs of the local population, their cultural practices, and the policy context within which these mechanisms are expected to operate.

PART I

BACKGROUND TO THE THESIS

Part I provides an introduction to the thesis, background information on Kenya, and a review of the relevant literature

CHAPTER 1

INTRODUCTION

1.1 The Place of Accountability in Health

In many countries, accountability through greater public participation is advocated as a means for improving public services. In health, accountability and wider engagement of users gained momentum from the 1970s as means for potential beneficiaries of health services to get involved in the design, implementation, and evaluation of activities [2, 3]. The overall aim has been to increase the responsiveness, sustainability, and efficiency of health services, especially in developing countries where health systems[1] are struggling to meet the growing challenges of disease burden and shrinking resources [4, 6-10]. Health system accountability[2] (HSA) is also seen as a means of providing mechanisms to open up the health profession and of improving both the perception and provision of health care [7]. The drive to open up physician-centred health care and hospital-based approaches to health provision, is also a result of the realisation that the operations of health systems are not purely based on technical knowledge and capacities; they are also shaped by the way leadership and authority are exercised to maximise scarce resources [12].

In low and middle income countries (LMICs) in particular, people have become more aware of their rights to health hence the need for governments to provide meaningful opportunities for individuals to participate in decisions that affect their health and to be answerable on their policy choices and performance [12]. With the rising challenges from diseases that were formerly not a threat to populations in LMICs - such as non-communicable diseases (NCDs) - the need for engaged citizens who can make informed choices about their lifestyles and how these choices affect their lives cannot be overemphasised. But facilitating populations to make these choices is not enough;

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[1] The term 'health system' is used in the thesis to refer to all organizations, people and actions whose primary purpose is to promote, restore, or maintain health**.** Its goals are improving health and health equity in ways that are responsive, financially fair, and make the best, or most efficient, use of available resources. Adopted from: 4. WHO, *The World Health Report 2000 Health Systems: Improving Performance* 2000, World Health Organization Geneva , 5. WHO, *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action*, 2007, WHO: Geneva.

[2] Throughout the thesis, health system accountability is used to refer the spectrum of approaches, mechanisms and practices used by the stakeholders concerned with health services to ensure a desired level and type of performance. This definition is adopted from 11. Paul, S., *Accountability in Public Services: Exit, Voice, and Capture.* World Bank Country Economics Department Working Paper Series, 1991. **614**.

efficient management of competition for policy attention and resources, with an acute eye for reducing the wide disparities in health and in access to health care resources and services is critical [13, 14].

With this background, HSA has received renewed vigour in the international health policy circles. More recently, growing interest in strengthening accountability within the health sector has been driven by a number of factors including: growing dissatisfaction with health system performance; the view that improved accountability is essential for ensuring delivery of basic health services for all citizens, especially for the underprivileged; the possibility that changes in the knowledge, scope and size of health care structures in both private and public sectors can tilt power relations among health system actors in a way that affects people's lives and well-being; the need to ensure proper accounting for all resources given primary health care[3] (PHC) consumes a lot of resources; and lastly, the realisation that health reform efforts designed without an accountability lens can actually hamper health system performance [16-19].

Nonetheless, despite the growing interest in accountability in health systems and its recognised potential for improving PHC service delivery, there are grey areas in HSA that need addressing. Firstly, the concept of accountability remains complex, contentious and vague. In their latest report on health systems research, the World Health Organisation (WHO) classified accountability and governance in health systems as one of the 'neglected health system research areas', noting that the complexity of the concept of accountability in health and the difficulty in applying it to health systems research could be discouraging research and researchers:

> *[R]esearch on governance and accountability has been neglected. It largely focuses on specific health interventions or services, with little work on the effectiveness of different regulatory, incentive, oversight, participation or decision-making options for wider health systems, including at the global level. Work in this area faces conceptual, analytic and design challenges and the*

[3] Primary Health Care or Primary Care refers to a strategy for organising health systems to promote health, and encompasses essential health care made universally available to individuals and families by a means acceptable to them and at a cost that the society can afford. Adopted from 15. PAHO, *Renewing Primary Health Care in the Americas. A position paper of the Pan American Health Organization. Available at: http://www.paho.org/English/AD/THS/primaryHealthCare.pdf (accessed April 16, 2013)*, PAHO/WHO, Editor 2007. It is the nucleus of a country's health system and in Kenya, this is usually the dispensaries or health centres, which are normally the first point of contact between the patient and formal health care system.

contested, political nature of the issues may discourage research and researchers [12 :1].

Secondly, little is known about the effectiveness of HSA, and how and under which environments or conditions it could be employed as a policy tool to improve health system performance. As a consequence, the knowledge and understanding available to inform policy and practice remain limited [12, 19-21]. Thirdly, within academic publications, there is a growing body of literature on ways and methods of conceptualising accountability, but very limited empirical evidence on its functioning and impact. This is particularly so in LMICs, where available evidence is often difficult to obtain because it is either documented in the grey literature or inaccessible for language reasons [20, 22]. This study addresses this knowledge gap in the context of HSA and PHC service delivery in rural Kenya, by investigating the factors that influence the performance and effectiveness of health system accountability (HSA) mechanisms on the delivery of primary health care (PHC) services.

1.2 Kenya – The Context of Health System Accountability

1.2.1 Economy

Kenya has an estimated population of slightly over 41 million (initially distributed across eight provinces), but now under 47 counties following the enactment of a new constitution in August 2010. About 75% – 80% of this population lives in rural areas [23-25]. In 2012, agriculture directly contributed an estimated 24.2% of the GDP, with the rest contributed by industry (14.7%) and services (61%) [24, 26]. Seventy-five per cent of the labour force is engaged in agricultural activities with the rest engaged in industry and services [24, 25]. Kenya has experienced a steady economic growth in the last decade. Although the gross national income *per capita* is $ 1,640, an estimated half of the country's population still live below the poverty line [23]. In 2009, under-five mortality was 74/1000, maternal mortality 488/100,000, 16% of children under five were malnourished, and life expectancy at birth in 2012 was 63.07 years [24-26]. The main health challenges arise from HIV/AIDS, malaria, TB, and the growing threat from NCDs. Adult HIV prevalence was estimated at 6.3% in 2009 and malaria prevalence among over-5s was 31% in 2007 [25, 26]. Directed towards these health challenges, the government's total expenditure on health as a percentage of the GDP was estimated at 4.8% in 2010 [27].

1.2.2 Kenya's Policy on Health System Accountability

In Kenya as elsewhere, participation in governance and greater public accountability is increasingly claimed as a goal of the health system. The principal approach has been to establish structures which are closer to service users, through decentralisation, and by including community representatives in at least some of these structures. Although the rhetoric of public involvement in Kenya's development agenda, including health, has percolated the country's development politics since independence in 1963, the concept of accountability has been lacking, only becoming relevant in the 1990s following Structural Adjustment Programmes (SAPs) imposed on the country by the World Bank (WB) and International Monetary Fund (IMF). Over the years, and in particular from the 1990s, when the Bretton Woods Institutions had much say on the country's economic policy through SAPs, efforts have been made by the government (at least in theory) to expand public participation and accountability not just in the health sector, but also in other sectors of government. Effectively, Kenya's overall reform agenda has been and continues to be much driven by external actors - mainly her development partners and international institutions. Much of Kenya's health system reforms and plans are aligned either to key international agreements to which she is a signatory or to the wishes of donors who finance a larger portion of the health budget.

To guide decentralisation and potentially improve HSA, various policy documents have been published and implemented beginning with the District Focus for Rural Development (DFRD) in 1983. The DFRD set to decentralise services to peripheral outposts. This was followed by the *National Guidelines for the Implementation of Primary Health Care in Kenya 1986,* which focused on decentralization, community participation, and inter-sectorial collaboration [28]. The guidelines were published following the 1978 WHO framework for Primary Health Care for all by Year 2000. The guidelines were then succeeded by the *Kenya Health Policy Framework Paper* (1994-2010), which geared health developments and reforms to provide 'quality health care that is acceptable, affordable and accessible to all' [29]. This framework was implemented as part of the first National Health Sector Strategic Plan (NHSSP 1) 1999-2004 [29].

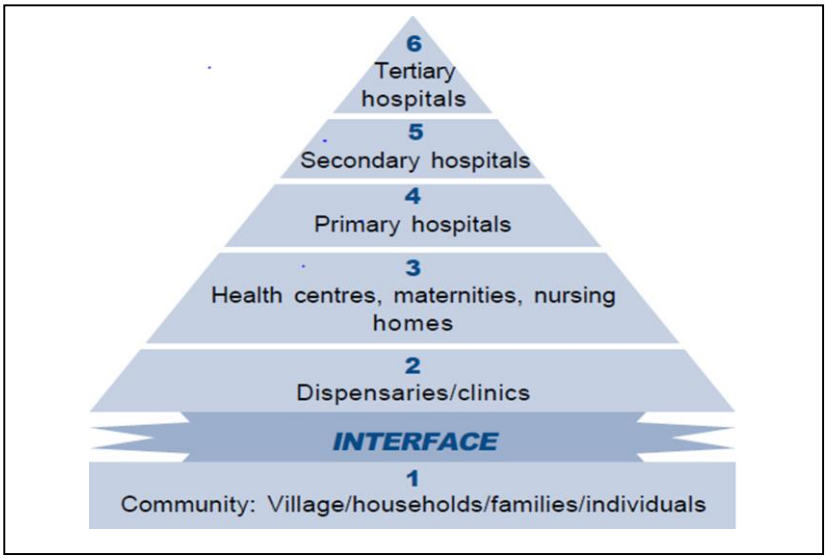
Despite the implementation of these plans, studies in Kenya suggest that decentralisation has been more rhetoric than reality, that in many cases power is not released by central government, and that reforms can in fact result in the complication of lines of responsibility and accountability [30]. Weaknesses in management at local and national levels, increasing local-level control over expenditure, and improving staff incentives and motivation have been highlighted as among the key issues that still need addressing. Further concerns include the selection of board members (in many cases relating more to political allegiance and patronage than respectability, integrity, and professional or technical expertise in their respective fields), as well as the related issue of the extent to which they represent a given community, particularly the low-income groups of that community [28].

Recognizing these issues, the Kenyan government developed the second National Health Sector Strategic Plan (NHSSP II) 2005-2010 as part of the country's development plan *Vision 2030* and as an effort to accelerate the achievement of the MDGs [31, 32]. Through a community strategy, NHSSP II aimed to: attain greater coverage and community involvement and empowerment by creating an interface between the community aspirations and expectations on one hand and the objectives of the health services on the other; strengthen the community to progressively realize their rights for accessible and quality care; and to seek accountability from facility-based health services [32, 33]. This was the first time that accountability was mentioned explicitly as a goal of Kenya's health system, marking a significant shift from previous plans, which lacked government commitment to enhancing HSA. In the plan, the government set out to remedy some of the weaknesses identified during the implementation of previous plans.

However, the rhetoric can be seen as a weaker take on accountability, taking a one sided view of accountability, where service providers (health workers) are expected to be accountable leaving out service users (the community) and the government (through the ministry of health). It risks being seen as giving patients much power ignoring the role, context and place of health workers in the accountability mix and in holding the central government accountable in releasing real power to the local accountability structures. Nonetheless, one significant change introduced by the

NHSSP II – considered to be one of its key innovations and which is of interest to this study – is the recognition of the community as a formal health service delivery level forming level 1 (see Figure 1.1) to support the delivery of the Kenya Essential Package for Health (KEPH) framework.

Figure 1.1: Kenya Health System Structure



Source: [32]

KEPH represents the integration of all health programmes into a single package that focuses its interventions on the improvement of health at different phases of the human development cycle. Its goal is to reduce fragmentation and to improve continuity of care by emphasizing the inter-connectedness of the various phases in human development [33]. In the first year of implementation, the interventions that were to be provided included: safe motherhood and reproductive health; child health promotion and Integrated Management of Childhood Illnesses (IMCI); Malaria, HIV/AIDS, STI and TB control; and sanitation and food safety all aligned to the health MDGs. With the multi-layered health system structure above, and the health system challenges described, the place of strong accountability structures to support the delivery of health system goals cannot be overemphasised.

1.3 Thesis Outline

To improve the performance of HSA and engagement mechanisms and to enhance the impact of these mechanisms on PHC services, an understanding of the role of process in the functioning of the mechanisms is essential. This thesis uses insights from

accountability and participation theories in health to investigate how the interplay of structure, process, and outcome influences the performance of health system accountability and engagement mechanisms in supporting PHC services. The study is set in the rural areas of Kericho district in Kenya, clustered around four public health centres providing PHC services. The study uses a variety of data collection methods to gather information from households, facility staff, community leaders and administrative staff.

Part I of the thesis continues with a review of the theoretical and empirical literature on accountability and engagement, and, in Chapter 2, their place in the provision of PHC in sub-Saharan Africa (SSA).

In Part II, the study design and methods for data collection and analysis are described (Chapter 3).

Part III comprises two results chapters (4 and 5). Chapter 4 describes the range and types of HSA and engagement mechanisms in the study area and their functioning, while in Chapter 5, the findings on the interactions of HSA mechanisms with the community are presented.

Part IV explores the implications of the results. In Chapters 6 and 7, the findings are analysed and discussed in the light of the existing literature. Finally, Chapter 8 concludes the thesis with a discussion on the limitations of the study, policy implications of the findings, an assessment of new knowledge gained, and research priorities for the future.

CHAPTER 2

REVIEW OF THE LITERATURE ON HEALTH SYSTEM ACCOUNTABILITY IN SUB-SAHARA AFRICA

2.1 Introduction

This chapter reviews the literature on accountability and engagement and their place in the provision of PHC in SSA. The review aims to identify knowledge gaps and informs the development of the conceptual framework presented in Chapter 3. The chapter is presented in sections: Section 2.2 traces the rise of accountability in health from its origin and in its development. Section 2.3 presents the various frameworks that have grown out of the rise of health system accountability (HSA) as an important international health policy agenda. Section 2.4 is a review of the evidence of practice of health system accountability in SSA. Section 2.5 provides a summary of the chapter and identifies gaps that the thesis will address.

2.2 Accountability and Participation in Health: Origin and Development

The importance of accountability in health through community participation and as a mechanism to open up the health profession gained prominence in the late 1970s. Drawing on the successes of community-led health interventions in China, India, and Indonesia, as well as on the growing voices for participatory approaches to development, such as Participatory Rural Appraisal (PRA), the WHO set the stage by publishing two reports – *Health by The People*, and *Primary Health Care* - that gave impetus to the HSA bandwagon [6, 7]. In the 1978 *Alma Ata* declaration, governments recognised that, 'people have the right and duty to participate individually and collectively in planning and implementation of their health care' [7]. The PHC approach was articulated as a holistic framework by which the physician-centred health care and hospital-based approaches were enlarged to accommodate mechanisms which sought to enhance responsiveness, sustainability, and efficiency, while promoting equity in PHC at the community and local government level [34]. By the end of that decade, over 150 countries had accepted the PHC policy [35], which has since then driven the agenda for HSA.

Many donor countries and institutions bought into the HSA agenda, with the UN and WB taking central roles in promoting it. The WHO and UNICEF led SSA countries in

adopting the Bamako Initiative (BI) in 1987, which committed governments in the region to decentralising health decision-making to local levels and establishing realistic national drug policies for enhancing the provision of essential drugs for citizens [36]. In implementing the BI across SSA, community participation in the management and control of resources at the health-facility level was identified as the main mechanism for ensuring accountability of public health services to users [36]. Shortly after, the WB published its first world development report focusing on health – *Investing in Health* – with an emphasis on greater public accountability in the manner in which health services are provided and on the space for clients' voices in these services [8].

Consequently, questions about procedures came to the fore. Citizens, it has been argued, should have the right to ask: how health service delivery plans and policies are to be formulated; how health care decisions are to be made; and how those who make and implement decisions are to be held accountable for their actions through a variety of community or local accountability structures such as, among other measures, the district health committees, village health committees, hospital boards, and clinic committees [37]. The theory behind all these changes is that having decisions made at these levels should enable problems voiced and demonstrated locally to be seen and responded to more quickly.

These developments should also be understood in the broader context of the political changes that took place in the late 1980s and early 1990s, which saw the rise of the liberal democracy tide that swept through Eastern Europe and Africa, dislodging perceived dictatorial governments from power. Subject to the hands of western countries and the Bretton Woods Institutions, aid was linked to certain conditionalities known as Structural Adjustment Programmes (SAPs), among a raft of other demands aimed at expanding democratic space and to improving efficiency in service delivery through expanded public accountability. The impact of SAPs on developing countries' economies has been well studied [38-41]. Within the health systems, SAPs led to the introduction of user fees in PHC facilities. Several studies have reported a catastrophic impact of user charges on PHC uptake in LMICs which include

reduced demand for care, expanding inequities and, contributing to medically driven household poverty, thereby negating the ideals of PHC [14, 42-52].

These political developments notwithstanding, HSA continued to grow throughout the 1990s into the 21st century, driven by the understanding that health systems design and operations transcend technical knowledge and capacities. They also include resource generation, allocation and rationalisation, getting public voice to bear on decisions, and enhancing human resource capacity to achieve efficiency and effectiveness [12]. This is critical because poorly managed health services affect the poorest strata, especially in LMICs [53]. Initial success of PHC [4, 54-57], led the WHO to encourage countries to reaffirm their commitment to the principles of PHC [58]. The recommitment to PHC has come with renewed vigour in strengthening health systems with a particular emphasis on accountability. The drive for greater accountability has also been due to the growth of human rights approaches to health supported hand-in-hand by the growing evidence on the significance of social determinants of health [59-61]. Achieving HSA is seen as important in tackling issues of transparency and corruption that prevents the health sector from achieving optimum performance and to assist a decline in poverty, mortality and morbidity as stated in the MDGs [53].

Over and above this tremendous growth in policy setting the stage for HSA and engagement in health, there are challenges that still need addressing with regard to developing countries. The first of these relates to the origins of the idea. As noted, donors and international organisations have largely driven the idea of HSA. It is therefore fair to question whether, with such external influence, local leadership is ready to adhere to the precepts, most of which challenge their positions of power and influence. With regard to local communities, one would question whether health facilities committees (HFCs), for example, are ready to accommodate extra scrutiny from the community and interested parties on their operations and decisions. Or whether health workers (HWs) are ready to accept that even though their clients are largely illiterate, it could be to their own advantage to involve them in decision-making about their (clients) health and perhaps even allow for scrutiny of the decisions they make. Or whether these new structures and concepts, could, result in an extra layer of bureaucracy that would eat into the scarce resources that could be best used to save

lives. While the growth in the drive for accountability has been accompanied by the developments of frameworks for implementing and evaluating it over time, it has not been matched with empirical knowledge of accountability in practice. In particular, the factors that influence the performance of accountability mechanisms are less covered [12, 62]. The following sections address these issues, firstly, by reviewing the literature on accountability frameworks, and secondly, by reviewing the available evidence on accountability in practice in the context of SSA.

2.3 Conceptions of Accountability and its Application to Health

There is extensive literature on accountability describing different dimensions of the concept [16, 63-66], with considerable overlaps. Three broad pathways to understanding accountability can be identified from the literature. These are:

1. By purpose of accountability / area of interest,
2. By type of mechanism,
3. By depth / level of involvement.

2.3.1 Purpose or Area of Interest

Accountability mechanisms can be classified on the basis of the purpose or area of interest. Mechanisms introduced to strengthen health system accountability can be aimed at achieving transparency, answerability and controllability [13, 16, 67-69]. Transparency requires that decisions and actions are taken openly and that sufficient information is available so that agencies and the general public can assess whether the relevant procedures are followed. Answerability involves an obligation on the part of the decision makers to justify their decisions publicly so as to substantiate their reasonability and rationality. Controllability provides for mechanisms to sanction actions and decisions that run counter to given mandates and procedures, often referred to as a system's checks and balances or enforcement mechanisms [13, 16, 67-69].

The purposes and types of accountability are described in Table 2.1, with illustrative health system issues for each type. According to Brinkerhoff [13], the three main purposes of accountability are therefore:

- to control the misuse and abuse of public resources and/or authority. This relates directly to *financial* accountability;

- to provide assurance that resources are used and authority is exercised according to appropriate and legal procedures, professional standards, and societal values. This relates to financial, performance, and *political or democratic* types of accountability; and
- to support and promote improved service delivery and management through feedback and learning - the focus here is primarily on *performance* accountability (see Table 2.1).

Table 2.1: Accountability Types, Purposes, and Health Service Delivery

Type of accountability	**Illustrative health system issues**	**Dominant purposes of accountability**
Financial	• Cost accounting/budgeting for: -Personnel -Operations -Pharmaceuticals/supplies • Definition of basic benefits packages • Contract oversight	• Control and assurance are dominant. • Focus is on compliance with prescribed input and procedural standards; cost control; resource efficiency measures; elimination of waste, fraud and corruption.
Performance	• Allocation of resources needed for effective system performance • Quality of care • Service provider behaviour • Regulation by professional bodies • Contracting out	• Assurance and improvement/ learning are dominant. • Assurance purpose emphasises adherence to the legal, regulatory, and policy framework; professional service delivery procedures, norms, and values; and quality of care standards and audits. • Improvement/learning purpose focuses on benchmarking, standard setting, quality management, operations research, monitoring and evaluation (M&E).
Political/democratic	• Service delivery equity • Transparency • Responsiveness to citizens • Service user trust • Dispute resolution	• Control and assurance purposes are emphasised. • Control relates to citizen/voter satisfaction, use of taxpayer funds, addressing market failure and distribution of services (disadvantaged populations). • Assurance focuses on principal-agent dynamics for oversight; availability and dissemination of relevant information; adherence to quality standards, professional norms, and societal values.

Source: Brinkerhoff [13].

It follows then that for accountability to work, it is important that sanctions are put in place. Such sanctions could, for instance, be equated with requirements and penalties

embodied in laws and regulations such as professional codes of conduct; incentives such as market mechanisms (where accountability is enforced through the ability of service users to switch from low quality facilities to high ones); and public exposure or negative publicity (e.g., self-policing among health care providers where professional codes of conduct are used as the standard) [13]. The purpose matrix by Brinkerhoff captures conventional thinking around accountability, i.e. as a two way relationships where those in positions of power (e.g., Facility In-charge) are obligated to provide information about and/ or justification for their actions to other actors, with possible imposition of sanctions for failure to comply with or to engage in appropriate action.

2.3.2 Type of Mechanism

Another way of looking at accountability is by distinguishing whether the mechanisms are within the government (horizontal or internal) or outside the government framework (vertical or external) [65, 68] and whether they possess high or low sanction capacity (Table 2.2). This schema reveals that there are potentially strong and weak institutions and mechanisms both within and outside the state.

Table 2.2: Typology of Accountability

	Accountability within government (horizontal)	**Accountability outside government (vertical)**
High enforcement/ sanctions capacity	• Supreme audit institutions • Courts • Comptrollers general • Law enforcement agencies • Parliamentary hearings • Legislative committees • Administrative review councils • Anti-corruption agencies	• Elections • Professional codes of conduct • National/international standard-setting bodies • Accreditation agencies • Referenda • Public interest law
Low enforcement/ sanctions capacity	• Advisory boards • Inter-ministerial committees • Ombudsman offices • Blue ribbon panels • Citizens' charters • "Sunshine" laws • Freedom of information laws	• Citizen oversight committees • Service delivery surveys • Civil society watchdog organisations • Policy research (e.g., by think tanks or universities) • Investigative journalism (media)

Source: [68]

The effectiveness of mechanisms is based on two key factors: the importance of capacity and political will on the part of public officials to use these institutions and mechanisms for the enforcement of sanctions; and the significance of having in place a

supportive legal and institutional framework that civil society organisations and private sector actors can utilise to exercise accountability functions successfully. These factors further point to the central role of government and the health system context within which mechanisms operate if accountability is to be achieved. Within this perspective, Brinkerhoff locates community accountability – which, based on this perspective, includes the interactions between community members and health providers within the health system – as a form of vertical accountability characterised by low enforcement or sanction capacity.

A second way of distinguishing types of accountability is by considering who initiates the structures that support the mechanisms. Khumalo [70] uses this principle to classify accountability mechanisms into bureaucratic, organic, and hybrid where:

a. Bureaucratic accountability mechanisms or structures are initiated by the national department of health and include clinic committees and suggestion boxes.
b. Organic structures are either a cultural heritage or introduced as a modern structure charged with developmental issues of the community, (e.g., the community development forum or the *Induna* or village chief in South Africa). Organic structures owe their origin to the community although they may receive government recognition.
c. Hybrid structures are neither purely bureaucratic nor organic but a combination of both, for example, home based caregivers.

The framework by Khumalo above is similar to the others in considering vertical (involving non-state actors) and horizontal (involving state actors) accountability, but highlights how they overlap in practice.

2.3.3 Depth or Level of Involvement

Another way of framing accountability is to consider the depth or level of involvement or participation, by considering whether actors' involvement is passive or active. In looking at accountability in terms of depth of engagement, a distinction can be drawn between simple information sharing with communities at one end of the spectrum, through consultation, to community influence and control at the other end [17, 66, 71-73]. Shifts in authority from health workers and managers to communities are proportional to increasing levels of community control. Other authors consider the

linkages between citizen 'voice' (ability to exert pressure on providers to influence the outcome of services) and service 'responsiveness' (provider response to citizen 'voice') to illustrate the varying levels of engagement [65]. They distinguish between three different extents of state engagement with citizens:

- *Consultation* – opening arenas for dialogue and information sharing. These may be one-off consultative exercises, on-going participatory poverty assessments, citizens' juries, or surveys.
- *Representation* – institutionalising regular access for certain social groups in decision-making.
- *Influence* – citizen engagement reaches the point where groups can translate access and presence into a tangible impact on policy-making and the organisation of service delivery.

Goetz and Gaventa argue that there are three major factors affecting citizen influence on the design, delivery, and assessment of public services, and state capability to respond:

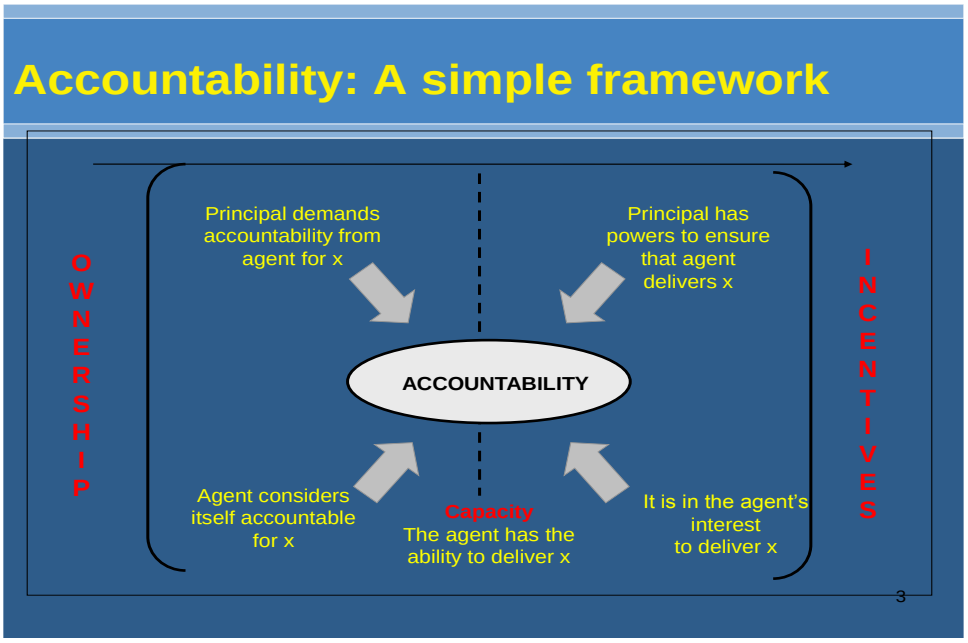
- *'The social, cultural, and economic power of the client group in question within civil society* – its power to mobilise resources and public concern to support its demands;
- *The nature of the political system* (the depth and procedural and substantive democracy, the configuration of executive/legislative/judicial power, the level of political participation), *and the organisation of political competition* (the number and types of parties, their ideologies and memberships, the relative importance of high finance or crime in political contexts);
- *The nature and power of the state and its bureaucracies* (whether it is a developmental state, whether it has the will and capacity to enforce change in the culture and practices of bureaucracies, whether there is a professional civil service, whether the public service has internalised a commitment to poverty reduction etc.)' [65:9-10].

The latter two are similar to the factors outlined by Brinkerhoff [68] as influencing the level of enforcement/sanctions capacity of horizontal and vertical accountability types.

2.3.4 Principal-Agent Approach

A final way to view accountability within the health system is through the principal-agent approach (Figure 2.1). This approach proposes a principal (individual or institution) with specific objectives and agents needed to implement activities to achieve those objectives. The principal is the 'residual claimant' to the outcome of the agent's actions [74].

Figure 2.1: Principal-Agent Relations



Source: [75]

In recent years, the principal-agent approach has also been used by sociologists, economists, and others in the field of health care to analyse the relationship between provider and patient and more recently, contracting-out arrangements. In practice, principal-agent relations are not only ubiquitous, but also characterised by imperfection mainly due to diverse objectives combined with information asymmetry. Principals might like to overcome information asymmetry, but gaining information has significant costs and may be impossible. In addition to the information asymmetry, the principal-agent approach also focuses on who controls information and how to improve monitoring [Chai, 1995; Hurley et al., 1995; cited in 76]. A problem with the principal-agent approach is its limitations in analysing a system where there are many different principals and agents, as well as shifting of roles, as is the case in the health sector. The approach also does not adequately conceptualise the ideas of trust and power, which are likely to play a key role yet are difficult to measure.

2.4 Health System Accountability in Practice in Sub-Sahara Africa

The growth in the literature offering various frameworks on health system accountability (HSA) and participation highlighted above has not been matched by empirical studies. This is despite a general consensus in international health policy circles that HSA is a key strategy for health improvement especially in LMIC [4, 77-80]. Within academic publications, there is limited coverage of accountability, particularly in LMIC, and what is available is often difficult to obtain for language reasons or because it is documented in grey literature [22, 78, 81]. For instance, the most recent systematic review in this area - [77] - only found four studies – three from SSA [82-84] and one from Latin America [85] - in which there was a structured evaluation and rigorous analysis linking the accountability mechanisms of interest (HFCs) to relevant output or outcome measures.

The next section summarises the methods for conducting the studies, the evidence of effectiveness and the factors affecting the performance of the mechanisms reviewed.

2.4.1 Methods for Studying Health System Accountability

Existing studies on HSA primarily draws on qualitative approaches such as in-depth interviews and key informant (KI) interviews, participant observation, and focus group discussions (FGDs) to understand user experiences with accountability mechanisms, perceived effectiveness and outcomes. These data are often supplemented by a review of the literature among other descriptive methods. Because most of the studies in this area are either projects supported by external actors with their own goals and objectives, the results they present may not be completely free of bias [77, 78]. It is unhelpful that a lot of these studies rely mainly on descriptive methodology, which limits the control for the influence of potential confounders on programme effects.

There is therefore need for studies that can assess aspects of accountability mechanisms in their 'normal setting' or without the influence of external factors and actors. Such data can then provide good grounds for interventions to improve performance of HSA. Beyond the data collection methods, many studies have limited generalisability. Nonetheless, most of the methodological weaknesses exhibited in the studies are not unique and could be a reflection of the fact that this research area is relatively new. The complex nature of the concept of accountability means that many

studies (and researchers) are faced with limiting conceptual, analytical and design challenges [12, 86, 87]. To overcome challenges of methodology in researching accountability, the use of a range of study designs, a mix of qualitative and quantitative methods have been advocated [88], and an analysis of process emphasised, with 'a greater level of sharing of analytic frameworks, parameters, concepts and terms'[12 pg.8].

2.4.2 Types and Characteristics of Accountability Mechanisms

Literature on accountability illustrates the various forms and types that accountability mechanisms take. Broadly, the mechanisms can be grouped into three main categories based on their origins: those formed from government or formal initiative, e.g., HFCs and hospital boards; those established as projects either by government, Non-Governmental Organisations (NGOs), or a public-private partnership; and those based on existing traditional structures (e.g., the Induna in South Africa or the Village Elder (VE), or the local Chief in Kenya). In many cases there is, however, no clear line of distinction between the three categories. For instance, a donor may collaborate with the government to initiate and support Village Health Committees (VHC) as is the case in coastal Kenya reported by Sohani [82]. Other scholars make a distinction between 'formal' and 'informal' mechanisms, with formal forms being those officially sanctioned and operating within the health system or through other formally recognised bodies such as NGOs or Community-Based Organisations (CBOs), and informal referring to those that emerge spontaneously out of the community such as self-help groups [89].

The most common accountability mechanism evaluated are the health facility committees, which took various forms, including: village development committees [70, 90]; ward development committees [90, 91]; ward management committees [92]; community or clinic committees [70, 91, 93, 94]; village health committees [93, 95, 96]; dispensary health committees [82]; and general community committees [70]. These were followed by groups (mainly women groups). Other reported, but less covered mechanisms, includes patient rights charters (PRC), suggestion boxes (SB), and citizen report cards.

Community-based health committees are a product of recent decentralisation efforts (mostly taking the form of de-concentration) aimed at increasing the responsiveness of the health system to the needs of clients. They are usually comprised of elected members from the community and health workers (HW) representatives. In countries such as Kenya, they also include a representative of the government security arm and that of the local government as *ex-officio*. Studies from Kenya, South Africa, Zimbabwe, Uganda and Nigeria report similarities in the composition of committees, whether they were VHCs, HCCs, HFCs or clinic committees [70, 82-84, 96, 97].

General community groups are formed to represent specific interests or deal with specific issues of which health may be one. They include, for example, user associations, women groups, youth lobby groups, and clubs [71, 95]. While there are no strong indications that such groupings have a strong influence on accountability and therefore service delivery, they can be important in fostering group cohesion, empowerment, self-esteem, and bargaining skills [98].

PRCs have been adopted in many countries and include a range of commitments by a country's health ministry through its HWs to improvement of service delivery and increased patient involvement in decision-making about health care service delivery [70, 92]. Charters are one of three strategies used to advance the rights of patients. The others are legislative, either specifically applied to patient rights, or the inclusion of patient rights in general health legislation [92]. PRCs are framed as guidelines that target the relationship between health professionals and users of health services and can be seen as a vertical accountability mechanism [13]. With PRCs, standards of care are set that patients can expect to receive and demand as rights that are due to them by virtue of being human, while a set of responsibilities for users are articulated. The charters disseminate information defining standards that providers must agree to uphold and therefore shift accountability downwards from providers to patients [98].

2.4.3 Evidence of Effectiveness of Accountability Mechanisms

Committees

Much of the prior work on health committees and their role in the health system has been as part of on-going interventions, reforms, and management systems [see for example 84, 99, 100-103] or on their role in supporting the quality of specific health

care services [70]. Reviewed studies provide mixed experiences as to whether committees were effective in improving service delivery or even meeting the stated purpose. These experiences are described here.

Schmidt and Rifkin [95] report that, in general, VHCs were successful in involving the majority of the village in the assessment of local needs. The study found that people usually went directly to the village Chairman to articulate their needs concerning health problems for instance when they felt they were not given good service by the staff. Even though the study does not report whether the Chairman was able to act on the complaints, it ensured the highest local authority was aware of villagers' views, findings that are reflected in another study within SSA [104]. However, Schmidt and Rifkin also found that neither the community nor the VHC had any control over finances though this should have been the case according to government policy. For instance, it is reported that some years ago, the community had collected money (which was kept by the committee Chairman) to pay the health worker but it transpired that he had not received a salary for two months. In another instance, financial contributions to solve water problems at the health centre, which were not under the control of the VHC, disappeared, a clear indication that the committee had no powers in the management of health centre resources [95].

Similarly, a later study in the same district reported mixed results with respondents in one of the study areas complaining of no improvements at the health centre, continued shortage of drugs despite paying user fees, deterioration in service provision, unascertained deaths as a result of drug shortages, few health workers to attend to patients and persistent exclusion from priority setting even though village and ward committees existed with some elected community representatives [90].[4] Yet in another location (within the same study), respondents reported that since the establishment of the VHC, there were general improvements such as availability of malaria drugs, and building of new care centres, showing variation in the impact of VHCs in the study area. These variations were not explained, an indication of the need for methods that can help in illuminating factors behind them.

[4] The study was done in the same district of Lushoto, though exact dates when the study was done is not reported, it seem it was done a few years later following the study by Schmidt and Rifkin.

In South Africa, committees exhibited little evidence of effectiveness. Some had no clear structures, others experienced member drop outs, while in others, meeting schedules were not kept [91]. The authors report that all the ward and clinic committees in the studied area seemed to lack consistency and regularity in their functioning, adding that the structures appeared to be affected by milder problems, such as not keeping to meeting schedules or not having enough members present at meetings to form a quorum. A ward committee member in the study described the situation as follows:

> *...so we have not been holding regular meetings, not attending some workshops like any other wards. In that note we ended up being torn apart as ward committee members. Now I think we were left with 4 or 5 persistent members in the ward committee* [91:6].

In Nigeria, committees assisted in improving health care in the villages by getting involved in the planning and execution of health activities, in the provision of equipment, and in identifying those to be exempted from user fees [96]. The authors report that all HWs were aware of the existence of the health committees; 95% of HWs were members of the committees and 95% of committees had female members. However, only one committee had a female Chairman. Moreover, in the handling of user fees and drug revolving funds (DRFs), community representatives in VHCs were reportedly excluded from the co-management of user fees and DRFs. There were also incidences of deliberate efforts to exclude the community from priority setting, with minute books showing no evidence of community involvement in co-management of DRFs and a deep feeling among community members that health facility heads did not want them to participate in 'money matters'. Similar experiences have been reported in Niger, where despite initial enthusiasm, health centre committees did not have effective control over the administration of drugs and finance [105].

In the Nigerian study, there were reported occasions when community members refused to participate in some health activities due to opposition to leadership of the health committees [96]. Other noted problems include: polarisation into different political parties and religious differences; fear that the government would stop funding the health centres; and inadequate remuneration. Nevertheless, the authors report notable improvements in how committees functioned, with each committees consisting of 8-12 individuals - representing diverse groups - who also appointed the

Chairman. The committees met at least once every month in their villages and districts, where minutes were recorded, adopted, and signed by the Chairman and secretary before next meeting. The authors posit that community participation from both the perspective of health workers and of the community seem to have been enhanced by the introduction of Bamako Initiative [96].

In rural Zimbabwe, a case-control study of Health Centre Committees (HCCs) which had received support from an NGO, showed that, compared to non-control sites (with no HCCs), control sites (with HCCs) had significantly higher likelihood of health service use for the last illnesses, a significantly greater use of antenatal care, fewer cases of diarrhoea and greater use of oral rehydration solutions, more staff, better community health indicators (health knowledge, health practices, knowledge and use of health services), and stronger links between communities and HWs [84]. Additionally, clinics with HCCs tended to be better staffed and better funded a fact that the authors attribute to a possible virtuous cycle whereby improved capacity helped to draw in further resources. Even with these successes, significant limitations were observed. The authors report that many people were unaware of the HCC or their work, that despite good relationships between the HCC and some sections of the community, vulnerable and poor groups were often overlooked and underrepresented in HCC meeting. As in the other studies reported above, the HCC did not have a direct control over budgets or over how clinics were managed and run. Additionally, the staff did not see such roles as being within the remit of community members.

Other positive outcomes, such as, increased health care utilisation and revenue generation, improved drugs availability, and motivation among HWs have been reported in rural Kenya and Uganda [82, 97, 99, 106], underscoring the similarity in the impact of the context within which these facilities operate. In Kenya, more effective fee exemptions and deferrals due to an improved financial accounting system are reported to have reduced revenue loses [82]. Nonetheless, many of the challenges reported above such as lack of control of the finances by the committees were also noted. In Mozambique, the use of Community Health Team is reported to have improved accountability about activities done, which were then shared among team members and with the community [107]. Involving the community through the team is reported

to have enabled community members to discuss problems. The community then proposed solutions aimed at expanding access to services, medicines adherence through decentralisation of services, timely referral, and information flow between the community, the health facility and providers. Such experiences have been reported elsewhere [100, 101], albeit in varying degrees.

Citizen and Patients Charters

Patients' charters are a relatively new concept, particularly in SSA. This explains why only few studies (two in this review) have evaluated this form of accountability. Even among these studies, only one - covering two major provinces in South Africa [92] - was comprehensive enough. The study evaluated the patients' rights charter and monitoring mechanisms for human rights in the health sector. The study found that different actors in the health system had received the charter variedly. Many providers openly expressed discomfort with the charter, complaining that it gave patients' rights without emphasising corresponding responsibilities. The following quotes from two providers are illustrative:

> *…try to move away from that mentality to say it's like… patients have rights, we [health workers] don't have rights. And it's not supposed to be like that. It's like we are putting our patients above our health workers [92:8]*

> *…They [health workers] think we have given patients more power, you know like we say criminals have more rights than us law-abiding citizens. It's the same thing* [92:8].

Generally, however, most patients and providers felt that the instrument was good. Some providers regarded it as a tool with which to raise awareness among both providers and patients about the rights and responsibilities of the later. These were interpreted as benefitting patients, especially if providers were aware of the charter. One provider noted:

> *I think it's a very good, tool. It makes you aware of what the patients' rights are. It makes the patient aware of what his rights are and …what his responsibilities are. It helps you as a provider to improve your service, to improve the quality of your service. In doing so, you are able to treat the patient better [92:10].*

An illustrative example is the report that the visible display of posters resulted in some staff being more mindful of the rights and responsibilities of patients. This had practical consequences in terms of how providers responded to patients. Many staff

members also agreed that the display of the charter reminded them of what they learnt many years ago. Some staff members thought the charter had helped to improve the quality of care, understood in such terms as giving more time to patients, showing more respect, or and having greater compassion. Some saw it as an instrument that could enable them to learn new things about patient care. On the other hand, these positive effects might be short-lived since many staff noted that once they had read the charter, they seldom looked at it again. Similarly, charters can be a significant tool for motivating HWs, especially where there are reward schemes for those who uphold them.

2.4.4 Factors Influencing the Effectiveness of Accountability Mechanisms

This section deals with the factors that affect the functioning of HFCs since this is the most studied mechanism.[5] Various factors influence relationships within the health system by either enhancing or constraining accountability mechanisms. These factors can be grouped into four main categories namely: features of the HFC (clarity of roles and functions, clarity of mandate and authority, accountability arrangements and capabilities and resources); features of the health facility and its staff (staff attitudes and perceptions, staff skills and resources); features of the community (socio-political, socio-cultural, and socio-economic); and process factors (community mobilisation, facilitation and support) [77, 79].

Committee Formation and Composition

Many studies of HFCs point to the manner in which a committee is set up as an important determinant of its effectiveness [70, 84, 90, 97, 99, 108, 109]. Structures formed through a participatory and all-inclusive approach tend to function efficiently and gain general acceptance of the community. For example, in Kenya, the inclusive manner in which dispensary committees were set up - the community having been briefed and involved in proposing and directly electing members of the committee – is reported to have enhanced the committee acceptability and success in managing facility affairs [82]. However, many studies report a lack of transparency in the manner in which HFC members are selected. In many settings, committee membership seemed to be obtained through connection to powerful political authorities [105] or due to

[5] Patient charters are dropped from the analysis since only two studies assessed this mechanism.

socio-economic status or gender, with male dominance being the common case [84]. Problems resulting from poor or unrepresentative selection processes include: low awareness of HFCs among community members [84, 108]; poor or absent linkages between HFCs and the community [104]; and, in some cases, difficulty in holding HFCs accountable [105]. In Niger for example, a study reported that the village chief appeared to select committee members related to himself or to the treasurer, leading to difficulties in dealing with their misappropriation of funds [105].

Committee Roles, Functions, and Powers

Closely related to committee selection are the questions of whether Committee members understand their roles and functions, and whether there is clarity on accountability relations between community representatives and the facility [77]. Many committee members exhibited confusion and a lack of clarity in regard to their roles. In some instances, there were conflicts on where decision making power lay between stakeholders [70, 83, 90, 96]. For example, in Tanzania, facility committee members reported that district authorities gave orders for the community to follow in order to accomplish certain activities planned at district level, even if they [committee members] did not know much about the plans:

> *We sometimes face a big challenge by finding ourselves implementing things whose origin is not known to us* [90:6].

In South Africa, members of the clinic committee felt that they had no authority to question the behaviour of health workers because they (committee members) were not educated or because this would have been seen as 'interference.' Some felt that their roles within the clinic was only limited to being advisors, and that they did not have any power to influence the behaviour of health workers [70]. The following quotation is illustrative:

> *[What]…we often fear is that nurses will think that since we did not go to school we are talking rubbish, what will we do if we go to the clinic and these nurses ask us whether we understand the questions we are asking them? What are we going to say? We are uneducated therefore; we would not know how to answer any questions. Nurses might even say we went to the clinic to rule them…* [70:43].

In Tanzania, village residents were thankful that in the near future they were going to have a health centre in their area, even though the place where it was being constructed was not the one the community suggested [110]. In Kenya, despite the

successes reported in an intervention to empower dispensary committees to manage local health facilities, conflicts between community representatives and staff over the control of dispensary finances still hampered their operations [82]. Similarly, another study describes how a treasurer of a local committee quit their post reportedly due to rumours in the village that he was misusing facility funds [97]. These findings not only point to the sense of powerlessness among facility users, but also indicate a lack of trust in the ability of established accountability structures to ensure any meaningful engagement. These challenges have been attributed to the lack of thorough institutionalization of accountability mechanisms [91].

Other studies have identified staff attitudes, skills, and perceptions on community participation in health as important factors impacting on the performance of HFCs [77-79]. Where staffs were supportive, responsive, and willing to accept that, despite the education levels of community members and their representatives, the latter could make useful contribution to the benefit of the facility, the HFCs also tended to be effective [82].

Resources Available to Committees

Resources - whether human or financial -, are another significant determinant of accountability. When considering resources available to HFCs, a distinction is made between those that touch on HFC members themselves on the one hand, such as their health knowledge, management skills, confidence, leadership skills [77, 111, 112], and those resources available to the community on the other, such as comparative information on quality of care that can facilitate accountability relations between HFCs members and the community [83]. Although little is available in the literature on the role of leadership skills within HFCs and in relation to the community, it has been emphasised as a key factor in shaping health system accountability and associated structures.

Where the leadership lacks general acceptance, mechanisms tend to suffer from a lack of trust among members and the community in general, thus hindering participation, as in the reported case from Nigeria [96]. The selection of appropriate leadership can be seen as a pluralistic approach in the community, one where there is interplay between positional leaders, those who have been elected or appointed, and

reputational leaders, those who informally serve the community [113]. The dominance of one leader may result in them using their power over the community or groups within the community to manipulate situations to their own advantage. Able leadership can mobilise the community to participate in health by providing the requisite link between the local health committee and the community. This may require properly established procedures of electing such a leadership and providing it with necessary resources to perform its roles.

Also important are material and financial resources to enable HFCs members - especially from the community - to participate effectively in facility activities. Several studies have highlighted how financial assistance provided to committees to facilitate their work, such as allowances for their transport costs or for food provision during meetings, can greatly improve the functioning of HFCs by acting as a motivator [82, 97, 99, 106, 114]. This is because, costs of participation, can be substantial and prohibitive when other basic needs have not been met [115]. However, there is little evidence on how accountability processes in HFCs operating in the normal health system setting (devoid of external intervention or support) would evolve, given that all the evidence currently presented involved some external support, either through a public-private partnership, donors or direct NGO involvement.

Process Factors

In terms of process, there is a strong argument about seeing accountability and participation not purely as a matter of policies and legislation, but as a complex process entailing customs, beliefs, ways of life, and power [22, 64, 116, 117]. Recent systematic reviews report that successful case studies tended to emphasise the significance of process in the functioning of HFCs. [77-79], yet little is available in the empirical literature on process. Some significant process factors identified in the literature include: wider community mobilisation before and during the establishment of HFCs; external facilitation and support in order to help staff and HFCs achieve effective working arrangements; as well as time and commitment among HFCs stakeholders, especially in the development of trust and skills necessary for HWs and community representatives to work harmoniously and for the empowerment of those most in need of quality health care [77, 79].

However, despite the central role played by process in the functioning of HFCs, there is very little analysis of it in the literature. Instead, the focus has been on accountability structures and their outcomes. This is perhaps explained by the fact that no study reviewed here, evaluated the functioning of HFCs in a normal health system context, i.e., without the support of donors or government intervention, which are known to follow the traditional model that considers accountability in health as a linear process in which actors can take rational decisions with ultimate responsibility [118]. Yet this view overlooks the fact that health systems are complex organisations, dependent on rules, social norms, and informal practices, aspects which warrant careful analysis [22].

Health System Context

Distinction can be made between the influence of the wider health system (legislative, regulatory, and policy framework) and the cultural environment within which local communities and clinics operate [14, 22, 77, 79, 117, 119-121]. In their review, McCoy et al [77], conclude that the functioning of the primary health care system has a clear effect on the effectiveness of HFCs, while Loewenson et al [84], document how the strength of HCCs in Zimbabwe exhibited a positively reinforcing virtuous cycle relationship with that of the primary health care system. Similar experiences were reported in Tanzania, where, due to a weak primary health care system, staff lacked resources to meet community needs, which in turn led to the disenfranchisement of the community from participation [95, 109]. These experiences highlight the need for HFCs to be owned by the local communities rather than constituting a policy directive from above [105], and that HFCs need to be nurtured by the health system in order to be effective [77].

Studies also highlight context issues that are beyond the health system but which can influence HFCs either through the health system or through the community. These include socio-cultural and political factors, such as participatory culture or lack of it, the nature of the state (whether democratic or dictatorial), or cultural beliefs and practices about illness and healing [77].

2.5 Summary and Limitations of the Literature

The rise in the significance of health system accountability in international health policy circles has been accompanied by a growth in the body of literature providing

various frameworks for examining and understanding this concept. The literature provides rich background information, bringing out common themes and patterns (with considerable overlaps) relating to accountability and its application to health service research. For example, accountability has a directional dimension (vertical versus horizontal and downward versus upward), a content dimension (e.g. financial, managerial, meeting of performance targets), and a temporal dimension (maintenance of feedback loops between citizens and authorities). In obligatory terms, being accountable means having the responsibility and commitment to answer questions regarding decisions or actions taken by health care providers. From a relational perspective, it can be defined in terms of answerability *to whom* and *for what*; and for accountability to work, it requires sanctions or enforcement, which can include a range of negative to positive sanctions or internalized ethics such as codes of conduct.

Within SSA, most studies have focused on committees as the main accountability mechanism, with very little information on other mechanisms. In their composition and formation, there is not much variation across SSA. Most committees consist of community representatives, health facilities staff representatives, and representatives of local administration. The literature provides a mixed scorecard regarding committee effectiveness as a mechanism for accountability and engagement. The various intervention projects described in the literature show that committees can be effective in enhancing primary care delivery in many ways such as: by mobilising the community to contribute to the management of their facilities and to identify priority areas; by ensuring drug availability; by holding HWs accountable for their work; by overseeing facility development projects; and, by facilitating health outreach programmes, among other activities. These issues are dependent on: whether HFC members understand their roles and authority; HFC resources; staff attitude and perceptions; local political dynamics; health system and socio-cultural contexts within which the committees operate. Little, however, is known about the impact of process in achieving the outlined outputs and outcomes.

The reviewed literature highlights several key gaps concerning the functioning and impact of accountability mechanisms.

Firstly, there is very little empirical data to match the growing international interest in this area even beyond SSA, as demonstrated by the most recent systematic reviews in this area [77, 79].

Secondly, the focus on the functioning and impact of accountability mechanisms is almost purely on a model which seeks causality [122]. Available studies provide very little information on the role of processes that sustain and are sustained by the mechanisms [22]. This may be partly due to the role of donors being involved in many of the studies thus far available, who, in many cases, are keen to see the impact of their investments. They therefore put less emphasis on process and the interaction between intervention and context. It is important, however, to understand the processes by which mechanisms were successful, the context in which these processes took place, and the interaction between intervention and context [77]. Such a study should transcend the current boundary that focuses entirely on either committees or the community perspectives on committees, and provide analysis of the interaction of both.

Thirdly, given the almost singular focus on committees, literature on other mechanisms such as facility/provider service charters and suggestion boxes is almost non-existent, yet in many cases these mechanisms are embedded within the broader committee operations and can as such be analysed as variables along other influencing factors.

Fourthly, considerable efforts have been put into providing theoretical frameworks that can guide studies on accountability, but there is relatively little information on their applicability in guiding empirical studies. Furthermore, the frameworks are inclined to view accountability from the perspective of western-democratic models that assume a liberal market and defined decision-making space for stakeholders in accountability. They are therefore of very limited utility to health systems operating in contexts such as SSA which have unique social, cultural, and political circumstances. Moreover, most of the studies have relied on descriptive qualitative methods, while failing to capture important aspects, such as socio-demographic information, that could provide rich data sets for elucidating why the mechanisms perform and produce the outcomes outlined. There is therefore a glaring need for mixed methodology

approaches sensitive to the context of the study which can explain the *how* and *why* of accountability. McCoy et al [77], argue for research designs that allow for the description and measurement of both process and outcomes, using mixed data sources in order to achieve reflection and analysis of the complex web of interactions in HSA and participation.

The research described in this thesis addresses these gaps in several ways:

Firstly, a special focus is placed on the role of process in accountability relations. The process analysis also distinguishes between 'intra-committee relations' and committee – community relations or 'inter-mechanism relations'. Specifically, the study examines internal dynamics of the HFCs (intra-committee relations), and the perspectives of facility users, allowing a comparison to be made across committees and facilities.

Secondly, the process analysis is augmented with quantitative data on the socio-demographic characteristics of survey respondents, providing a rich interface showing how individual socio-demographic characteristic combine with process factors to influence accountability relations in the study area. This analysis is currently lacking in the literature.

Finally, an integrated conceptual framework – developed from the literature on accountability frameworks above and as well as a pilot study - taking into account the structure, process, and outcomes of the mechanisms is used, allowing for a thick integration of mixed data sources and analysis. The integrated methodology is informed by the fact that whilst processes can be predicted to some extent, by their very nature, they are context-specific and likely to consist of local adaptation and variation. The framework, and its rationale, will be provided in the next chapter on methodology.

PART II
METHODOLOGY

CHAPTER 3
STUDY DESIGN AND METHODS

3.1 Introduction

This chapter covers the study design, study sites and methods for data collection and analysis. Section 3.2 on study design specifies the aims and objectives of the thesis, the conceptual framework is described, and the scope of the study defined. Section 3.3 covers the selection of study sites and their characteristics. In Section 3.4, methods for data collection and analysis are described, including ethical issues, and details of each data collection activity, and their analysis and timing.

The choice of these assessment methods was informed by the fact that accountability in the health care system is a very complex research issue, lacking a standard definition, and context specific. As highlighted in the literature review, the complexity of accountability has been identified as one of the main reasons that has discouraged research on accountability [12, 22]. It was therefore imperative for this study to employ innovative ways to overcome this weakness and to contribute to the development of research in this area. Thus, the study took the position that accountability in any setting is context specific and that its processes influence and are in turn influenced by the everyday ideas, opinions, practices, and cultures of the population including issues of power, trust, gender, and stakeholder positions. As such, they must be understood in context and as relational to structure and outcome issues.

3.2 Study Design

3.2.1 Aims and Objectives

The aim of this thesis is to analyse the factors that influence the performance and effectiveness of health system accountability (HSA) mechanisms on the delivery of primary health care (PHC) in Kericho District of Kenya.

Specific objectives are to:

1. Describe the range, nature, and composition of existing HSA mechanisms supporting primary care in peripheral health facilities in Kericho District of Kenya;
2. Analyse the perceived impact of the above mechanisms on PHC delivery through an assessment of their depth of engagement, responsiveness, and impact on PHC services;

3. Examine the key factors that influence the performance of the above mechanisms with a focus on the role of process; and to
4. Identify policy options for improving HSA at the peripheral level.

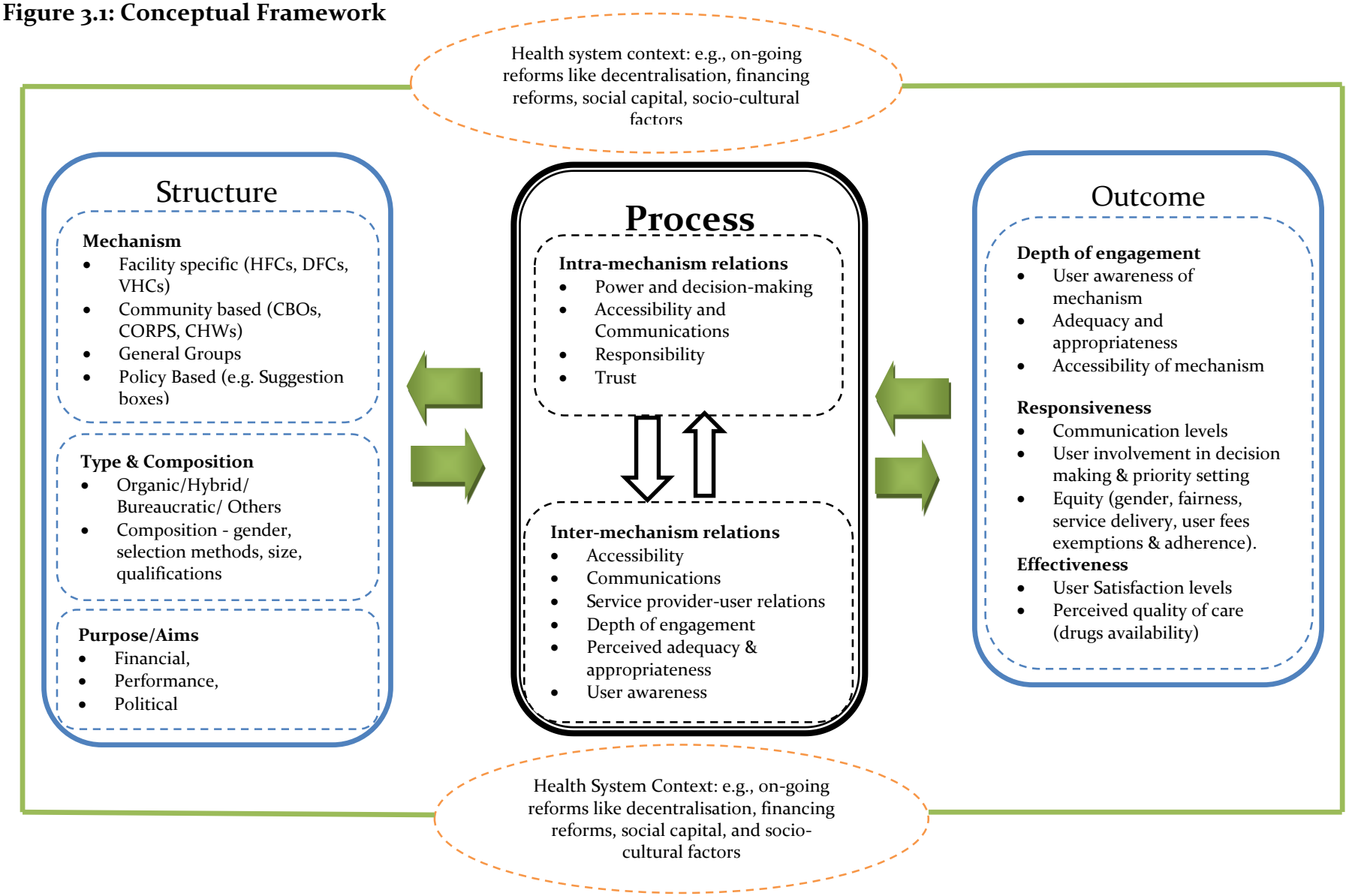
3.2.2 Conceptual Framework

The conceptual framework to guide the study is presented in Figure 3.1. The framework is an attempt to create a multidisciplinary approach, benefiting firstly from a triangulation[6] of distinct but interrelated theories presented in Chapter 2, and secondly from a pilot study conducted specifically to contextualise the study tools in order to suit the overall study objectives. A key element of the framework is its departure from the current pattern in the literature that looks at HSA structure, process, and outcomes issues as distinct.

The framework developed, and used here, considers the three as interconnected, and as based on reinforcing interrelationships not just between the three elements, but also between the various stakeholders in HSA mechanisms. In developing this framework, the idea was to create an over-arching framework for analysis that takes the kernel from theory and uses it to develop a way of understanding the complex concepts and practice of accountability and engagement in the health system [117, 123, 124]. The approach does not deny the 'rich universe of the theories, arguments and debates that exist in the theories' [117:4]. Instead, the framework contributes to the theoretical developments in HSA, by offering a chance for an analysis of HSA that takes into consideration its complexity, non-linear nature and context-specific nature without trying to assume a theoretical prerogative of truth or superiority over other approaches.

[6] Triangulation refers to finding patterns of convergence by comparing result across multiple sources of evidence, across methodological approaches, with theory, in this case the literature review and the pilot study data. Adopted from 119. Gilson, L., ed. *Health Policy and Systems Research: A Methodology Reader*. 2012, Alliance for Health Policy and Systems Research, World Health Organization: Geneva.

Figure 3.1: Conceptual Framework



In order to facilitate engagement and accountability, it is envisaged that the health system will require **structures or mechanisms** that provide an organisational framework of activities [124-127]. These structures or mechanisms could take the form of: health facility committees (HFCs), community based organisations (CBOs) whose aims may be health-specific or development-oriented with health as one of the core areas of concern, general development groups like women groups, health interests groups, or NGOs [128]. The mechanisms could also take the form of governmental or community initiated legislative or policy instruments like suggestion boxes (SBs), patients' rights charters (PRCs), provider exit surveys, or score cards [92]. The aim is to identify the existing structures in the area of study through a mapping exercise, to describe the forms, types and composition that they take, and finally to analyse their aims, purposes and objectives and how these feed into or overlap with the health system goals as defined by the Kenya government's community strategy for health [33].

Linked closely to structures or mechanisms are the **processes** that sustain or are sustained by the processes themselves. These are the activities themselves, interaction between facility staff and activities, and between staff and users. Analysis of the process issues will be interwoven with an exploration of which actors are involved, and how far each may be exerting influence on policy (decision-making) [22, 117, 129]. This is because processes do not have a life of their own, but are dependent on actors to give them expression [117, 124, 129-131]. Process analysis is also important in order to identify issues of trust, power relations and mechanism capacities to enhance or hinder fair and equitable participation among the various health system actors [14, 119, 123, 132-134]. Thus, several issues come to fore: accessibility as defined by the level of use of facility by different population groups; adequacy and appropriateness; quality of relationship within the mechanisms; communications between HWs and community representatives, HWs and patients; plans and procedures followed and their documentation. Process is envisaged to be particularly central to this study because effects of interventions do not solely depend on the inputs; how they are administered is important too [123, 129, 135-138].

The final part of the framework facilitates an assessment of **outcomes** of accountability and engagement mechanisms and processes. 'Outcomes' relates to

effectiveness, efficiency and equity. Of interest are issues like the responsiveness of the health professionals to client needs and concerns 'measured' in terms of the improvements on facility structure and consultation times, fee waivers and adherence to official policy on out-of-pocket charges, regularity of mechanism meetings, financial accountability, and trust-building between the community and their representatives, community representatives and the HWs, and HWs and the community. 'Outcomes' such as user satisfaction levels with services offered at the facilities depend on process outputs [125, 139-141]. Because an exclusive assessment of outcomes can only ever provide a partial snapshot view of HSA in practice, it is important to locate them within an interactive model that takes into account process factors.

Engagement and accountability structures, processes and their outcomes are not stand-alone health system variables. They are anchored in the broader **health system milieu** within which various policy interventions are mediated [12, 142]. Health systems worldwide operate within a context which often shapes policy, and is in turn shaped by policy outcomes [143, 144]. It is envisaged that the engagement structures or mechanisms will be products both of various policy options taken within the broader context of health system reforms in Kenya, and also of the sociocultural context within which they are implemented. With this in mind, it will be important to place HSA processes within this broader context, and view their outcomes as products, not just of specific peripheral facility structures and processes, but also of broader local, national and international reform processes [12, 144-148]. Therefore, the framework does not oversimplify the complex issues, concepts and practice of HSA. Structure, process, and outcomes are not linear processes that can be disentangled and causality ascertained as portrayed in most studies [77]. That is why it is envisaged that structural- process-outcome issues will feed into each other within a system-wide arena with back and forth feedback loop.

3.2.3 Defining the Scope of the Study

The analysis addresses the link between HSA mechanisms and PHC. The main focus is on the dynamics informing the performance of the accountability mechanisms – mainly the health facility committees (HFCs), but as HFCs are only the overall umbrella structure that brings together other mechanisms, such as facility service

charters (SCs), and the local administrative forum (the *Baraza*), a comprehensive analysis of HSA performance in this area must consider all these important factors influencing PHC delivery. The thesis aims to assess the processes that give or are given meaning by the direct interactions between HFC members themselves and with patients (the community), rather than between HFCs and household[7] heads, without losing grip of the cultural context.

3.3 Study Sites

3.3.1 Study Site Selection

Several factors informed the choice of Kericho District for this study. The main goal was to find a setting that would be ideal for assessing the performance of HSA mechanisms in supporting PHC delivery. Kericho district was chosen because:

- It has a high disease burden, especially for those diseases targeted under KEPH i.e., malaria, HIV and AIDS, and TB [149]. Malaria transmission is stable throughout the year but peaks during the wet season. HIV/AIDS rates are fairly high among the population, given the high rates of labour migrants and interaction due to tea growing companies in the area. It is one of the districts in Kenya with a high TB burden. A combination of these factors means that the rural population here would rely to a great degree and perhaps more frequently than usual on the local health facilities to meet their health needs. This frequent interaction provides an excellent context within which to assess the performance of HSA mechanisms in terms of their performance and impact on services provided.

- The district has high poverty levels, with over 44% of the population living below the absolute poverty level. Ideally one would expect HSA mechanisms to promote equity (of access and costs) and to shield the poor and the vulnerable from the extremes of care costs. Given that the study was interested in assessing the factors impacting on the performance of these mechanisms through the angle of equity, efficiency, and overall effectiveness, these dynamics make Kericho an ideal study location.

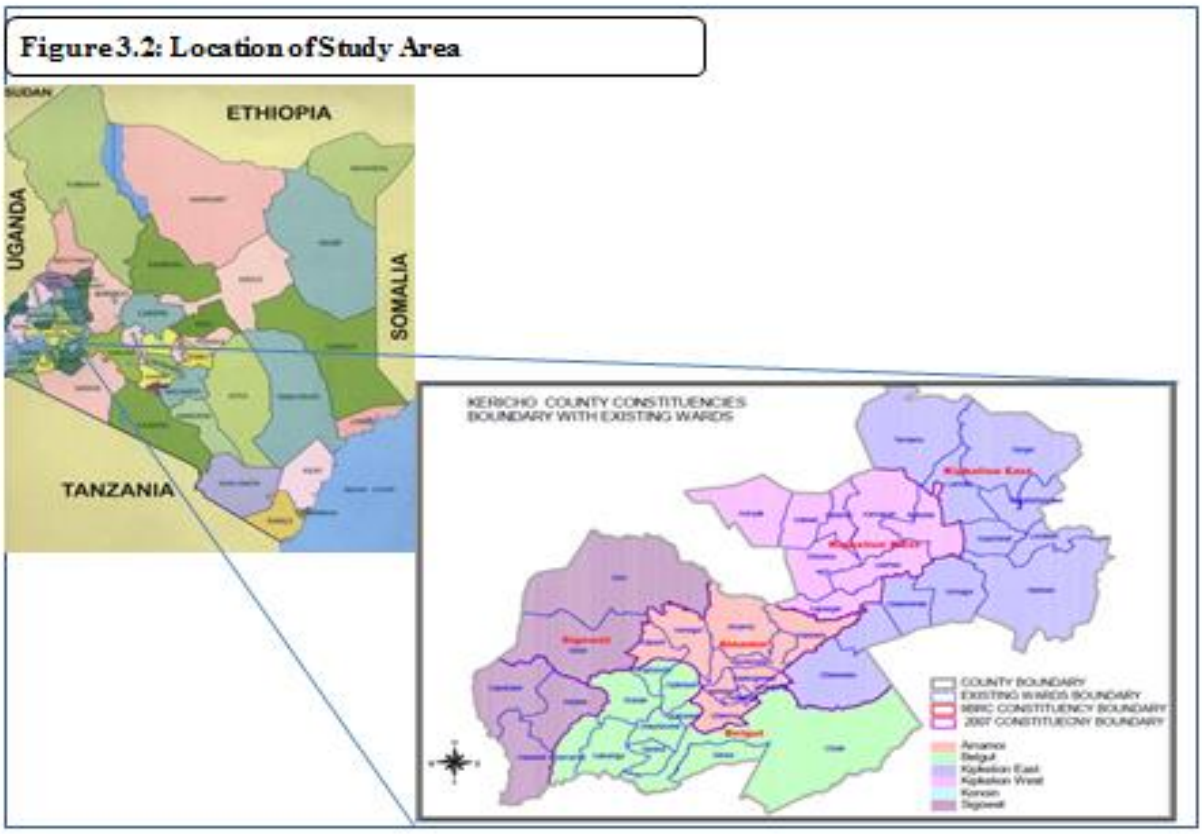
[7] Household is used throughout the thesis to mean a group of persons living in the same area, who are answerable to the same head and share a common source of food and/or income.

- Thirdly, the study aimed to understand the factors impacting on the performance of HSA mechanisms in a setting with little or no external interventions, such as those by NGO and or private-public partnerships that could influence intervening variables in the performance of HSA mechanisms. Kericho district offered this context given that there were no external interventions that directly targeted the health centres chosen for the study when the fieldwork for the pilot and the main surveys were done.

- Lastly, even though the study does not aim to provide generalisable conclusions for the rest of Kenya, the area chosen for this study is typical of most of rural Kenya and SSA, albeit with marked cultural differences. The findings of the study are therefore likely to be representative of most of rural Kenya and to an extent SSA, where there are socio-demographic and health systems similarities.

3.3.2 Characteristics of the Study District

The study was conducted in Kericho district of Kenya (Figure 3.2) The district has an estimated population of 758,339 (50% male, 50% female), distributed in 160,134 households with a density of 306 per square kilometre, over an area of 2,479 square kilometres [150]. The population is predominantly Kipsigis, a sub-group of the Kalenjin ethnic group. The main occupation is small-scale agriculture, which is estimated to contribute 80% of all household income. Most families grow maize and keep cattle for subsistence, while some grow tea for sale. Poverty levels are relatively high with 44.2% of the population estimated to be living below the absolute poverty line. The most affected categories are unemployed youth, women, members of female-headed households, children, and the landless [26]. Poverty data are important to the study given that the HSA mechanisms are expected to cushion the poor and vulnerable groups from adverse effects of care costs, which have been identified as one of the major causes of poverty [26, 151-160].



Source: [161]

A mix of private and government health centres and dispensaries serve the district. Currently, there are 29 government-owned facilities (nine health centres, one district hospital, and nineteen dispensaries). The district hospital – Kericho District Hospital – is located in the town of Kericho and also serves as the nearest referral facility [162].

The key health indicators (the most recent data) for the district are summarised in Table 3.1 and survey data on illness and morbidity from the study area are provided in Table A2, Appendix of Tables. Data from the survey on illness and morbidity in the study area reflect a general trend across Kenya and some other parts of SSA. Malaria was the most commonly reported illness (44%) of all reported cases, followed by Acute Respiratory Illnesses (ARI) at 27.6% (household survey April –May 2011). There were no significant variations across the four study clusters. The high rates of malaria and ARI are partly explained by the fact that fieldwork was done during a rainy season, a time when households are general exposed to these infections due to a rise in mosquito breeding and the effects of change in weather on ARI (among other predisposing

factors). Illness and morbidity data were verified by checking patients' records (books held by patients where diagnoses are reported).

Table 3.1: Kericho District Key Health Indicators Compared to National Indicators

Indicator	Kericho District (Estimate period)	Kenya (Estimate Period)
Crude birth rate (CBR)	-*	32.1/1000 (2012)
Crude death rate (CDR)	-*	7.9/1000 (2012)
Life expectancy	-*	62.2 years (2012)
Infant mortality rate	35/1000 (2012)	47.7/1000 (2012)
Under five mortality rate	100/1000 (2012)	74/1000 (2009)
Total fertility rate	4.7 (2012)	3.97 (2012)
Doctor / patient ratio	1/15,000 (2012)	2.3/15,000 (2012)

Data Source: [25]
*data not available

3.3.3 Characteristics of the Study Facilities

The main characteristics of the facilities reported in this study are provided in Table 3.2. Respondents for the study were drawn from catchment areas of four public/government owned health centres, referred to throughout this thesis, for purposes of anonymity, as FA, FB, FC, and FD. Generally, all the facilities were understaffed, with FA and FC operating without a clinician or Officer-In-Charge (FI) (as normally required by government regulations). The facilities were instead manned by Kenya registered nurses, although at the time of the survey the District Medical Officer of Health (DMOH) informed the researcher that plans were underway to send qualified clinicians to the two facilities. Compared to the rest of the facilities, FA served a large number of population spread over a larger area. All the facilities provided basic PHC services with FA providing some limited inpatient services.

The facility and study area characteristics described here, are, on the whole, representative of most rural primary care establishment in Kenya. As already noted in the background section, health centres and dispensaries are the first point of contact for primary care services in most of rural Kenya and by extension most of SSA. The problems of poverty, gender inequality, burden of disease (especially malaria, HIV/AIDS, TB and ARIs), HWs shortage, accessibility, user fee charges, and corruption are not unique to the study area. Therefore, even though the experiences of HSA and

engagement presented in this study are a product of the data gathered in Kericho District, there are marked similarities that are likely to be representative of many rural areas in Kenya, SSA, and LMIC.

Table 3.2: Summary of Key Facility Indicators/Characteristics

Selected Facility Indicators	Health Centre/Facility			
	Facility A (FA)	Facility B (FB)	Facility C (FC)	Facility D (FD)
Demographics				
• Male	70,000-75,000	32,000-37,000	29,000-34,000	28,000-33,000
• Female	66,000-71,000	29,000-34,000	30,000-35,000	28,000-33,000
• Total	136,000-146,000	61,000-71,000	59,000-69,000	56,000-66,000
• Area (Sq. Km.)	240-245	220-230	175-185	110-120
• Density per Square Km.	550-650	300-320	375-400	580-600
Number of staff per category				
• Clinical officers (FI)	0	1	0	1
• Kenya Registered Nurses	4	6	2	6
• Public Health Officers	2	1	1	2
• VCT Counsellors	3	1	2	4
• Support staff	4	5	2	5
• Total	13	14	2	18
Services offered at facility				
• Outpatient curative	Yes	Yes	Yes	Yes
• In-Patient	Limited	No	No	No
• Laboratory	Yes	Yes	Yes	Yes
• Deliveries	Yes	Yes	Yes	Yes
• Voluntary counselling & testing	Yes	Yes	Yes	Yes
• Prevention of mother-to-child-transmission	Yes	Yes	Yes	Yes
• Antiretroviral therapy (ART)	Yes	Yes	Yes	Yes
• Insecticide treated bed nets (ITNS)	Yes	Yes	Yes	Yes
Average monthly outpatient attendance				
• Under 5s	853	306	712	725
• Over 5s	1,890	688	1,686	1,874
• Total	2,743	994	2,398	2,599
HSA mechanisms present at facility				
• Health facility committee (HFC)	Yes	Yes	Yes	Yes
• Suggestion Box (SB)	No	No	Yes	No
• Patients Rights' Charter (PRC)	No	Yes	No	No
• Facility Service Charter (SC)	Yes	Yes	Yes	Yes
• Community Health Worker (CHW)	No	No	Yes	No

Data sources: Demographics - Kericho District Statistics Office;
All other - Household Survey April – May 2011

3.4 Methods for Data Collection and Analysis

3.4.1 Overview of Data Collection

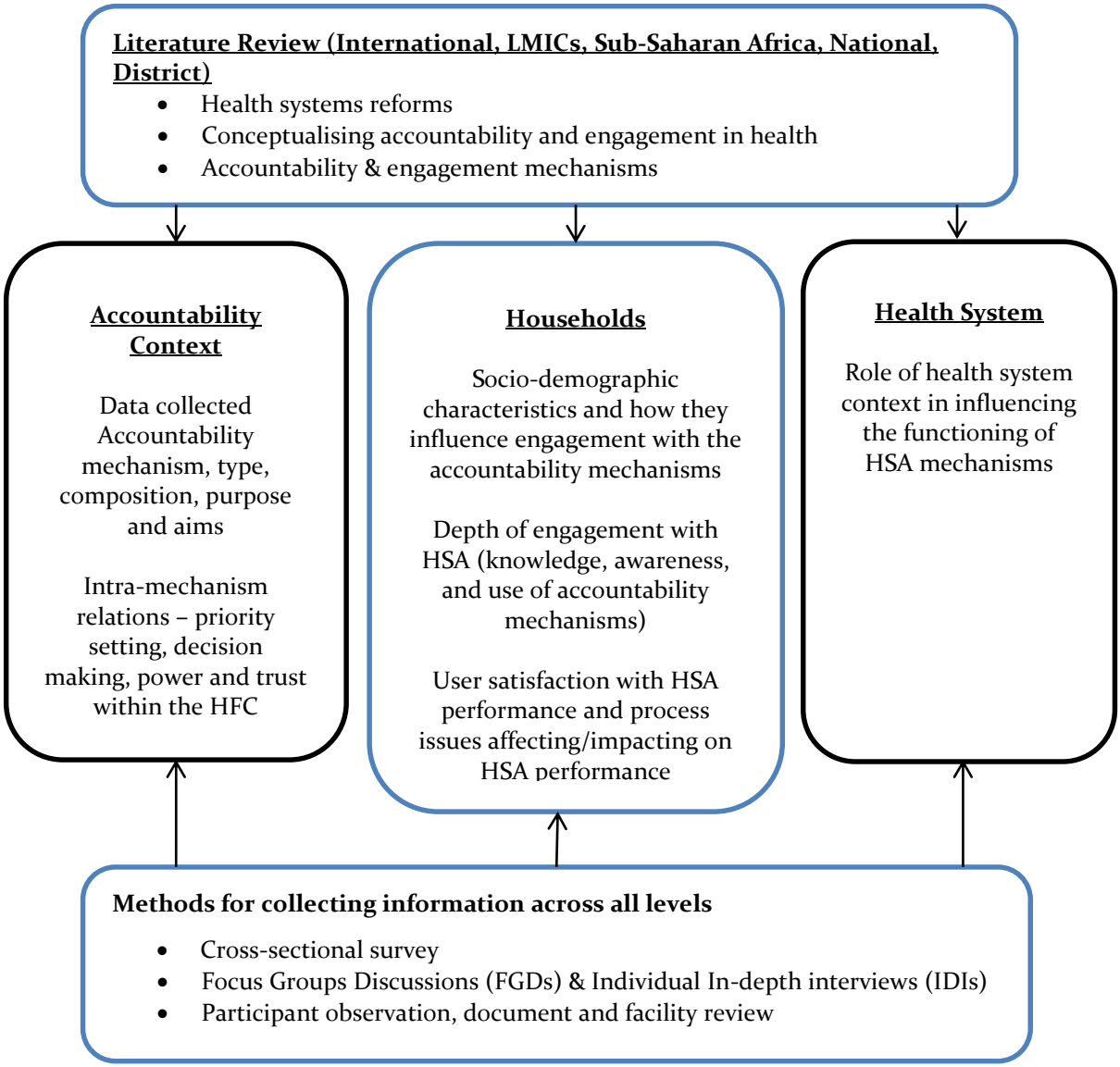
Due to the limited amount of previous work on processes underlying accountability mechanisms, and on factors associated with their awareness, it became imperative to employ a wider range of data collection tools (Figure 3.3). Furthermore, a broad range

of quantitative and qualitative methods were employed, as these have been shown to be important in providing better understanding of the unique experiences of both users and providers [125, 144, 163], getting rich data that can help illuminate complex accountability relationships [77, 164], and in capturing different dimensions of the central phenomenon of focus [165].

The study thus adopted an 'innovative strategy that combined different perspectives, quantitative and qualitative methodologies while at the same time respecting the distinct branches of philosophical thought from which they are derived' [126:141]. Data were collected from households and health facilities within the four cluster areas. Facility users' data were collected through a cross-sectional household survey using multiple data collection tools. The use of mixed methods offered a chance for triangulation, which has been shown to reduce weaknesses associated with one specific method [119]. For this study, the use of qualitative techniques (in-depth interviews, group discussions, and key informant interviews), participatory research (attending committee meetings and observing HWs-client interaction), photography, and document analysis provided a rich context on the 'how' and 'why' of the performance of accountability mechanisms. On the other hand, survey methods provided statistically representative data on the study population, thus improving reliability [126]. However, it is the bringing together of the multiple methods, through triangulation, that proved to be a powerful tool, permitting a yield of different types of information about HSA in Kericho District.

Data collection instruments were drafted in English, translated into Kiswahili with the support of a language expert at APHRC and native speakers, and piloted in exit patient surveys in two of the four facilities finally included in the survey (facilities FA & FC). All interviews were conducted in Kiswahili and English where the respondents could understand English. A few interviews were conducted in the local language – Kipsigis – for respondents who could not understand Kiswahili or English. English versions of all data collection instruments are contained in Annex 4. All data collection activities were designed and managed by the author. The data for this thesis were collected between November 2010 and May 2011.

Figure 3.3: Summary of Data Collection Activities



3.4.2 Training of the Research Team

The survey was conducted by the researcher with the help of five research assistants (RAs) - three recruited from the locality of the study and two graduate research interns recruited by the African Population & Health Research Center (APHRC). Of the five RAs, (four male and one female), only one male helped during the pilot and was specifically recruited due to his knowledge of the area and linguistic skills (to help with translation in the rare cases where the respondent could not speak Swahili or English). The other four helped during the survey and two of them - one male and one female - were recruited due to their knowledge of the area and ability to conduct interviews with female respondents (specifically the female RA), who could have been uncomfortable talking to male researchers.

The RAs received two weeks intensive training on the contents of the questionnaires and techniques for achieving scientific validity and trustworthiness of the data [165] by establishing a rapport with the respondents while maintaining the neutrality essential to obtaining the most accurate data possible. Specific topics covered included introduction to research, background and aims of the study, basic communication skills, how to introduce the work, informed consent, giving constructive feedback, data collection, mapping, expected problems and their solutions, how to complete the questionnaire and other basic field work information. The training was participatory, consisting of role-playing and practice sessions aimed at ensuring that the RAs fully understood their role and that they were able to complete the data collection tools without any difficulties. The researcher not only supervised the RAs throughout the research period but also carried out a substantial number of interviews as a quality control mechanism.

3.4.3 Establishing Rapport with the Community

Prior to the start of the main study, the author led the research team in establishing contact with the community, a process that involved seeking clearance from the district administration (the DMOH, Division Officer, local Chiefs and community[8] leaders) (See Annex 3, A3.4-3.6). This exercise involved providing these key individuals in the community with detailed information pertaining to the nature of the research, its potential benefits to the community, and what help the research team would need. In this regard, the pilot exercise carried out earlier in November 2010 proved very useful, as the few community members interviewed at the pilot carried on with the discussions at the household level. We later discovered that this took place with a 'sense of relief and in a new discursive space', whereby facility issues that were hitherto considered too sensitive or sacrosanct to the health workers (HWs) were discussed. For this reason, the research team found the ground fertile and receptive.

[8] Community is used in the thesis to refer to a specific group of people usually living in a common geographical area, who share a common culture, are arranged in a social structure and exhibit some awareness of their identity as a group. This definition is adopted from 166. Allman D, M.T., Cockerill R, *Concepts, definitions and models for community-based HIV prevention research in Canada, and a planning guide for the development of community-based HIV prevention research*, 1997, Faculty of Medicine, University of Toronto: Toronto.

Getting to know the community also proved vital in that it helped develop a sense of ownership among community members. This was different to previous research activities in the area such as those conducted by government agencies. This exercise, made the community feel that their views were important given that their consent was sought before the interviews and the study was conducted by one of their own. In the end, the local administration gave the research team a group of community leaders to take the team around, and in many cases individual households volunteered on their own to help the team find their way around the community and to introduce the team to the next household, thereby reducing the time taken to conduct the survey and establishing an excellent research environment where individuals opened up and discussed the research questions freely. Finally, involving the community in the planning and promotion of the study was useful in generating findings that are relevant and reliable.

3.4.4 Ethical Clearance and Informed Consent

Ethical approval for the study was obtained from the institutional review committee of APHRC (approval reference HSC/2010/59), the ethics review committees of the Kenya Medical Research Institute (authorization reference KEMRI/RES/7/3/1 PROTOCOL NO.247), the National Science and Technology Commission (permit number NCST/RR1/12/1/MED/222/4), all provided in Annex 3. The research team visited the households and health facilities sampled for each data collection activity to inform them about the study, deliver a letter of invitation, and make an appointment for the survey where it was necessary. Village Elders (VE) and staff of the District Health Management Team (DHMT) were also informed.

Before the start of all interviews, the interviewee was read an information sheet explaining the purpose of the research, the institutions involved, the nature of their requested participation, and given the opportunity to ask questions. It was emphasised that the information collected would be confidential and in health facilities, that no individual details would be passed on to district authorities. Written consent was obtained from all interviewees (household, community HFC members, and KIs) or, where one could not sign, a thumbprint was taken or a nominated close relative signed on their behalf. Consent was also sought specifically for the use of tape recorders

during qualitative interviews. Care has been taken in the presentation of results to avoid identification of any specific health facilities or individuals, unless where consent was specifically obtained, especially where data or pictures have been attributed to particular individuals or facilities.

3.4.5 The Pilot

In mixed methods studies, a pilot study can be used to develop detailed understanding of a phenomenon which is then followed by a large scale structured survey to generate more extensive understanding of the same phenomenon [165]. Thus, a pilot study was conducted in November 2010 in order to help develop a conceptual framework to guide the main study and to help refine data collection tools, including getting data for the calculation of sample size for the main household survey. The pilot took two weeks and was conducted by the researcher with the aid of a locally trained and experienced RA who had been involved in several studies in the area before. The pilot involved a survey of two facilities: one considered a poor performer and the other a good performer based on the recommendations of the DMOH. During the pilot, in-depth interviews were conducted with 20 randomly selected patients (10 male and 10 female, 5 per facility) using a semi-structured questionnaire.

Following the literature review presented in Chapter 2 that identified key gaps in the knowledge on accountability, especially in the place of process in informing the performance of accountability mechanisms in rural and resource-scarce settings, it was important to adopt innovative methodologies that could help explore this complex and research sensitive issue [12], while at the same time enabling the collection of insightful and rich data that could help in the design stages of the questionnaires for the main household survey. Qualitative approaches have been shown to have great potential in capturing contextual issues (form and nature of HSA), in being explanatory (reasons for or associations between various variables interacting to inform the performance of accountability mechanisms), in offering flexibility for assessment (appraising the effectiveness of the mechanisms), and in being generative (aiding the development of theories, strategies, or actions for understanding accountability in the health system) [126, 165, 167, 168].

For these reasons the pilot adopted a more qualitative approach, using semi-structured questionnaires enabling the study to 'unpack' what accountability meant for users in this community, how key stakeholders (the DMOH, HFCs members, and HWs) understood their roles within the health system. Respondents were allowed to describe and display issues of accountability and service delivery as they experienced them, in detail and in their own terms. The data were then analysed by the researcher using a thematic approach following a path of familiarisation with the data, construction of a preliminary coding scheme, followed by manual qualitative content analysis and interpretation using a method adopted from Graneheim and Lundman [1]. After initial open coding, each code was examined in great detail, the coding scheme was refined, and finally codes were grouped under key themes which were then used to develop the tools for the main household survey in April-May 2011 (see Table A1, Appendix of Tables). The analysis also benefited from feedback received on a presentation made at an international conference.[9]

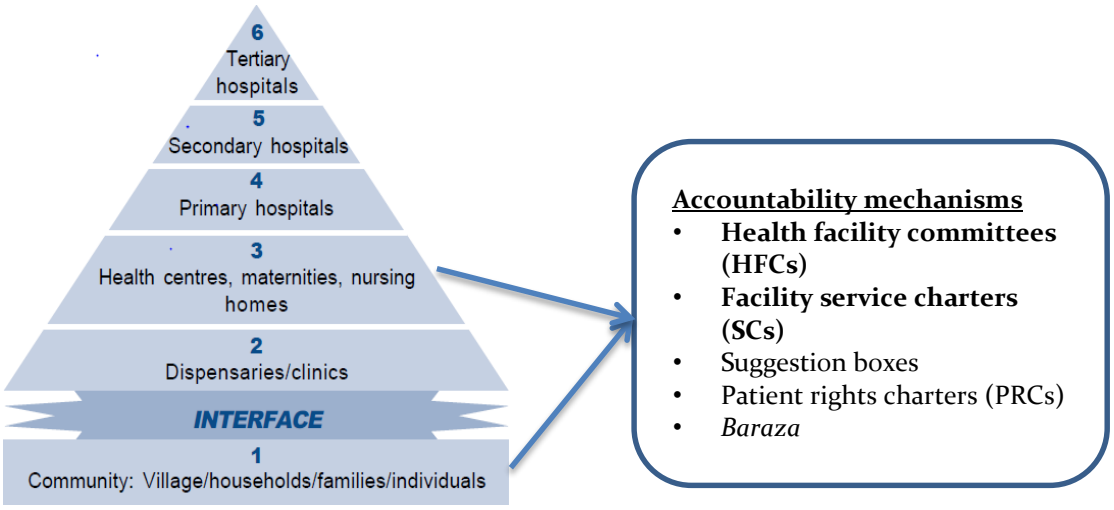
Following the pilot and literature review, particularly on conceptions of accountability, the following variables were derived for assessing the HSA in Kericho district:

- HFC responsiveness (HFCs priorities vis-à-vis user's priorities)
- Health seeking behaviour (HSB)
- Equity (user fee adherence, waivers)
- Quality of care given (whether users were given drugs on payment of prescribed user fees, were required to buy additional treatment items outside the facility, were satisfied with the care given).
- Depth of engagement (knowledge/awareness of HFC – selection method, HFC work, knowledge of any HFC member, choice of redress mechanism – HFC vs. non-HFC, and reasons for these choices, HFC communication with facility users).
- Experience with facility service charter (SC) - whether user had read the SC, and, if so, whether the information on the SC was useful or not and why.
- Other (financial accountability – whether a facility issues receipts on user fee payment or not).

[9] The results of the pilot were presented as a poster at the Royal Society of Hygiene and Tropical Medicine research in progress conference held in London in December 2010.

To build a robust assessment tool, the study augmented the context specific accountability assessment tools with the recommendations made by the most recent literature reviews in the area [77-79, 139]. In the end, the pilot proved a useful tool for involving the community in the planning and promotion of the larger survey. It provided evidence that is relevant and reliable since the researcher took an open-minded approach concerning which questions were worth addressing, which aspects of HSA merited assessment, and what health outcomes were important in the study area [169]. It also acted as a mapping exercise by which two HSA mechanisms (HFCs and SCs) present in all the HFs in the study district were identified for further investigation in the main survey, and those present in fewer than four facilities (SBs and PRCs) dropped from the questionnaire (see Figure 3.4 below).

Figure 3.4: Accountability Mechanisms Selected and the Health System Level Where They Operate



Source: Government of Kenya [32] and Pilot Study, November 2010

3.4.6 Household Survey

The household survey was based on a total sample of 1024 respondents from randomly selected households drawn from the Kericho District database. The sample was stratified by health facility catchment area, and 256 respondents were selected, from each the catchment areas of the four health centres, i.e., FA, FB, FC, and FD.

The sample size was determined using the following formula:

$n = (z^2)\ (r)\ (1\text{-}r)\ (f)\ (k)/\ (p)\ (\tilde{n})\ (e^2)$ where:

z = confidence level, which was set at 1.96 in order to achieve a 95% reliability in the results;

r = prevalence/awareness of health accountability mechanisms, was set at 40% based on pilot results for awareness of HFCs;

k = non-response rate, set at 15% to represent a conservative value;

$\tilde{n}$ = average cluster size, set at 4, based on most recent Kenya Health and Demographic Survey (KHDS);

f = design effect, set at 1.5

p = probability, representing the proportion of the total population accounted for by the target population and upon which the parameter, r, is based, and was set at 1;

e = margin of error (%), pegged at 10% for enhanced reliability.

Thus sample size n = $(1.96^2 \times 0.4 \times 0.6 \times 1.5 \times 0.15) / (1 \times 4 \times 0.4^2) = 254.22$ adjusted to 256 households per catchment area.[10]

Households in which one or more members were not present were revisited three times. Households that had closed, declined participation, or in which individuals were not present on a third visit were replaced. The interview was conducted using a structured questionnaire. The design and wording were informed by previous quantitative and qualitative work on accountability generally, survey work going on at APHRC, and the KHDS of 2008 [26]. The survey questionnaire was administered face-to-face to any household member who was 16 years and above and had lived in the area for at least six months. The questionnaire was divided into five parts.

- Part 1 of the questionnaire covered socio-demographic variables, including: household membership; gender; age; marital status; education level; and main economic activity.

- Part II covered household morbidity and HSB including: illness experienced in the last six months; whether and/ or where treatment was sought; main reasons for choice of provider and treatment type; whether respondents received medication or not; treatment outcome; and distance to nearest health facility.

- Part III covered financial accountability including: whether respondents paid any user fees for the service; if yes, how much; and if they were not charged, why;

[10] Households were used primarily as a means to reach the target population, i.e. individual respondents, and were not the subject of interest as such, given that the study was interested in personal experiences with the health system.

whether they were issued with a receipt or not on payment; whether they asked for a receipt if one was not issued and what response they received; respondents awareness of user fee setting and usage at the facility.

- Part IV covered knowledge and awareness of various HSA mechanisms (HFCs, SCs, *Baraza*, local chief). Respondents were asked: whether they were aware of the HFC; whether they knew any HFC member (not necessarily by name); how HFC members were selected; the role of HFCs; and whether they had approached any HFC member with any facility issue. On SC, respondents were asked: whether they had seen one at the local health centre; whether they had read it; whether they found it useful; and why they thought it useful or not.

- Part V of the questionnaire addressed user experiences with HSA in their area. Respondents were asked: what they would do in case they experienced a problem at the HF; which authority/HSA mechanism they would approach; and who would be their first choice in dealing with facility issues and why. Based on a Likert scale, respondents were also asked to rate generally their satisfaction levels with the services received at the local facility and to give reasons for their answers. Finally, respondents were asked what they thought the main priorities for the facility should be.

The survey returned a 100% response rate (1024 respondents) due to the replacement and the community involvement strategies adopted. However, five questionnaires from respondents clustered around FB were discarded due to incomplete information. The analysis presented thus consists of 1019 questionnaires (Table A2, Appendix of Tables). Basic data on household and individual characteristics of respondents are reported in Chapter 4.

The survey method was chosen as most appropriate for collecting the data above because it allowed for data collection in a natural setting through face-to-face interviews. Moreover, the sampling technique involved enables statistical inferences to be made in regards to the broader population and allows generalisations to be made, thereby increasing the external validity of the study [126, 140, 170, 171]. The survey method was also most appropriate because it is cost and time effective. The flexible

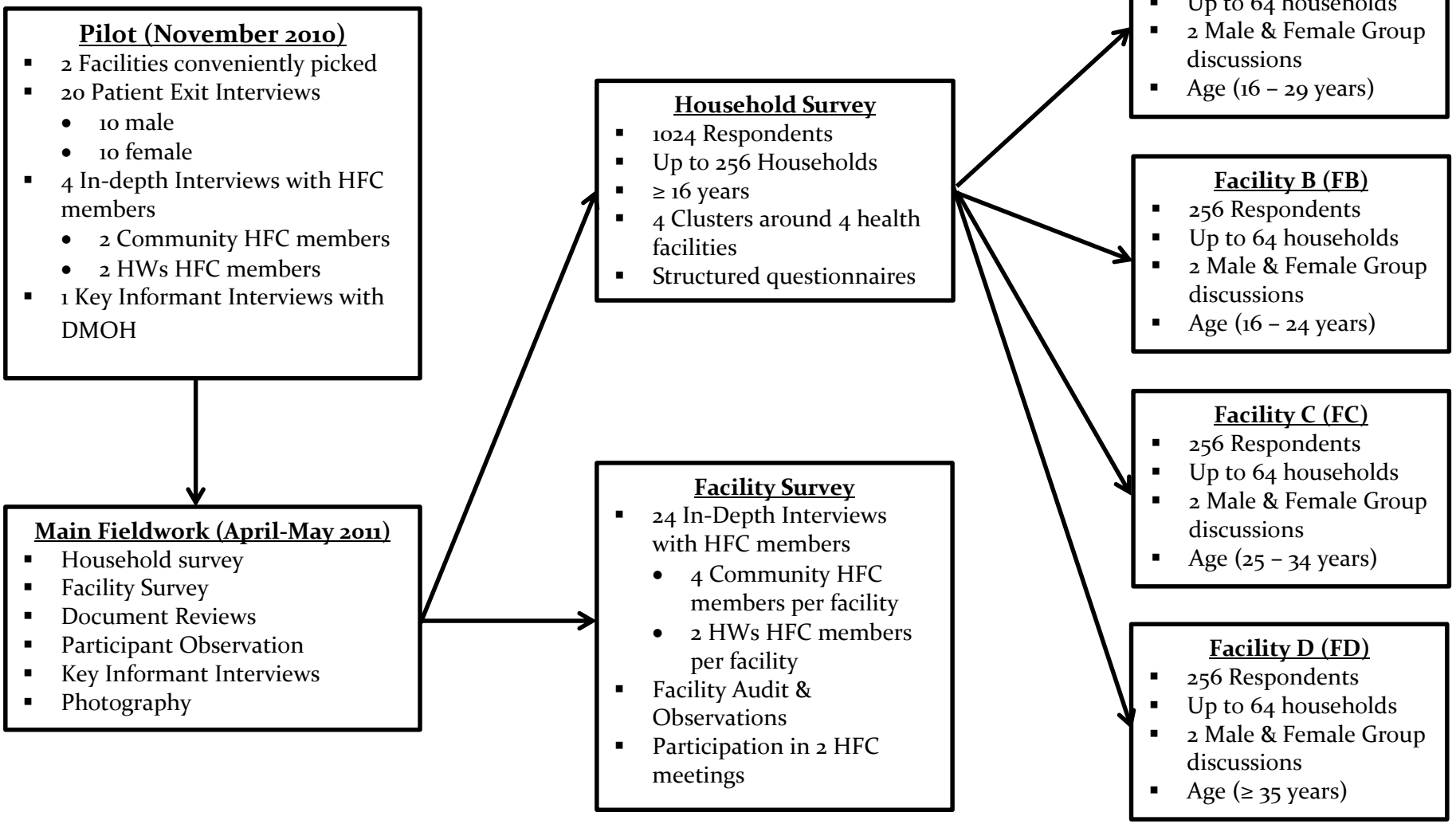
nature of face-to-face interviews ensured that even illiterate respondents could have their voices heard, allowed for clarification of questions where necessary, and allowed for the rephrasing of a question if problematic. Moreover, it helped in establishing trust, thus encouraging participation in the survey.

In order to overcome the disadvantages associated with the face-to-face method of collecting data during the survey, such as interviewer bias influencing data collected, the effect of interviewer-interviewee interaction, and unwillingness to open up by interviewees due to fear of lack of anonymity, the researcher took several measures.

a. RAs received intensive training as described above.
b. Field tools were piloted to ensure RAs mastered interview techniques and captured the best data possible.
c. The author shadowed the RAs in rotation during the initial interviews to make sure they were doing the right thing and, where necessary, provided positive feedback to ensure improvement.

The community was fully informed of the aims and objectives of the study and, as far as possible, their ownership encouraged before the survey began. Strict confidentiality and anonymity was emphasised and the voluntary aspect of the study underlined. Figure 3.5 is a summary of these activities and Figure 3.6 is a pictorial account of the research activities.

Figure 3.5: Summary of Research Process and Activities



Figures 3.6 A-C: Research Assistants Administering Household Survey Questionnaires

A

B

Figure 3.6 D: Research Team at Work

C

D

Figure 3.6 E: Typical Health Centre

E

Figure 3.6 F: The Researcher in the Field

F

3.4.7 Semi-Structured Qualitative HFCs and Provider Interviews

Qualitative interviews have been shown to be useful in gathering information set within the context of personal experience, where issues being investigated are complex and require detailed exploration [172]. Therefore, a number of semi-structured in-depth interviews (IDI) were conducted with community members, health facility administrative staff, and HWs who were members of the HFCs, based on an ontological approach most closely to what has been described as 'subtle realism' [130, 173].[11] The interviews were done with two main objectives. Firstly (in reference to the first four IDIs done during the pilot), they informed the design of the main survey done in April-May 2011, by generating hypotheses for quantitative investigation, providing background information for the HFC audit methodology, and identifying the most appropriate and comprehensible wording to use. Secondly, they facilitated generation of in-depth personal and subjective perceptions. Accounts of members of the HSA structures enabled exploration of accountability relations in depth and detail, and the exploration of sensitive and complex accountability and engagement processes and issues especially around power, trust and status, which are not readily addressed using quantitative methods [172, 174].

A sample of 24 HFCs members was selected purposively, stratified by health facility, i.e. 6 per facility. The 24 interviewees were selected to capture the diversity within the HFCs, such that all the four main accountability stakeholders within the HFCs were represented, i.e. community representatives, representatives of the local administration (mainly the chiefs or their assistants), and HWs representatives. Moreover, based on the literature review and the pilot in November 2010, female members of the HFCs were also interviewed to capture gender perspectives and to understand the depth of their voice within the HFC decision-making structures, given that women are the majority clients at the HFs. Finally, two key informant interviews were carried out with the district health administrator and the DMOH in order to

[11] Subtle realism, accept that the social world does exist independently of individual subjective understanding, but that it is only accessible to us via the respondent's interpretations, which may then be subject to researcher's further interpretation. It acknowledges that respondent's different vantage points will yield different types of understanding, which does not negate the existence of an existence of an external reality which can be 'captured. A subtle realist approach thus takes the view that external reality is itself diverse and multifaceted and it is this diversity of perspectives that adds richness to our understanding of the various ways in which reality has been experienced. The aim thus, is to apprehend, and convey, a whole picture as possible of the nature of that multifaceted reality [130, 173].

bring in the health system context as outlined in the conceptual framework. A full description of the HFCs is provided in Chapter 4.

The author and four RAs visited each health facility in April-May 2011. The interviews took between 45 minutes and 2 hours. Following each interview, the research team held a debrief session to discuss the issues raised, impressions about the interviewee's attitude and behaviour, and any responses needing clarification, which in some cases necessitated repeat visits or phone calls. Between interviews, some minor changes were made to the interview guide in order to make the questions clearer and to incorporate new areas of discussion or to remove unfruitful ones. The author then initiated informal analysis of the interview data through the drafting of memos to summarise important findings, emerging themes, and research questions and hypotheses.

The interviews were tape-recorded, fully transcribed in Kiswahili, translated into English, and the translations checked against the original Kiswahili manuscript. Where translation proved difficult, terms were left in Swahili with accompanying notes in English. These were supplemented by notes on observations during the interviews. The general approach to data analysis followed the same path used during the pilot described in section 3.4.5 above. Examples are provided in Table A1 and Figure A1 in the Annex of Tables of Figures.

3.4.8 Focus Group Discussions

A total of eight group discussions were conducted, two per facility, and each containing 8–12 participants. Respondents were selected based on age and gender. The main aim of the group discussions was to generate information that would deepen and offer meaning to the survey data and document analysis, and to identify areas of consensus as well as differences of views, since this often emerges through group discussion more than during one-to-one interviews. The group process was used to explore what shaped respondents' ideas about accountability and to provide an opportunity for participants to reflect and refine the issues they raised during the survey [164]. The discussions were also used to explore further issues that were identified in the survey as being sensitive or polemic [175] among respondents and could benefit from group dynamics. Thus, in each facility, potential issues were noted

based on field reports from each RA, and the data merged to identify what issues to pursue further during the discussions (Table 3.3).

Table 3.3: Group Composition and Discussion Guide for the Focus Group Discussions

Age group and gender of FGD participants	Number of participants per gender in each facility				Issues discussed/ Discussion guide
	FA	FB	FC	FD	
16 – 24 years Male Female		 12 10			• Barriers to youth/women involvement in HF management. • Awareness of HFC, its functions, and selection. • Experiences with engaging HFC members. • Perceived effectiveness/ responsiveness of HFs and HFCs to youth/ women health needs. • Ways to enhance accountability within the HFCs and to attract youth/women interests in HF affairs.
25 – 34 years Male Female	 10 8				
35 year and above Male Female			 10 10	 11 9	

Source: Household Survey April – May 2013

Finally the FGDs were used to help in generating themes for analysing the survey data. The discussions for the FGDs were guided by the author with the support of the research team (who also took notes). The discussions were tape-recorded after group consent was obtained. In analysing the FGD data, the focus was on the key areas of consensus and disagreement among individuals and groups of individuals, and, where necessary, on triangulation with other data sources to meet the study objectives.

3.4.9 Quantitative Data Entry and Analysis

Data from the household survey, facility survey, and HFC audits were entered using *Sirius*, a software programme used at APHRC to process and manage survey data. The data was checked for logical consistency and coding errors. Analysis was performed using IBM SPSS version 19. Differences in proportions were tested for significance using the Pearson chi-square statistic with the adjusted standard residuals. Logistical regression models were used for multivariate analysis of variation in key outcomes (awareness of HFCs, user perception of facility SC usefulness, and general user satisfaction with services received as a function of various socio-demographic and HSA predictor variables).

3.5 Summary and Plan of Analysis

The aim of the thesis is to analyse the factors that influence the performance and effectiveness of health system accountability mechanisms (HSA) on the delivery of PHC in Kericho district, Kenya with a particular focus on the role of process. Data were collected from rural households clustered around four public health centres in Kericho District of Kenya. The results are presented in the next two chapters. The chapters have been organised by theme of analysis, rather than by data collection activity, in order to synthesise and triangulate data from different sources and to provide a richer understanding of each theme.

The results begin in Chapter 4 with an assessment of intra-mechanism relations (intra-committee relations) and processes of main HSA mechanisms in the study area - HFCs and the facility SC - (Objective 1). This is followed by Chapter 5, where the results are presented on user engagement with accountability mechanisms (committee-community relations). The importance of the *Baraza*, a key engagement forum for the community and the HFCs, and the context within which HSA relations take place, are woven into these two results chapters, where appropriate.

Chapters 6 and 7 draw together the findings from the two results chapters and consider them in the light of the existing literature, leading to an assessment of the main process factors influencing the functioning of HSA mechanisms supporting primary care in the area of study (objective 3). The fourth and final objective is addressed in Chapter 8, which focuses on policy implications that can be drawn from the results and analysis. Overall, the analysis presented in the next two chapters provides a detailed, holistic account, drawing on multiple data sources to overcome methodological weaknesses of single data sources which fail to address adequately conceptual and empirical gaps identified in the literature review provided in Chapter 2. Analysis, therefore, consisted of a two-pronged approach: quantitative and qualitative as described above, while a further meta-level was achieved by integrating and linking the types of data as various issues emerged.

PART III

FINDINGS

CHAPTER 4
HEALTH SYSTEM ACCOUNTABILITY MECHANISMS & THEIR OPERATIONS IN THE STUDY AREA

4.1 Introduction

This chapter addresses the first objective of the thesis: *to describe the range of existing health system accountability and engagement mechanisms supporting primary care services.* Sections 4.2 and 4.3 set the context for the analysis. On the client-side, Section 4.2 provides background information on the study population, through a description of the household and individual characteristics of household survey respondents. On the service provider-side, Section 4.3 reports the range and type of health system accountability (HSA) and engagement mechanisms in the study area, and survey data on their composition and variations, if any. The main accountability mechanism - the health facility committee (HFC) – is described. Here data from three main sources – In-depth interviews (IDIs) with HFC members, household Survey, and document review -, are used to provide a detailed description of the composition, committee selection criteria, the rules and procedures governing committee functions, HFC members training and skills, HFC role and powers, and the committee influence on service delivery.

Section 4.4 describes the second major accountability mechanism – the Facility Service Charter (SC) - from users' perspectives, supported by photographic evidence of the various SCs from the four cluster sites, given the SCs are facility-based. Variations in the information provided in the SC across the four HFs are highlighted. Finally, Section 4.5 concludes by summarising key findings of the analysis, and setting the agenda for the next results Chapter.

4.2 Characteristics of Individuals and Households

The socio-demographic characteristics of households and individuals included in the household survey are presented in Table A2, Appendix of Tables. Overall, the survey captured more women (63.6%) than men (36.4%). Several factors explain this bias. First, in rural Kenya, it is common for men to leave their families (wives) in the rural home to look for jobs in the city. Many respondents in the survey reported this. Second, men in this community tend to leave home very early and return very late at

night even if they are unemployed. Even though the research team tried to reach the homes early as was advised by the members of the households, we could only reach so many. In each household where a potential respondent was absent at the time of the visit, the research team visited the household again three times after which they would be replaced if still absent. Nonetheless, stark gender differentials in survey response for studies conducted among rural populations have been noted in Kenya [26].

Nonetheless, the potential bias as a result of the gender imbalance is substantially reduced given that men in this area tended to disassociate with health and facility issues, as will be shown later. This 'intentioned absenteeism' from matters of health (for instance not wanting to be seen to be taking a sick child to the hospital for fear of being seen as less manly or being controlled by the wife), is one of the major cultural practices undermining the performance of accountability mechanisms and health services delivery in the area. It was not uncommon for women to know a lot about health facility issues given that they were expected to carry out the role of ensuring the wellness of their families and thus, by default, act as the main links between the household and the health facility.

The majority of the respondents (34.2%) were aged 16-24 years reflecting the Kenyan demographic structure. There was no significant variation in age groups across the sites even though FC had a higher proportion (37.9%) of respondents aged 16-24 years, a 3.7 percentage points difference compared to the all the clusters combined. There was no significant difference in age structure between men and women. Of the individuals that responded to the survey, 68.3% were in a marital relationship, 27.8% reported to have never married, and 3.9% were separated, divorced or widowed. A larger percentage of women (70.8%), were in a marital relationship compared to only (63.9%) of men. The mean household size was 6.16 persons with the modal household size being 5. This household size is slightly higher than the national average of 4.6 persons for rural areas according to the latest government survey [176], perhaps reflecting the tendency for early marriages or low education levels for the females as shown in the survey data. Household sizes ranged from 1 (n=8) to 20 (n=1).

Education levels were generally high for a rural area with 58.6% having primary education or less, 33.8% secondary education, and 7.7% post-secondary education. There was no significant variation in education levels across the clusters, except in the cluster around FD, where those who had completed some primary school education or less stood at 65.6%, about 7% points above the level for all clusters. In order to validate reported levels of education, literacy levels were investigated and the results (87.6% being able to read a simple sentence in Swahili and English) are in tandem with the education levels reported, and with the national literacy average of 85 – 87%.[12] However, there was a significant variation among the genders with a higher percentage of males (43.4%), having achieved some secondary education compared to only 28.2% of females. The majority of females seem to drop out at primary level, perhaps due to early marriage, or because the families in this area, like in many parts of Kenya, still prefer to educate the boy child due to cultural reasons.

Agriculture (small scale farming, commercial farming) was the most common occupation practiced by 62.3% of respondents in all the four cluster areas. Students constituted 14.4%. Income levels were generally low with more than half (54.3%) reporting a monthly income of KES 2,000 or less (approximately £ 15)[13] translating to a daily income of less than a dollar. Income inequality was evident between the genders though less significantly so. 18.6% of men were in the highest income category (KES 5001>) compared to only 14.7% of women, while 52.8% of men compared to 55.1% of women were in the lowest income category of KES 2000 or less. There was not much variation across the clusters. Given this data (low income levels, general high poverty rates, and general income inequality), an effort was made to understand how this interacts with aspects of accountability (such as user fee payment and management, user satisfaction with accountability mechanisms) in this area and the results are reported here and in the next chapter.

[12] To assess reported education levels and because one might have expected a stronger relationship between education and literacy on the one hand, and knowledge and use of accountability mechanisms on the other, respondent were asked whether they could read a letter written in Swahili and English. The answers were verified by asking the respondents to read simple short sentences previously used in the Kenya Demographic and Health Survey. These sentences were 1. The child is reading a book. 2. Farming is hard work. 3. Parents should care for their children. 4. The rains were heavy this year.

[13] At the time of the study GBP 1 = KES 135 based on http://www.xe.com/ rates. This rate is used throughout the thesis, but income categories are quoted in KES.

4.3 An Overview of Accountability Mechanisms in the Study Area

There were four main accountability and engagement platforms linking households to the health system. These can be grouped into two main categories - facility specific and non-facility specific. Facility specific mechanisms were the Health Facility Committee (HFC), Facility Service Charter (SC), Patient Rights Charter (PRC) and the Suggestion Box (SB). Only FC had a SB (Figure 4.5), while a PRC was present only in FB (Figure 4.6) and therefore, the two mechanisms were dropped from the main survey. The non-facility specific mechanisms included the *Baraza* (an administrative forum convened by the local administration, usually the chief's office to discuss development, law and order issues), and the local administration (Chief and Village Elders).[14] These mechanisms are described below in detail.

4.3.1 Health Facility Committees (HFCs)

Composition

The characteristics of the HFCs in all the four facilities surveyed are summarised in Table 4.2. All the HFCs can be described as hybrid in composition and structure [128] given that they are embedded in the health system structure and supported by various government policies yet they draw their membership from both traditional and government bodies. There were no major differences in composition; all the HFCs surveyed were homogenous in make-up. They drew their members from four main sources:

1) Community representatives (either elected by the community or selected to represent special interests). In most cases the community representatives were five in total although the number was not constant. In all the committees a distinction

[14] All the mechanisms described here, though sometimes operating at distinct levels and serving certain distinct roles were inextricably linked to the HFC. The service charter is put up at the HF by the HFC and is essentially a platform facilitating interaction between the HFC and the community on one hand and the health centre on the other. The Chief or his deputy are members of the HFC by virtue of their posts in the community. The office of the area Chief convenes the *Baraza*. The *Baraza*, though initially a law and order forum, has evolved over time to take up a more developmental face and as such, health and HF issues are only but part of the larger agenda dealt with at the meetings. The idea (of incorporating the local administration into the HFC) apart from serving as a political tool for control, is driven by the Kenyan government integrated approach to development where each sector is expected to feed into the work of the other ostensibly to avoid duplication of roles. This study was interested in mechanisms that had a direct role in linking households to the health system and whose impact could be measured. As such the Office of the Chief and the *Baraza* will only be used as explanatory variables since they are linked to HFC and do not have any defined role directly touching on the HF except through the HFC. Nonetheless, a description of each is provided in this chapter to provide a context for the following analysis.

was made for gender/women representatives who were two in total for each HFC. It was not clear whether the women representatives would still be picked even if in an election, two female community representatives were chosen. In all the committees, the chairperson and the treasurer were selected from the community members though none were female.

2) Government administrative representatives (mainly the local Chief/Assistant Chief representing the local administration and considered as ex-officio members of the HFCs).
3) Health workers represented by the FI who also served as committee secretary, the Public Health Officer (PHO) and in some committees the facility clerk in charge of facility finances
4) Area councillor serving as an ex-officio member

In general, the HFCs had nine members (five community representatives, two HWs, and two *ex-officio* members). However, depending on the facility, the number could be bigger given that some HFCs co-opted more health workers, such as the Nursing Officer In-charge, to serve as the need arose.

Table 4.1: Characteristics of Facility Committees (n = 4)

Health Facility	FA	FB	FC	FD	Mode (all HFCs)
Committee characteristics					
Number of community HFC members	5	5	5	5	5
Number of community female HFC members	2	2	2	2	2
Number of HWs in the HFC	3	2	2	4	2
Number of community HFC members trained in facility management and financing	2	3	3	3	3
Number of HWs HFC members trained in facility management and financing	1	2	2	2	2
HFC tenure (years)	3	3	3	3	3
Number of HFC meetings held in the last quarter	2	2	1	3	2
Number of community HFC members present in last meeting	5	5	5	4	5

Source: In-depth interviews with Facility In-charge (FI) and selected members of HFCs and reviews of HFC minutes

Committee Selection

Although official guidelines from the MOH required that the community elect HFC members from the community, this was not always the case. From the IDIs with HFC members across the four facilities, it was unclear whether the community elected

committee members or if they were handpicked to join the committees as accounts differed. For instance, a female member of the committee for FB reported that she was handpicked by the Chairman to join the committee and that this decision is often based on how active one is seen to be in the community:

> *I was chosen by the Chairman to join the committee; they look at how active you are, before and after you join the committee. When they [referring to the Chairman and the local Chief] feel you are inactive, they drop you and pick someone else to join them* (Female HFC member, FB).

The Chairman, on the other hand, offered a different account. He reported that villages, based on juxtaposition to the facility, selected HFC members who then met to elect from among themselves the committee officials (Chairman, Vice-Chairman, and Treasurer):

> *The proposal [of names for the committee] comes from the villages; we don't actually interfere with that; it depends on their modes of selection either picking somebody and they say ok this particular person can represent us and once the committee members have been elected from this particular area [village] it will be the responsibility of those who have been selected to go and elect their officials*. HFC Chairman, FB.

Other committee members interviewed reported that they were elected in a *Baraza* summoned by the Chief for that purpose, although they could not categorically state when and how this was done and the accounts varied. In FC, the committee term was renewed by the DMOH in order to facilitate HSSF programme (it was a requirement by the Ministry of Health (MOH) that there be a functioning committee before any funds are sent to the facilities). It was only in Facilities FA and FD where the committee members were unanimous about their election by the community.

Some committee members felt that the mode of selection did not result in getting the best people to run the facility since involving community members in voting did not necessarily result in a good committee. Some pointed out that the HF needed professionals who understood the operations of the facility and this could not be guaranteed when populist politics took centre stage and community members voted for people based of perceived friendliness:

> *What I prefer myself is the government to have a nominating panel composed of MOH, area councilor, area MP who can then select the people based on professional background from within community unlike this system where the majority who are not organized as such end up electing people that have no idea*

> *how the health system functions. I don't think it's the best system.* HFC Treasurer, FA.

The treasurer for FA cited his HFC as a case in point. He noted that the Chairman and the Councillor had personal differences because of populist politics and yet both owed their membership to the committee through an election process which he considered flawed in that it did not reward merit. He lamented that this mode of election resulted in people making their way into the committee by virtue of their other positions in the community (the Councillor here being an ex-officio member of the HFC by virtue of his political office and the Chairman because he was also the local teachers union representative making him popular):

> *The [HFC] Chairman is temperamental but the Councilor is worse (laughter) … ok you see the current DMOH has no problem with him (the Councilor) but like the Chairman he is also very temperamental. The Chairman likes advocacy and is also involved in the community as the local teachers' union representative because he is a teacher. Now committee meetings are sometimes chaos (laughing). So with the current system of elections we invite all manner of people and you end up with the most popular and not necessarily the best to run the facility [more laughter]* (HFC Treasurer, FA).

To understand the process from the service recipients' point of view, respondents in the household survey were asked whether they knew how HFCs were selected. The descriptive results are presented in Table A4 column 4 (Appendix of Tables) and analytical results presented in Chapter 5. These factors are also explored in depth in the *Discussion* chapters especially the mode of committee selection as an important influence on its acceptability, perception and by extension its effectiveness. In all cases, committee tenure was three years and there was no limit as to how many terms one could serve in the committee, contrary to the provisions of the constitution governing HFCs (see Annex 2).

Committee Members Training and Skills

Most of the community committee members were professionals such as teachers or, practising nurses, while some were farmers. FB, for instance, had a university lecturer as Chairman, FA, had a professional qualified accountant (Kenya Certified Public Accountant – CPA (K) as its treasurer and a primary school head teacher as Chairman. FD had a retired teacher as Chairman while FC, had a retired telecommunications engineer as Chairman. The women representatives were also well-educated by local

standards – FA had a practising nurse, FB two teachers, one retired and one practising. This is in contrast to findings by studies elsewhere in Kenya [97] and SSA where low education level was highlighted as a major issue undermining HFC performance [79].

Although a good level of education for HFCs would seem to translate to a better functioning committee, data from the survey indicates that community members, especially the youth, were disenfranchised by the committee composition. Most of the young people and women complained that the committees were made up of elite or *wazee* [the elderly] in the society and were not representative of their voices. This highlights the tension between a desire to achieve representativeness and having the required skills to participate effectively in HFCs. Many reported that HFCs are either handpicked by the chief or area politicians to represent their interests or are elected at the *Baraza* where the youth have no voice or could easily be victimised or penalised if they spoke out. The use of the *Baraza* as the main medium of engaging the community is presented in chapter 5.

Most of the executive committee members had some training in committee management and financing through a government initiative to finance HFs through the Health Sector Services Fund (HSSF) programme.[15] As mentioned earlier, this programme was only beginning to be rolled out countrywide and by the time of the survey in April 2011 was only picking up. Prior to this programme there was no formal training for committee members, who relied on their everyday life skills to run the committees. All the committees reported to have at least two of the community representatives trained in committee management and financing which also involved staff who were members of the committees. Most committee members were happy with training noting that it helped them build skills especially on handling finances transparently:

> *One thing we learnt is that if you want to do anything in the facility, you have to sit, plan, then you do a voting [allocate vote heads], then you withdraw money based on what you want to do. Initially, somehow we could say ok, we want to construct these things, we decide ourselves how much it would cost, we call a fundi (mason), we make an agreement we sign, and then we construct. But in the training we learnt we must sit together as a committee, prioritise and then tender the job publicly…* (HFC Chairman, FC).

[15] The HSSF is a programme that now funds health facilities in Kenya by directly transferring money to their accounts for general administrative use.

However, some HFC members reported feeling inadequately prepared to take on their roles in managing the HF especially when it required negotiating and engaging other third parties, including the community members. Some HFC members singled out fund raising and negotiating with the political class to support the HF, as areas of challenge, and for which they were not adequately prepared, since, it often resulted in programmes not being implemented when sufficient finances were not available. Yet, in such instances, the committee would bear the blame:

> *I don't think we are adequately prepared for our roles. You can see this in programme implementation. Most of the things we plan are not being implemented, not all of them are being implemented. I think it's partly because we are not trained for this kind of work. For example, the sourcing of the funds is somehow cumbersome, every now and then we have to go to mheshimiwa [area MP] or run to the Councilor for any assistant and may be when we have that problem we cannot reach mheshimiwa, like this time round you cannot reach him because of these other things [referring to Kenya's cases going on at the International Criminal Court] and maybe we have a need which needs to be solved and we are not able to reach him. In the end though, the committee takes the blame (*Area Assistant Chief, Committee ex-officio member, FB).

Other committee members even felt the three-day training was too short and not enough to cover everything that would enable them serve the community well.

> *I think I should be trained, I should get more training, I feel inadequately prepared to perform my roles in the committee because there are some issues which am not conversant with, even this other training [HSSF training] in which assistant chief went to, was just for three days which I don't think covers all the things which are supposed to be done (*Area Chief, Committee ex-officio member, FA).

HWs also felt that community HFC members needed to be trained on their roles in order to be effective. Some reported that because of the lack of understanding of roles among community HFC members, HWs ended up performing the roles they would ordinarily not play, leading to conflict in some cases.

> *I think that each member of the committee should be trained on his/her role; I think they are not well trained on their roles. For example, when the HSSF was introduced, we have to pay these people - the suppliers through cheques, so when the goods are delivered you are supposed to sign the cheques. Now the signatories include the treasurer and the Chairman and for the two you have to go looking for each one as they do not understand their roles. So if it were possible if we could have members who are well trained and committed to their work (*FI, for FA).

Committee Rules and Procedures

None of the HFCs had a constitution outlining rules and codes of conduct regulating committee functions, nor were they aware of the existence of such a document, even though the MOH has prescribed one (see Annex 2).[16] Although a general guide is provided by the MOH, ideally committees should have their own locally developed constitution to guide their operations. Such a document would also signify some level of independence, voice and accountability and would provide an enabling environment for an accountability relationship with their clients. Instead, all the HFCs depended on regular guidelines from the DMOH office and the MOH.

At the time of the survey, there seemed to be regular interaction between the DMOH and the committees ostensibly because there were plans to roll out the HSSF programme countrywide. Moreover, the personal leadership style of the serving DMOH at the time, endeared him to the local communities. Committee meetings were fairly regular (quarterly) though there was a noticeable change in frequency between the time of the pilot (November 2010) and the time of survey (April –May 2011). Reviewed committee minutes revealed that all the committees now met monthly, a change that was attributed to the need to operationalize the HSSF programme and an increase in sitting allowance from about US$ 2.5 to US$ 6.25 per sitting provided for in the HSSF programme:[17]

> *Before they [community HFC members] were saying there were no motivations but now it is a bit fairer because they can get some allowances from the HSSF money (*FI, for FA).

In most cases, committee minutes of the last meetings were available. The minutes also showed most of the meetings recorded full attendance after the HSSF was introduced, though initially, most HFC secretaries and the Chief's being ex-officio

[16] The research team was surprised when the PHO, also a member of the Committee, FB provided a copy of the HFC constitution developed by the MOH, yet she had admitted no knowledge of the existence of such a document despite the fact that it was in her custody. With further interrogation, she admitted she had never bothered to read it and had only stumbled upon it when she was asked to preside over a local dispensary committee election and was informed that the constitution is among the documents in her files by the DMOH's office.

[17] HFCs sitting/meeting allowances are proposed by the committee members and sanctioned by the DMOH. Before the HSSF, committees received this money mainly from the user fees funds though two HFCs had income generating activities, which supplemented the user fee money. A review of committee minutes from two facilities revealed the committees are not adhering to MOH guidelines for committee allowances, drawing approximately £ 7.40 per meeting instead of the official £ 3.2.

members reported a general lack of seriousness among community HFC members mainly exhibited in absenteeism from meetings or lateness:

> *There are times meetings are called and they [community HFC members] fail to turn up; that is an indication that they are tired and should be replaced (*Area Chief, and HFC ex-officio member, FA).

Even then, most HWs especially those in charge of the facilities reported a general lack of commitment from the community HFC members, mainly due to lack of motivation especially before the introduction of the HSSF, and also because this group of HFC members were busy with their own activities. In some cases, it meant that the HWs had to perform HFC roles adding to their already heavy schedule of work:

> *Members of the committee like the treasurer, he is supposed to monitor the funds; that is his work, but you will rarely see him here, he is committed elsewhere so now his work is left to us (*Facility In-charge, for FA).

All the committees reported using short message service (SMS), phone calls and in some cases memos to summon meetings; an indication of the evolving role of mobile phones in the delivery of health services. Depending on the management style of the HFC Chairman, the duty of summoning meetings was the responsibility of the FI who also doubled as the committee secretary. The facility in-charge did this in consultation with the Chairman with whom they also agreed in advance on the meeting agenda. However, the practice varied from one committee to another. In FA, for instance, there was conflict between the facility in-charge and the Chairman and as such the committee had not held meetings as required. Instead the Chairman resorted to running committee issues with a few members of the committee and ignored the input of the facility in-charge. From the in-depth interview with the DMOH, this was not the first time; the DMOH had on several occasions stepped in to calm tensions between the Chairman, health workers, and local leaders.

Meeting agendas were not communicated in advance to HFC members; a fact the study investigated in order to understand how this affected the process and quality of decision-making. Many HFC members agreed that accessing the meeting agenda in advance would help them prepare well, for instance by consulting the community on the matters to be discussed and thus getting their views. They did not feel, however, that the HFC roles were onerous and that most of the decisions required much initial thought. None of the HFCs reported prior consultations with the community on

matters of discussions at their meetings. In fact, some HFCs members viewed this as negating the spirit of accountability in that they have the authority to make these decisions on behalf of the community by virtue of their election. As such, they argued, it would make no sense to keep 'consulting the community' who were also not very responsive to meeting summons.

Other HFC members however felt that having an agenda in advance was a good idea that they had been ignoring yet it had the potential to improve the level of engagement with the community and to get them to understand what is going on at the facility. Some attributed it to a system-wide weakness, characteristic of the health system in Kenya where there are two ministries handling health issues compared to education where there were clear rules and procedures governing the operations of the school board of governors and clear lines of accountability. To this group, because the MOH now had two ministries, complicated lines of accountability translated to weak systems of management and accountability at the health facility level. Some HFC members felt the current system of running health facilities did not tap into existing capacity, limited the room for manoeuvre and creativity and was prone to much control from the DMOH:

> *We have the capacity but what is lacking is the structure; either we should be allowed to come up with our own structure like I know how the school board of governors looks like, the rules and regulations of governing schools so either the ministry should prepare a clear structure like in the ministry of education or allow the committee to come out with their own internal structures... I believe that in the nominations or elections you will find people who come into the committee but cannot talk or make any meaningful contribution* (HFC Treasurer, FA).

During meetings, the FI takes minutes, which were made available to the research team in all facilities. All the committees had a small executive committee made up of the Chairman, Secretary, and Treasurer (and in one committee the Vice-Chairman) that met on an ad-hoc basis to handle urgent or minor issues that they deemed did not require full committee attention. The practice was then to report these issues/decisions at the full committee meeting and in some instances to seek approval for the decisions already taken. However, there was not a clear *modus operandi* that defined what is urgent and thus required executive committee meeting and what kind of decisions needed full committee approval. The practice varied from one committee to another mainly depending on the management style of the Chairmen. For instance,

in FA, committee members reported that the Chairman tended to be rash and to act on his own with a few selected committee members when it seemed convenient. Similar experiences were reported in FB, where the woman representative felt that the Chairman and the Treasurer often made decisions unilaterally without involving other members of the committee yet they [other committee members) would do nothing about it as the centre of power seems to lie with the two:

> *There are the some leaders like the Treasurer and the Chairman who decide when they need us and when they don't need us, they make decisions themselves, and in such cases what can I possibly do? Once they've made the decisions, we just accept them as committee decisions* (Female HFC member, FB).

In FC, the committee and the community seem to have immense trust in the FI allowing him to make most of the day to day facility decisions with little consultation with the committee, while in FD the Chairman worked hand-in-hand with the FI and in many cases spent most of his time at the facility. All these leadership styles had a direct impact on the functioning of the committee and how the community viewed the committee; elements that are discussed further in Chapters 6 and 7. None of the HFCs had sub-committees for addressing specific issues, an indication that the smaller group of the executive run most of the activities and only involved the larger committee as they viewed fit. All committees received a sitting allowance of about US$ 6.25 after the introduction of the HSSF and US$ 2.5 before, except the HFC for FD, which reported receiving US$ 12.6. None reported receiving any other benefits though some HWs in some facilities reported that they at times provide free services to committee members and their families. Figure 4.7 is a picture of a committee meeting (consent received to use picture for this purpose).

Committee Roles and Powers

As mentioned in the methods chapter, this study was interested in understanding the roles and functions of the members of the HFCs as they viewed them and to take into consideration contextual issues that informed their performance as 'role holders'. The study was thus designed such that the HFCs' performance is assessed taking into consideration what these HFCs thought and saw as their roles without necessarily using a benchmark developed elsewhere. Attention was paid to the official roles and powers as provided by the MOH (see Table 4.2). The measures evaluated in later chapters were developed in the pilot, during which, four HFC members (the Chairmen

and FIs) from two facilities were interviewed about their roles and functions including their powers. The information was corroborated by in-depth discussions with the DMOH.

Table 4.2: Roles and Powers of Health Facility Committees

Committee Roles	**Committee Powers**
1. To oversee the general operations and management of the health facility; 2. To advise the community on matters related to the promotion of health services; 3. To represent and articulate community interests on matters pertaining to health in local development forums; 4. To facilitate a feedback process to the community pertaining to the operations and management of the health facility; 5. To implement community decisions pertaining to their own health; 6. To mobilise community resources towards the development of health services within the area.	1. The committee shall have the authority to raise funds from within itself, the community or from donors and other well-wishers for the purpose of financing the operations and maintenance of the facility; 2. The committee shall have the authority to hire and fire subordinate staff employed by itself in the health facility; 3. The committee shall oversee the development and expansion and maintenance of the physical facilities within their respective area.

Source [177].

In general, HFC members from the four study sites saw themselves more as HF managers in charge of overseeing HF operations, together with the HWs, rather than as representatives of the community voice in the HF. Some of them did not understand their roles beyond being 'members of the HFC'. The majority emphasised the development of the HF as their main function, i.e. that the committee existed to help with fund raising in order to improve the outlook of the HF. The Chairpersons were particularly outspoken about this, and could mention the development projects (mainly physical) they had initiated to improve service delivery at the HF:

> *As a chair, mine is to ensure there is progress and development in the facility; there should not be a stand still. We have to fundraise so that we develop this place because government alone cannot come and do all these things, so mine is to persuade the leaders, the MP, Councillors, and NGOs so that they can come in, they do projects. Currently we need staff quarters and wards so that's the role of the Chairman to see that we engage the leaders so that we can fund the facility and move ahead. That's my interest as a chair, to see that there is progress in the facility* (HFC Chairman, FC).

Some HFC members saw their relationship with the community not as one of mutual cooperation and accountability when it came to their roles and powers, but rather one of 'aid providers' or 'favour' only accountable to the DMOH and at a certain level the local politicians. This perhaps explains why none of the HFCs had formal structures for consulting with the community except through the Chief's *Baraza* and why none of them felt it was necessary to gather community views in a structured way before making decisions such as to which project to commit scarce facility resources. HFC members were asked to describe their roles and powers in specific situations. The data are summarised in Table 4.3 below.

Table 4.3: Committee Roles in Selected Scenarios (n = 24, 8 HWs – 2 per facility, and 16 Community HFC members - 4 per facility)

Situation	Respondent	No role to play	Be consulted	Make final decision
Deciding how HFF are spent	HFC	0	2	14
	HW	2	2	4
Setting user fees	HFC	1	3	12
	HW	0	4	4
Deciding how user fees are spent	HFC	0	4	12
	HW	0	4	4
Handling disciplinary issues among staff	HFC	9	7	0
	HW	7	1	0
Employing new casual staff	HFC	0	4	12
	HW	0	4	4
Employing new MOH staff	HFC	16	0	0
	HW	8	0	0

Source: In-depth Interviews with HFC members and HWs
HFC = Community HFC members, HW = Facility In-charge and PHO

As shown in table 4.3, there was a general consensus on four issues across all the facilities: deciding how health facility funds are spent; setting user fees; deciding how user fees are spent; and, employing new casual staff. Even then, it was difficult to know who the exact decision maker was in each situation. For instance, in setting user fees, the majority of HFC members agreed that they relied heavily on the advice of the FI, who proposed the various charges taking into consideration the socio-economic circumstances of clients and the prevailing market conditions in the area including regularity of government drug supplies. The HFCs would then meet to sanction those proposals in consultations with the community and then pass the same on to the

DMOH for approval. Even though in most cases the DMOH would approve majority of the requests, that office also relied on the MOH for guidance. This is in spite of the government official 10/20 policy[18] which the HFs are expected to adhere to and the HFC's role in ensuring clients are not overcharged by health workers.

Decisions on how to spend user fees and general other facility funds were also unclear. There was a consensus across the four facilities that the HFCs make the final decision on how these funds were spent, although in reality the practice varied. In FA, health workers and the committee ran parallel systems in which the staff held on to the user fees while the Chairman held on to the Drug Revolving Fund (DRF) generated from the facility community pharmacy mainly due to conflict and mistrust between the FI and the Chairman. The facility in-charge claimed that the Chair did not consult them when making decisions about the community pharmacy, which had been set-up to run in parallel with the facility pharmacy stocking government supplies, while the Chairman felt he needed a hands-on management of the community pharmacy given it was initiated through his personal efforts.

In FB, the FI, though working in harmony with the HFC, made most of the decisions without consulting the HFC. The FI argued that many of the decisions required her skills as 'a clinician and would therefore not be trusted to untrained HFC members'. In FC, there was mutual trust and HFCs members interviewed confirmed that they trusted the FI to make the right decisions about expenditures since he already enjoyed good relations with the community (see Box 1).

[18] According to this policy, dispensaries and health centres are supposed to charge a maximum of KES 10 (£ 0.07) and KES 20 (£0.14) respectively per visit irrespective of a patient's condition. The policy was introduced during the SAPs described in Chapter 2, policies that were imposed on the government of Kenya as part of donor aid conditionalities. One of the key aims of the 10/20 policy was to show-up facility funds through cost sharing systems (the patient paying either KES 10 or KES 20, and the government providing the rest of the treatment costs). The assumption has been that these facilities only offer outpatient services, but experiences from this study area showed that in some cases the facilities were forced to admit critically ill patients reporting at night or who could not be immediately be transferred to the nearest referral hospital, Kericho District Hospital.

Box 1: Income Generating Activity – Facility Garden (FC)

Compared to all the three facilities studied, FC had the smallest land size. But this did not seem to inhibit the facility committee from utilising the land. On arriving at this facility, I noticed a thriving garden with a variety of crops planted. During discussions with the Facility In-Charge, HWs and other HFC members, I am informed that the garden generates about KES 20,000 per month for the facility. This figure is reflected in the committee records and the facility account records. The management of the garden is in the hands of the FI, though from the look of things, the HWs have an equal say and take weekly rounds in managing the facility. The HFC Chairman confirms during an interview that they completely trust the FI to manage the garden and its income. This they argued was because the FI had kept them informed about every activity in the facility, accounted for the monies generated from the garden produce, and that they had never received any complaint from the community about him. The FI, in turn, delegates the responsibility to other HWs, who are required to account for how they used the money during the week they were in charge in monthly staff meetings. The income from the garden is spent mainly on staff meals, supplementing the drug revolving fund, general facility maintenance, and supplementing support staffs pay. From interviews and chats with HWs, the staff meals were singled out as a major boost for staff morale. From the DMOH, FC is one of his best performing facilities and tends to attract patients from facilities around it. The Chairman and the FI are quick to point out the harmonious working relations between the HFC, the HWs and the surrounding community; information that is supported by a majority of respondents in the survey.

Community members interviewed as part of the survey reported about trusting their FI, with some noting that sometimes they would get well, or feel better 'just by speaking to the FI'. Many of them also mentioned that the FI was attentive, listened to their problems, often offered waivers when they could not afford the cost of care, and was very accessible to the community generally. On comparing our notes after finishing surveying the cluster around FC, we noticed a pattern among women commenting that they preferred to deliver at this particular facility since, unlike other facilities, the FI handles them *'with gentleness, listens to their needs, and can be trusted to act on complaints against particular staff'*. In one instance, I met a HIV positive lady who had come for her regular dose of ARVs, who narrated how, on one occasion, one of the HWs had demanded pay before issuing her with the drugs. She then informed the FI, who ordered that she be issued with the medication and reprimanded the member of staff concerned in the presence of patients who were queuing. But all was not rosy. On investigating why the facility is squeezed into such small piece of land; the FI informed me that the Chairman, in collusion with a local council official, had fraudulently acquired part of the land where he subsequently established a thriving private school. He also mentioned that he tried to avoid confronting the Chairman over the issue to avoid antagonising the committee. Instead, he had chosen to use the local community elders to handle the matter.

Source: Field notes

Financial issues were a major indicator of accountability relations not only between the HFC and HWs, but also with the households and the health system at large. Many HFC members felt they lacked the powers/authority to manage funds that came from the government as they came with vote-heads already assigned, meaning they had little manoeuvring space to realign these funds to local priorities if need be. They felt the important accountability element of authority and the responsibility that comes with it was clipped leaving them powerless yet the community expected so much from them. The HFC Chairman of FA, narrated how the facility had lost money, which they could not spend because the FI – who is one of the important facility bank account signatories - was transferred and due to government regulation, the unspent vote head was returned to the ministry, only for the transferred FI to collude with bank officials to withdraw all the money. On the other hand FGDs and survey data revealed a general dissatisfaction among community members who complained that user charges were often increased without involving them yet there was no corresponding improvement in service provided signified by regular drug stock-outs forcing patients to buy drugs from outside the facilities. These issues are considered in detail in Chapter 5.

Finally, there was consensus on the HFC employing and disciplining new casual staff. However they had no role in disciplining HWs employed by the government. This was a grey area in the role and function of HFC as a mechanism for accountability. It was clear that the HWs were not answerable to the HFC in any way, neither were there clear guidelines on the lines of accountability between the two groups:

> *That is an area where there is a big weakness because we are not consulted when the HWs are being hired and even when they are deploying they don't consult us as the committee and then the worst part of it when it comes to disciplining them we don't have power over them. It is not clearly spelt out but I believe that should be the role of the committee but if you don't have power what can you do?* (HFC Treasurer, FA).

As explored in Chapter 5, this lacuna left many community members lost as to whom they would approach in case of problems with health workers. Many respondents reported preferring to approach the politicians (mainly in the case of men), their family members or to shift to another facility, in most cases a local private clinic, entirely (mainly in the case of women). Many HFCs also felt that the government

needed to consult them whenever they wanted to transfer or employ new staff. This way, they argued, they would have a hand in holding the new staff accountable and also ensure services are uninterrupted due to unplanned transfers leaving clients unattended. In general, the cases presented in Table 4.3 pointed to the mismatch between the committees' 'theoretical' roles as prescribed by the government (Table 4.2), and how the committees operated in practice, highlighting the challenges and dilemmas that these committees face in trying to be accountable the government (upward accountability) and to the community (downward accountability).

4.3.2 Committee Influence on Service Delivery

Interviews with HFC members produced varied opinion on the impact HFCs were having on service delivery. In general, committee members across the four clusters felt that they were making an impact in two broad areas: leading facility infrastructural development (identifying and planning for projects to fill gaps in key areas of need, fundraising and project management); health promotion (mobilising the community to seek care from the local facilities, challenging traditional cultural practices that undermined the health and wellness of the population, and mobilising the community to attend health talks and outreaches). For instance, in FB, HFC members reported on an exclusive breast-feeding seminar they had attended after which they mounted a campaign to enlighten the community about the benefits of exclusive breast-feeding:

> *In January we had some seminar on exclusive breast-feeding; when community HFC members came back from the seminar they went to various villages and disseminate the information on breast-feeding. Mothers from the villages were encouraged to visit the facility where they were trained, so there was some awareness on exclusive breast feeding, information that most of the women did not possess previously* (Area Assistant Chief and HFC member, FB).

Experiences also varied from one HFC to another with facilities where there seemed to be harmony between the community committee members and the HWs (Facilities FC & FD), reporting significant support for primary care, while facilities where there was disharmony between the two groups (mainly FA), reporting that the wrangling indeed hampered service delivery. For instance, in FC, the committee had made tremendous progress in fundraising through local income generating projects such as converting a once idle piece of land into a fruit and vegetable farm. In order to bring the community on-board, the HFC built a sense of community ownership around the project by

employing members of the community to run the farm. Money generated from this project and other funds raised were used to expand the maternity wing in the facility for deliveries and overnight stays in the case of complications. The Chairman explained thus:

> *When I joined this place as a treasurer, we managed to call for a Harambee [fundraiser], to complete the outpatient block. Now it is complete. We also wanted this place to look clean, so we bought a mowing machine because initially, there were cattle that were grazing here, but we decided to lock them out and bought a mowing machine, thereby improving hygiene around the facility. Also, this garden [showing the research team the garden], we are supposed to construct a patient ward there, but because it is still idle, we decided to do some gardening so we can get some money monthly – vegetables, fruits, so that when we sell from it, we can boost the money coming from service charge. We can then pay the support staff. We also sought government permission to ensure we have a laboratory here because patients were suffering a lot, having to go to neighbouring facilities. So these are some of the major achievements of the committee.*

In FA, health workers were forthright with their comments about community HFC members arguing that the committee members were often too busy with their own personal businesses and hardly performed their roles at the facility. Ultimately, this meant, in some cases, that the HWs would take on more administrative responsibilities, thus reducing their time with patients.

The Facility In-charge at FA further stated that it was inconceivable that the committee should have any impact on service delivery when in the first place they did not understand their roles and were not using the facility altogether:

> *I think also that each member of the committee should be trained on his/her role I think they are not well trained on their roles. I doubt [that they influence service delivery] because you see some of our community committee members, we have ARVs now and the HIV clinic but instead of mobilizing the community members to come and take their services here, they themselves [the committee members] do not use the facility, I don't think they help much.*

However, further investigations in the survey revealed that it was not just the community HFC members who were avoiding this facility as male members of the community were too. This was because the facility had recently received a young female clinician as the FI, and the male members found it unacceptable to be seen by her. Interviews revealed that the community did not consider a female to be a 'doctor' as they considered female HWs to be nurses. Most community members also reported

that they would have preferred a clinician from outside the community for confidentiality purposes. When the research team visited this facility, there was obvious tension since we had arranged to interview the Chairman and the FI the same day. During our interview with the Chairman, he often referred to the FI as 'that woman'.

4.4 Service Charter

The second major mechanism providing a platform for interaction between the clients and the health system is the Facility service charter (SC). According to interviews with the DMOH, the SC should ideally be placed in a clearly visible place, in most cases at the entrance of the facility. It should be clearly written in visible, legible and client friendly language (for this study area, a Swahili and Kipsigis translation should be available) and it should be updated regularly to reflect any changes in the facility. Additionally, it should contain the names of committee members and where appropriate their phone numbers to enable accessibility by the community whenever they require help from the HFC. The SC should also contain basic financial information like the costs of various services for different categories of patients, the waiting times, facility operation hours and other relevant health information. Interviews with the MOH officials also indicated that the HFC should commit to provide basic facility income and expenditure information as part of their SC.

These ideals are captured in the government's open data policy and reflected in several legal and policy documents, particularly the community strategy and the guidelines for managing HFs [29, 31-33, 177, 178]. The SCs from the four study sites are provided in Figures 4.1 – 4.4. It is clear that they fail to meet the basic minimum requirements. Each facility had varying information and a different location for the SC. However there were some similarities in the SC across all the facilities. These included mainly information about the type of service offered (consultations, lab tests, drugs available), the attendant costs, and the facility working hours. In addition to these, FB had a patients' rights charter as part of its SC, though the print was very small in size and pasted somewhere near the consultation room entrance (Figure 4.6).

Figure 4.1: Service Charter, Facility FA

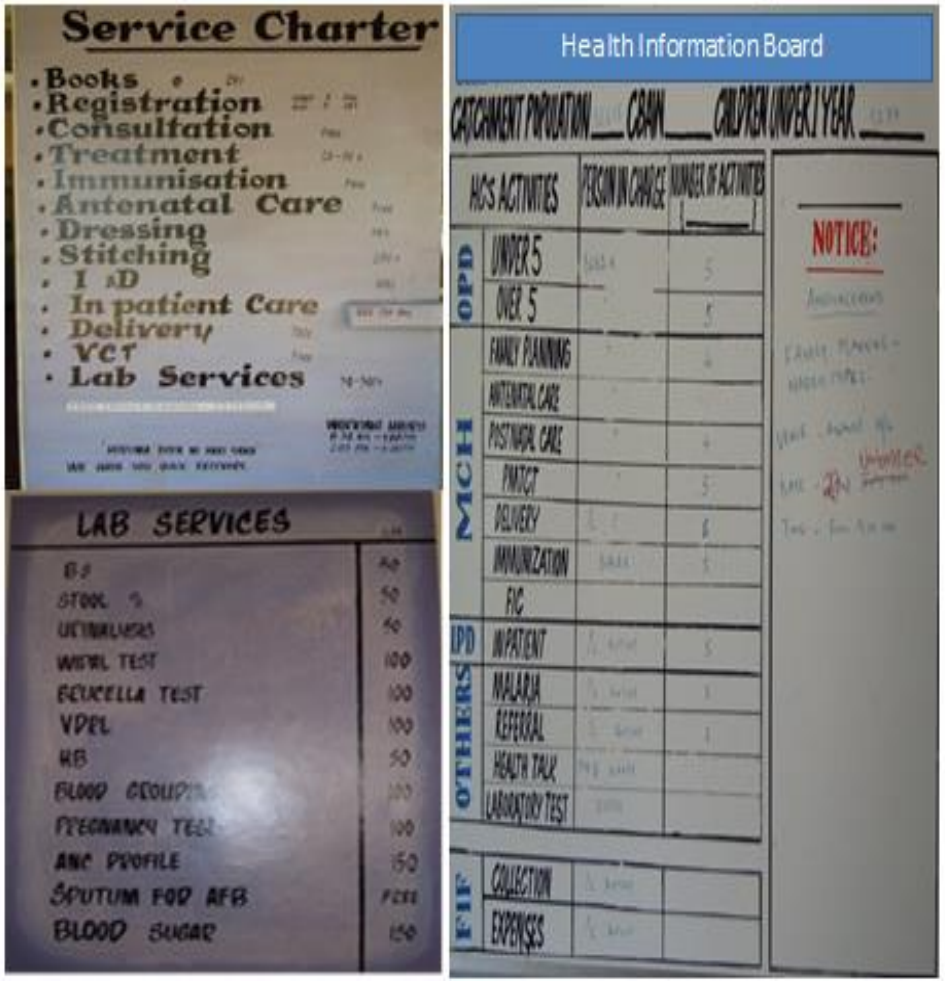


Figure 4.2: Service Charter Facility FB

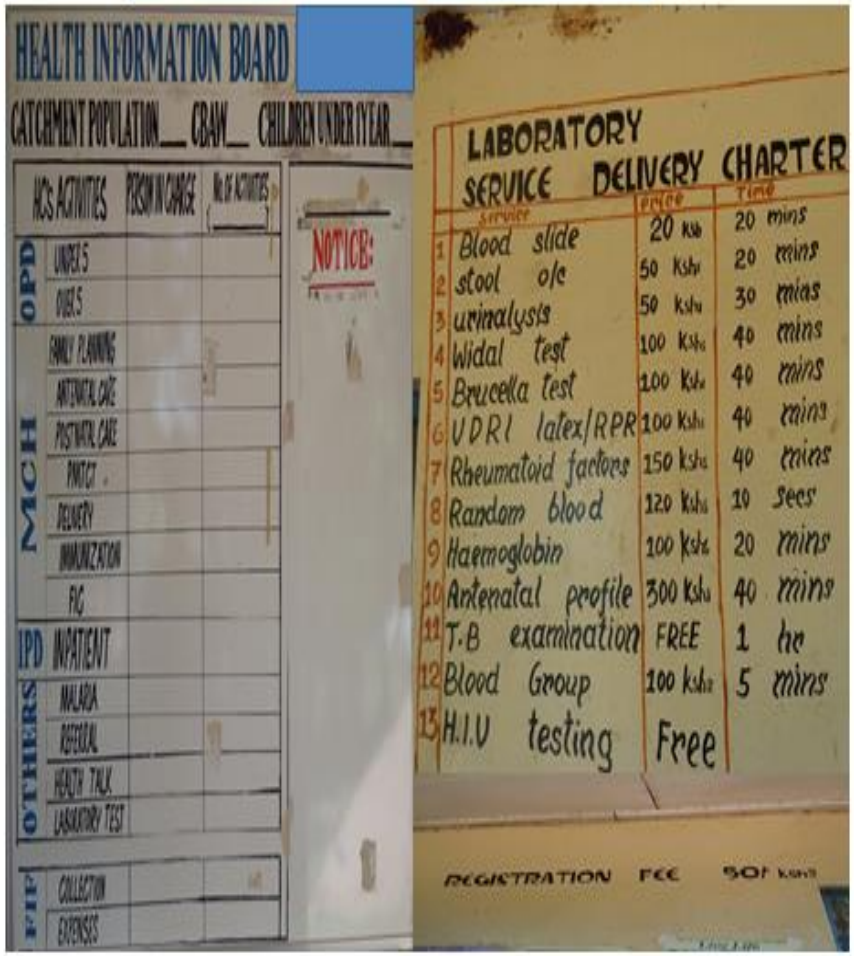


Figure 4.3: Service Charter, Facility FC

Figure 4.4: Service Charter, Facility FD

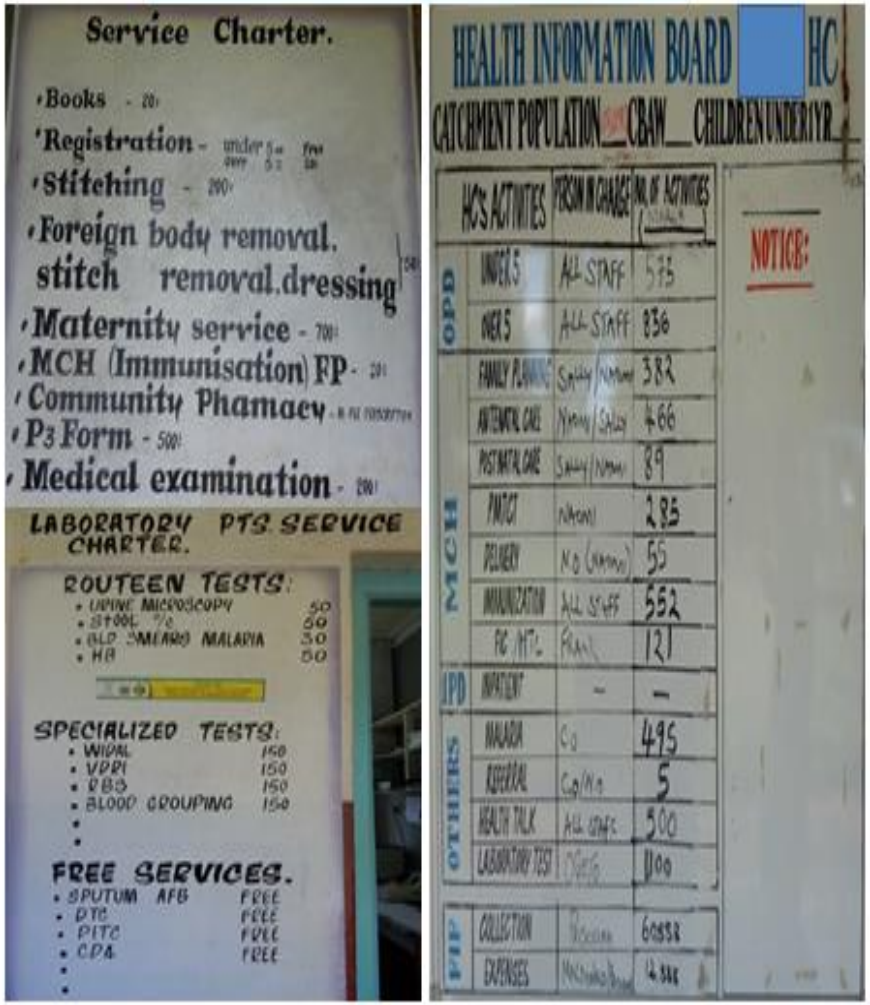
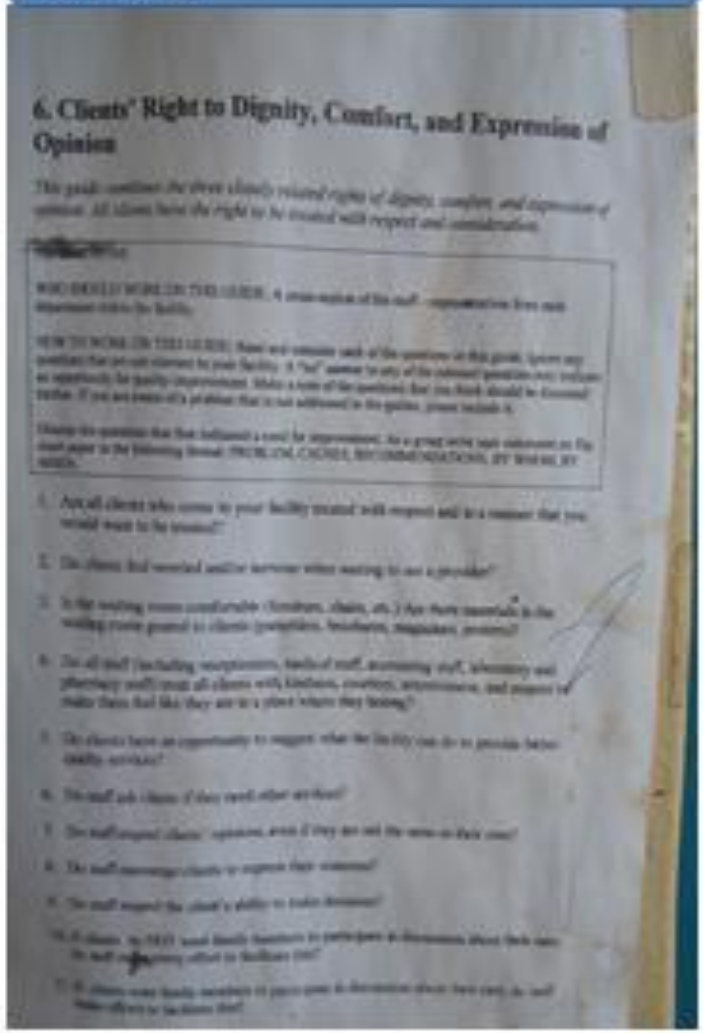


Figure 4.5: Suggestion Box at Facility FC

Figure 4.7: Committee Meeting in progress at a facility

Figure 4.6: Patients' Rights Charter, at Facility FB



Across all the facilities, the information provided on the SC was fragmented, incomplete, selective, and in some cases incomprehensible to the users.

To understand whether this accountability mechanism was relevant/useful to clients, respondents were asked whether they had seen the SC, and if they had, whether they had read it, and whether they found the information on the SC to be useful in light of their everyday experience with care at their local facility. The outcome variable was coded into four categories (1 = Very useful, 2 = useful, 3 = less useful, and 4 not useful), and recorded into two categories (0 = Not useful, 1 = useful) for purposes of analysis. There were varied views about the usefulness of the SC among the community and HFC members, variations that were investigated through a univariate and bivariate analysis (Table A3, Annex of Tables) and multivariate logistical regression analysis (Table 4.4) and qualitative interviews.

Variables that were significantly associated with the perception of SC usefulness following bivariate analysis were: respondents' cluster facility (p value < .001), occupation (p value < .001), income (p value <.001), marital status (p value < .001), whether one was given drugs at the facility after paying user charges (p value < .001), and whether a user was required to buy additional drugs from outside the facility after paying (p value < .001). Gender was non-significant. However, despite a higher percentage of women (65.8%) compared to men (63.2%) reporting to have seen the SC in their local facility, a higher percentage of men (86%) had read the information on the SC, compared to 82.8% of women. There were no major variations across the age groups, though a significantly lower proportion (49.7%) of those aged 45 and above had seen the SC compared to the other three age categories that reported 66% and above.

Similarly, significant differences were noticeable among those reporting to have read the information on the SC among the age groups (60.8% for those aged 45 and above compared to over 87% for each of the other age categories). Noticeably, a higher proportion (66.9%) of those who had been charged more than the HFC set KES 50 (£ 0.37) on their last visit to their facility had also seen the SC. This is in comparison to 58.8% of those who were charged the HFC set amount. The same findings were seen among those who had read the SC (84.6% for those who were charged more than KES

50 and 74% for those who were charged KES 50 or less), meaning that users were still overcharged even though they had read the information on the SC.

Table 4.4 : Multivariate Logistical Regression for Determinants of Perceived Service Charter 'Usefulness' (N = 498)

	Useful vs. Not Useful	
Variables	Odds Ratio	95% C.I.
Cluster Facility (Ref = FD)		
FA	6.36***	[2.70 - 15.00]
FB	4.30***	[2.01 - 9.18]
FC	1.18	[0.54 - 2.58]
Gender (Ref = Female)		
Male	1.13	[0.62 - 2.05]
Age (Ref = 17 - 24 Years)		
25 - 34 Years	1.04	[0.39 - 2.77]
35 - 44 Years	1.10	[0.44 - 2.72]
45 and above	1.19	[0.46 - 3.03]
Occupation (Ref = Agriculture)		
Skilled Labour	1.37	[0.62 - 3.05]
Unskilled Labour	0.24**	[0.10 - 0.59]
Student	0.77	[0.21 - 2.80]
Income (Ref = KES ≥ 5,001		
KES ≤ 2,000	6.32***	[2.82 - 14.15]
KES 2,001 - 5,000	1.11	[0.53 - 2.32]
Ill Household Members (Ref = Over 5)		
Under 5	1.17	[0.65 -2.12]
Education (Ref = Post-Secondary)		
Primary of less	0.81	[0.27 - 2.43]
Secondary	1.02	[0.35 - 2.93]
Marital Status (Ref = Not in a Marital relations)		
Married	0.63	[0.26 - 1.51]
Given Drugs at HF (Ref = No)		
Yes	3.85*	[1.03 - 14.43]
Required to buy drugs outside facility (Ref = No)		
Yes	0.47**	[0.27 - 0.83]
Given Receipt (Ref = No)		
Yes	1.78	[0.94 - 3.36]
User fee Charged (Ref = KES > 50)		
KES 50 or less	1.81	[0.58 - 5.68]

*p<.05, **p<.01, ***p<.001
Source: Household Survey April - May 2011

Table 4.4 shows multivariate analysis results for determinants of perceived usefulness of SC, with 'not useful' being the base outcome, - that is, those who found the SC 'useful' are being compared to those who found it 'not useful'. The estimates presented for each variable are adjusted, controlling for all other variables in the model. Holding all else constant, respondents using FA and FB had significantly higher odds of finding their SC useful (OR 6.36; p value <.001, OR 4.30; p value <.001) respectively. Those in unskilled labour were significantly less likely to find the SC useful (OR 0.24; p value

<.01) compared to those in agriculture. Individuals in the lower income category of KES 2000 or less had significantly higher odds (OR 6.32; p value <.001) of finding the SC useful compared to those in the income category of KES 5001 or more. Holding all else constant, users who had received drugs at the facility had significantly higher odds (OR 3.85; p value <.05) of finding the SC useful compared to those who did not get medicine at the facility. Conversely, users who were required to buy additional medicine outside the facility had significantly lower odds (OR 0.47; p value <.01) compared to those not required to purchase additional medicine. Gender, age, education, marital status, whether one was given a receipt, and user fee charged, were not associated with perceived SC usefulness.

The quantitative results were investigated further during in-depth interviews and focus group discussions (FGDs) to gain a deeper understanding of the process issues that influenced users' perception of SC usefulness. Users who found SC useful reported that it gave them a voice given they could query the HWs if they were charged more than what was indicated on the SC:

> *It's good because when you go to the doctor they will tell you pay KES 200 [£1.48], but you can ask them 'why doctor? Isn't the fee indicated not more KES 150 [£1.11], you shouldn't ask for KES 200 from me (*Female respondent, FA).

Others felt it was useful in providing general information and preparing them when they visit the facility, because they would know how much to bring with them to the facility, apart from knowing what services were offered at the facility. This, to some respondents, signified a level of transparency on the side of the facility management as implied in the following quotes from users:

> *Now people know the amount of money they should pay and that it depends on the type of service or medical tests required; its transparency, you know sometimes you go to the chemistry to get malaria drugs when they are supposed to be free. The doctor may ask for say KES 400 [£ 2.96]. In this case you can just report with the book, and inform them 'I don't have the money, haven't they been broadcasting through the radio that malaria treatment services should be free or TB free?* (Male respondent, FA).

> *It's good because nowadays it is a form of transparency; again it makes people aware of what is being done here (*male respondent, FD).

> *Yes, there is a difference, if there is no information displayed, you would not know how much you will pay, but if you see it on the notice board, if they overcharge,*

you tell them 'no, let's go and check the notice board, why are you overcharging and yet here you have indicated a lesser figure? (Male respondent, FC).

Interviews with some HWs at of the facilities confirmed this line of thought:

They [users] find it useful because at times somebody can come and complain that he or she has been overcharged … there was a time I was on leave, and a patient called me to complain that they had been overcharged. I asked how he knew he had been overcharged and by how much. After some time he called again to say he had confirmed the charges on the service charter and that indeed he was charged the right amount as indicated on the service charter, so I think it is very useful tool (FI for FA).

The most contentious issue arising on the SC was the user fees charged, accounting for the facility finances, and waiting and opening times. A spot check on the facilities showed that none adhered to its own user fee policy despite having its committee setting those charges over and above the official government policy of 10/20. It was not uncommon for clients to be charged more than what was stipulated on the SC. All facilities HFCs had set a uniform fee of KES 50 (£ 0.37) for outpatient services. In some cases, patients were forced to pay for services across all the counters they visited for instance at the registration desk, consultation desk, facility chemistry, and at the laboratory. Results for user fee charges as a measure of accountability are presented in Chapter 5. This led some patients to doubt the usefulness of the SC pointing out that the HWs hardly adhered to the provisions of the SC since they continued to overcharge despite the amounts being shown on the on the SC. They felt helpless and could not question HWs for fear of retribution or being denied service:

You know the doctor says pay this much, as he wishes, yea? Will you argue with the doctor? He says, pay this, you pay… how can you ask (With an expression of shock on his face)? If the doctor says, he wants you to pay this small amount of money, how can you ask what the money is for and I want to get better? All I want is to get better (Male respondent, FB).

You know if you ask such questions you will be seen as kimbelembele [naughty], but even if you ask you won't be told. They will 'mark' you if you insist on such questions (Participant, Youth FDG, FB).

Other respondents also questioned why this form of transparency was one-sided, in that the SC showed what people should pay yet no facility displayed the information on how the money collected was spent:

Why is it that we are only shown on notice what we are supposed to pay but once paid they do not put up notice showing how it was spent? (Participant, Youth FDG, FB).

But other respondents were cautious about displaying certain information on notice boards, especially financial information, a line of thought that was very much supported by the HWs:

> *You know you cannot expose such things, there are things you would not display; there are things you have to put in secret, such as money details* (Participant, Male adults FGD, FD).

4.5 Summary and Conclusions

The first objective of the thesis is to describe the range of existing health system accountability (HSA) mechanisms supporting primary care services in the study area. This chapter has identified the HFCs and the Facility Service Charters (SCs) as the main mechanisms supporting HSA in study area. Several points can be picked from the findings on the HFCs:

- An inherent gender imbalance within the committees having positions reserved for 'women representatives' and how this affects decision making and 'voice' representation within the committees. It was confirmed that female members of some committees did not have much say on what was going on in the committees, given that they owed their positions to the Chairman and the local administration.

- Power and trust within the committee and how this impacts on decision-making processes – how meetings are conducted, where the true committee decision making power lies, and how those who hold this power try to incorporate community voices into their decision-making.

- HFC members training and skills are important factors influencing both the perceived and real impact of the committees from the role-holders' point of view.

- Though most committee members saw their role as overall managers of the committees, a position supported by the government, it was not clear whether committee members understood clearly what this meant and in many cases, they acted in a manner that gave meaning to what they saw as their roles given the health system milieu within which they operate.

- There is inherent tension between the need to have committed and skilled members on the committee and the desire for representativeness, even from the committee members themselves.

These issues are pursued further in the next chapter but from the clients' point of view, providing an important triangulation intersection.

On the SCs, there were several similarities across all the facilities; these included information about the type of services offered (consultations, laboratory tests, drugs available), the user fee charged for each service, and the facility working hours. User perception of SC usefulness varied depending on one's occupation, cluster facility, income, and whether a facility provided drugs or not after user fee payment. Some respondents reported that the SC provided them with a useful platform to challenge perceived 'acts of corruption' and was therefore an important tool for ensuring accountability at the facility. The SC was also seen by some users as having useful information that ensures that they do not waste time when they visit the facility, including finding the right amount of money for specific services before they reported for treatment. Therefore, the SC was an important tool for planning one's medical budget and as a signifier of transparency at the facility.

The next results chapter (Chapter 5) explores how these two accountability mechanisms interact to support care from the users' perspective. Given the SC is a function of the HFC, and, like the *Baraza*, is used by the HFC to engage the facility users, the SC is incorporated in the analysis as a predictor variable on user awareness of HFCs.

CHAPTER 5

COMMITTEE- COMMUNITY RELATIONS

5.1 Introduction

The second objective of the thesis is to analyse the impact of health systems accountability (HSA) mechanisms – in this case the HFC - on service delivery. As specified in the conceptual framework, the impact of HSA on health care delivery arises from the interaction of the key stakeholders making up the mechanisms, i.e. the HFC, the MOH represented by the DMOH and the local administration, and the community – referred to in the conceptual framework as inter-mechanism relations. This chapter analyses the impact of HFCs building on the description of the range, nature and composition provided in Chapter 4.

A preliminary step in any analysis of the impact of the HFC is to understand the depth of engagement between the HFC and their clients. Therefore Section 5.2 addresses this based on three main outcome measures: users' awareness of the existence of HFCs; users' knowledge of the committee members (not necessarily by name); and users' knowledge of the HFC's selection criteria and roles. The underlying hypothesis is that an effective HFC should be well known among community members who depend on it to resolve any facility related issues. Therefore, the assessment is based primarily on evidence from the household survey on individual reported knowledge of the HFC, supplemented with evidence from qualitative interviews with HFCs members on their interaction with the community. Analysis of the depth of engagement is completed by the use of multivariate logistical regression to identify the determinants of user awareness of their local HFC.

The next step in Section 5.3 takes the analysis further by assessing HFC responsiveness to users' needs and priorities. This is done based on four main outcome measures: the nature and type of communication between the HFCs and the users; whether the HFCs involve users in decision-making and priority setting; how the HFCs handle equity issues and financial accountability; and users' engagement of the HFC to resolve any HF problems. As described in the introduction and literature review chapters, accountability is not a linear process; indeed this thesis takes the view that accountability within the health system is a complex social process that is facilitated or

hindered by everyday stakeholder relations. It is about relationships in which 'actors' negotiate and apply themselves in a manner as to enhance their positions. One straightforward method to evaluate its impact would be to ask each stakeholder whether they think the other party is having any impact on HF performance. However, this can be misleading. A different approach was used instead, where users were asked who they would approach to help resolve a HF issue and who would be their first point of call in dealing with facility issues. A key hypothesis is that an effective HFC should integrate users' perspectives into its planning process in order to capture user's needs and enhance responsiveness.

The assessment of HFCs' responsiveness in Section 5.3 is completed by an analysis of the main factors that influence the choice of accountability mechanism or authority to approach, by users in resolving problems at the facility. The section therefore identifies the main process issues that influence the performance and impact of accountability mechanisms in the study area. It is important to note that the four 'accountability markers' identified are not mutually exclusive, and given that accountability is a complex social process, these four process influencers permeate almost every aspect of every day accountability relations in this area.

Section 5.4 brings together the analysis by considering the effectiveness of HFCs based on the availability of drugs at the facility and user satisfaction and experiences during their visit to the facility. The availability of drugs, especially after one had paid the requisite user charges, is used here as an outcome measure, since it was identified as one of the key indicators of effectiveness during the pilot study. The analysis is therefore based on whether an individual got drugs from the facility, and or, whether they were required to buy additional treatment items/drugs from outside the facility after paying the requisite user charges.

The section is concluded by a multivariate logistic regression analysis to identify the determinants of user satisfaction with the service(s) one received during one's last visit to the facility based on two outcome variables: 'satisfied' or 'dissatisfied'. This is based on the hypothesis that an effective HFC would ensure user satisfaction with services at the HF. An important element of the analysis in this section is the consideration of user satisfaction through the lens of user-identified elements of accountability (receipt

issuance, drug availability, awareness of HFC among others), in addition to selected socio-demographic characteristics already identified as being significantly associated with user satisfaction through bivariate analysis. The analysis is complemented by qualitative data drawn from FGDs and IDIs.

The chapter is completed with a summary in Section 5.5 setting the stage for a discussion of the results in light of available literature and contextual data from the field.

5.2 Depth of Engagement

As shown in the literature review, to distinguish the depth of community-committee engagement, a distinction can be between simple information giving to communities at one end of the spectrum, through consultation, to community influence and control at the other end [71, 72, 179]. In many cases, the creation of opportunities for consultation does not in itself lead to community influence and control; there could be an element of 'manipulation' or 'tokenism' in initiatives. Therefore issues of legitimacy, representation and health system– community relations are important [71, 72, 78, 79], and are thus analysed in this section.

5.2.1 Committees Awareness among Survey Respondents

More than half of respondents (55%) reported being aware of the existence of a HFC in their area. There was a significant, though not a strong association between the knowledge of existence of a HFC and the associated cluster facility (health facility to which one received care). Respondents who used facilities FB, FC, and FD were significantly more likely to know about the existence of a HFC in those facilities (58.2%, 56.6%, and 57.8% respectively), compared to those attached to FA (47.3%). The majority of the respondents cited lack of involvement in the election of the HFCs, along with the general aspects of HF management, as the main reason why they did not know about the HFC. Other reasons cited were distance (that they reside far away from the HF and were thus unlikely to know when the elections were taking place), a general lack of information when the HFC was being set-up, and a general lack of a proper forum to discuss HF issues. As one person stated:

> *Because my place is very far from here, if I were here I would know a lot* (Male respondent, FA).

While others had never bothered with issues of the HF or the HFC because of their daily commitments elsewhere:

> *All along I have been busy with work; you know you get busy at work until some things you don't even bother to ask* (Female respondent, FC).

During FGDs, respondents, irrespective of gender or age drew parallels between the management of the HF and the local schools.[19] The majority felt that the latter were more inclusive, had proper structures for engaging the community and were generally responsive to their needs. Comparing the school system with the health system, participants in a female FGD at FA noted:

> *In the selection of the school's committee we get more involved…* (Participant 1, Female FGD, FA).
>
> *And we really get to talk…* (Participant 2, female FGD, FA).
>
> *They send our children home to call us for the committee selection…* (Participant 5, female FGD, FA).
>
> *But with the HFC, we do not even know who they are; we are not involved in their selection* (Participant 1, Female FGD, FA).

Qualitative interviews showed that many felt they were systematically ignored in the election/formation of the HFC, though there was some marked different between the age groups:

> *You know we are living in a world whereby people like me [women] do not qualify to join committees because they normally choose Wazees [old people], the retired people* (Female high school teacher, FC).

These views were also particularly expressed by young people (16 – 24 year olds) exhibiting a general lack of awareness about the existence of a HFC. This group felt that the forum where the HFC are selected – the *Baraza* - was unfriendly to them. They viewed the *Baraza* as 'elders' or 'an adult club' exclusively to be attended by the parents, and which had lost taste and favour among the young, apart from being seen as a historical system of local governance.

[19] The respondents easily drew comparison between the HFCs and the school management boards. It is misleading to assume the two are generally comparable given the differences mainly in structure: unlike the HFCs, school boards in Kenya are generally well-remunerated because of substantial resources including direct government funding; parents tend to interact with the schools more frequently as opposed to the HF where one visits only when one is ill. There was also a general feeling among respondents that health and HFs are a domain of the professional HWs, that they would add very little given they are not knowledgeable on issues of health. Surprisingly, it is this kind of feeling that accountability and engagement in the health system is meant to eliminate.

Quantitative data from the survey confirmed some of these views. Bivariate analysis showed that age, occupation, distance from the facility, income levels, and marital status were all significantly associated with knowledge of HFCs (p value <.001). Younger respondents (16 – 24 year olds) were less likely to know about the existence of HFCs (40.7%) compared to their elderly counterparts aged 35-44 years (68.8%) and those aged 45 and above at 66.5%. Awareness of HFCs seemed to rise with age, underscoring the views expressed during qualitative interviews that this society tends to entrust areas of responsibility to the elderly in society. Youths reported that they were not expected to take up active roles in community matters such as the HFC, areas that were seen as the domain of parents. Besides societal norms, ideals and expectations, it was important to investigate further what other factors played a role in influencing awareness of HFCs in this community, taking into consideration the context. The results of this investigation are presented in Section 5.5 below where key drivers of accountability are identified.

That said, a similar pattern was noted in social-economic status. A higher proportion (68.9%) of respondents on an estimated monthly income level of KES 5,000 knew about the existence of the HFC, unlike those in the monthly income bracket of KES 2,000 or less (only 49.4%). Variations in income levels and knowledge of HFCs could be an indication of inequality when it comes to who is selected to join the HFC. As described in chapter 4, members of HFC in the study area were fairly well-educated and well-off according to local standards. If indeed the community is involved in selecting HFC members then this reflects the broader Kenyan political system where the rich, irrespective of their education levels, tend to be given leadership roles in elective posts; an indication of the role of money in elective politics. If the opposite is true, i.e. community members are not involved in the selection of HFC, then one would question whose interests the HFC are representing and whether they are just an embodiment of elite interests. These issues are investigated further under the main reasons for using a given accountability authority for redress in Section 5.3.5.

The difference in awareness of the HFC was even more pronounced in the category of occupation, with a lower proportion of students (29.3%) reporting knowledge of the existence of HFCs compared to those in skilled employment (65%) and agriculture

(58.9%). Even among those in gainful economic activities, the >6 percentage point difference between those in agriculture and those in skilled employment is still significant.

The distance to the facility was significantly associated with HFC awareness. A lower proportion (44%) of those residing > 3 kilometres from the facility, knew about the existence a HFC compared to 57.7% residing within 3 kilometres (p value <0.001). This could be mainly because they would be expected to have less interaction with the HF or due to the high poverty levels, not being able to afford transport to a *Baraza* where HFC issues are discussed. The association between gender and knowledge of HFCs existence was insignificant, though a higher percentage of men (58.8%) knew about the existence of HFC compared to 52.8% women. However, marital status was significantly (p value <0.001) associated with HFC knowledge. Those in a current marital relationship (61.6%) were more likely to know about HFCs compared to 38.2% among those never married and 57.5% among those who were either separated or divorced.

A surprising finding was that user fee charges levels, education completed and the level of satisfaction with service received when a patient last visited a HF were not significantly associated with knowledge of HFC. Given the level of poverty in this area (with over 83% reporting a monthly income level below KES 5,000)[20], and given the evidence gathered in qualitative interviews which showed that women particularly felt overwhelmed by the user charges mainly due to non-adherence to user fee policies, one would expect that these issues would drive any associations with knowledge of HFCs. Again, all these findings are subjected to further analysis and the results are presented in later sections of this chapter.

5.2.2 User Knowledge of a Member of the Health Facility Committee

A second measure of depth of engagement between the HFC and the community that the study investigated was whether the respondent knew a member of the HFC (not necessarily by name). The responses from the qualitative interviews were not very different from those cited for not knowing about the existence of the HFC. Many respondents reported that besides never having been invited to the election meetings,

[20] Approximately less than US$ 72 per month, at an exchange rate of US$1 = KES 70 at the time of survey

no meetings had been held to introduce the HFC members to the community. This was quite a common response among those reporting awareness of the HFC:

> *I have heard about them but I have never seen their faces, I don't know who they are. They are people who are managing this institution but I don't know them* (Male respondent, FC).

However, other users felt that they would only know the HFC if there was something wrong going on at the facility. This was particular among FC users, which was considered a good performer by the DMOH and had received positive comments from users. In this facility, the FI had developed a good rapport with the community who reported that they trusted him. According to these respondents, this trust translated to good working relations with the HFC whose impact they were seeing in how the facility was being managed. As such, they did not bother to query much about what was going on at the facility:

> *Maybe it's because I have not cared to ask, you know kibaya chajitembeza [a Swahili saying loosely translated in this context to mean where there is smoke there is fire and it would be difficult to hide such] if they were doing wrong things, it could be easy to know as it would spread quickly, but there is no need for us to query more when you are seeing work here is organised. It depends on the management* (Female respondent, FC).

A significant number of users also reported that the HFC members were distant from them, that the HFC was composed of 'who-is-who' in the community, and that the committee was almost exclusively selected by the local elite. This group of respondents also felt that if they asked more about the health facility issues and committee operations, it would be seen as 'bad politics' or 'sowing strife' thus instilling fear in them:

> *I know there are health facility committees, but I haven't asked about one for this hospital specifically, I haven't spoken to them either. I fear…because they would say its 'fitina', [discord or bad politics]; people would say you are going to tell the committee 'fitina ya hospitali' [you are bringing bad politics into the health facility]. Now we fear* (Male respondent, FA).

These issues were investigated further in the survey and the results are summarised in Table A4 Appendix of Tables, largely confirming the data from qualitative interviews. The question was administered to 55% or 560 respondents who had reported knowledge of the existence of the HFC in their area. The factors that were significantly associated with knowledge of a member of the HFC included the nearest HF, *Baraza*

attendance, gender, age, income and education. Respondents from FB were more likely to know a member of their HFC (63.7%), compared to those in Facilities FA (57.9%), FD (54.7%) and FC (42.1%). Community members who had attended a *Baraza* (60.9%) in the last six months were more likely to know a member of their HFC, unlike those who had not (50%) representing more than ten percentage points' difference.

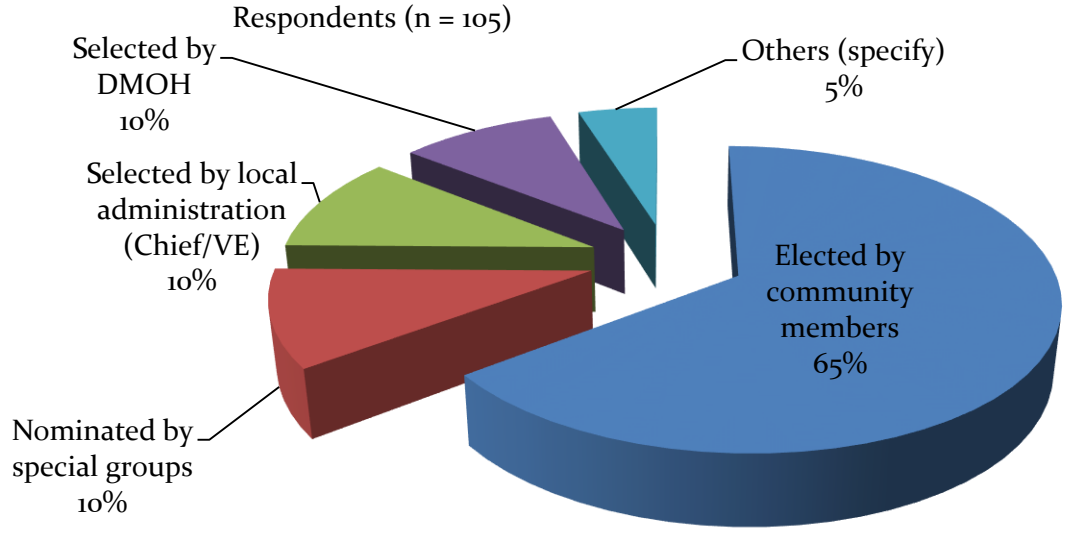
The variation was even more pronounced among the genders, with more men (67%) likely to know a member of the area HFC than women (46.5%); a massive >20 percentage points' difference. This is not surprising given that the majority of women reported not to have regularly attended *Baraza*s, the main forum where HFC issues were often discussed and decided upon. Just like in the knowledge of existence of HFC, respondents aged 35 and above were more likely to know a member of their local HFC as opposed to their younger counterparts aged 16 – 24 years. These differences are also reflected in income, where those reporting a monthly income of more than KES 5,000 were more likely to know a member of their HFC (69.9%), compared to those in the lower income bracket (KES 2000 or less a month) at 45.4%; and in education levels where those with post-secondary education are more likely to know a member of the their HFC (63.8%) as opposed to those with primary education or less at 48.8%.

5.2.3 Users' Knowledge of Committee Roles and Selection Process

Committee Selection

Of the 560 individuals reporting knowledge of the existence of a HFC in their area, only 105 (18.8%) knew how the HFCs were selected (see Figure 5.1). Awareness of HFC selection was significantly higher among respondents using FA (35.5%) compared to FB, FC and FD (16.4%, 11.7% and 14.2% respectively). A large majority (64.8%, n=68) of those who knew how the committee was selected reported 'election by community members' as the method of selection, and the rest 'other' (defined as nomination by special groups e.g. churches, selected by local administration, selected by DMOH). Committee selection methods also differed significantly across the four sites with 79.1% (n=34) of respondents from FA reporting that the community elected their committee compared with 71.4% in FD, 70.6% in FC and only 29.2% in FB; a pattern that was confirmed in IDIs with HFC members.

Figure 5.1: Committee Selection Criteria According to Survey Respondents (n = 105)



Data Source: Household Survey April – May 2011

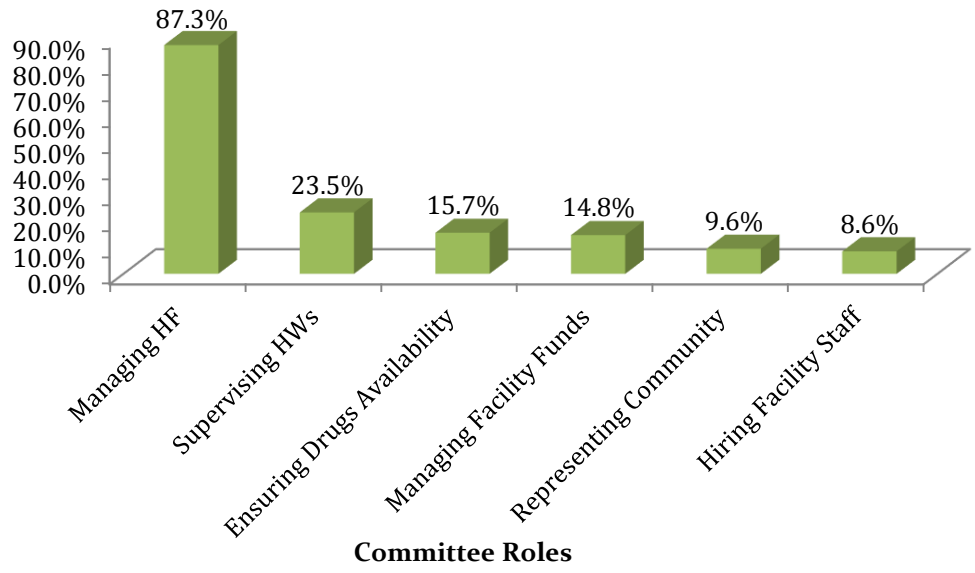
There was also a significant variation in the knowledge of HFC selection among the age groups, gender and *Baraza* attendance. Knowledge of HFC selection increased with age. Those aged 45 years and above were more likely to know how the HFC is selected (27%) compared to their younger counterparts aged 16 – 24 years (10.6%). *Baraza* attendance was significantly associated with knowledge of HFC selection; of those who reported knowing how the HFC was selected, 23.9% had been to a *Baraza* compared to 15.2% who had not. Being male was also significantly associated with knowledge about HFC selection; 27.5% of men reported knowing how the HFC was selected compared to only 13.2% among the women; a 14.3 percentage points' difference. Again, education was surprisingly not associated with knowledge of HFC selection, as was occupation and reason for choice of HF and provider. Marital status and income levels were marginally associated with knowledge of HFC selection.

Committee Roles

Data from the household survey confirmed the consensus among HFC members that they were in charge of general facility management as described in chapter 4. Figure 5.2 show that a larger percentage of respondents (87.3%) mentioned managing the HF as the main role of HFCs. However, a significant proportion of respondents (23.5%) also reported that the HFC should ensure the HWs performed their duties as well as ensuring there is a supply of drugs and being in charge of facility funds. Surprisingly,

only 9.6% reported that the HFC represented community interests at the facility. This also confirms the findings from the group and individual interviews, where some respondents expressed disappointment that the HFCs rarely advocated for patient interests. Instead, the HFCs chose to ignore respondents' complaints about issues such as HWs being rude to users or drug shortages. It is however important to recall that few HFCs ever saw themselves as representatives of the community. This might also be an indication of varying perceptions and understanding of accountability between the various stakeholders in the health system.

Figure 5.2: Committee Roles According to Survey Respondents (N = 308 in each case)



Data Source: Household Survey April – May 2011

5.2.4 Determinants of User Awareness of Health Facility Committees

Table 5.2 shows adjusted multivariate analysis results for determinants of HFC awareness with 'Unaware' as the base outcome – that is, those 'Aware' of the HFC are being compared with those who are 'Unaware'. The odds of being aware of the HFC tended to increase with age, education, and income, although non-significant results were observed for income category KES 2001 – 5000. Compared to students, those in agriculture, skilled, and unskilled labour, had significantly greater odds of being aware of their facility HFC (OR 2.88; 95% CI, 1.30-6.41, OR 2.97; 95% CI 1.23-7.19, and OR 6.22; 95% CI, 2.08-18.4), respectively. Similarly, those clustered around facilities FB, FC, and

FD, had greater odds of being aware of their HFCs compared to those in FA. Gender and marital status returned non-significant results.

Table 5.1: Multivariate Logistic Regression Model for Determinants of 'HFC Awareness'

	Aware Vs Unaware	
Indicators	Odds Ratio	95% C.I.
Socio-Demographic Indicators		
Gender (Reference Male)		
Female	1.23	[0.74 – 2.03]
Age (Reference 16 -24 years)		
25 - 34 years	1.99*	[1.11 – 3.56]
35 - 44 years	2.56**	[1.31 – 4.97]
45 and above	2.74*	[1.15 – 6.53]
Education (Reference Primary or less)		
Secondary	1.92**	[1.20 – 3.09]
Post- Secondary	3.45**	[1.42 – 8.39]
Monthly Income (Reference KES up to 2000)		
KES 2001 - 5000	1.18	[0.69 – 2.02]
KES 5001 and above	2.29*	[1.13 – 4.66]
Occupation (Reference Students)		
Agriculture	2.88**	[1.30 – 6.41]
Skilled Labour	2.97*	[1.23 – 7.19]
Unskilled labour	6.22***	[2.08 – 18.54]
Marital Status (Reference Married)		
Not in a Marital relations	1.23	[0.66 – 2.27]
Cluster HF (Reference FA)		
FB	2.87***	[1.55 – 5.32]
FC	2.26*	[1.15 – 4.45]
FD	1.82*	[1.01 – 3.26]
Health & Morbidity Data		
Distance to facility (Reference 3Km or less)		
> 3Km	0.51*	[0.29 - 0.96]
Don't Know	0.33	[0.07 – 3.05]
Age of Ill HH Member (Reference Under 5 years)		
Over 5 years	0.90	[0.58 - 1.42]
Given Drugs at HF (Reference Yes)		
No	0.34	[0.10 – 1.23]
Required to buy drugs outside facility (Reference No)		
Yes	1.77*	[1.13 – 2.77]
HSA Indicators		
Given Receipt (Reference No)		
Yes	0.91	[0.58 - 1.43]
Have attended a *Baraza* (Reference No)		
Yes	2.64***	[1.57 – 4.40]
SC Usefulness (Reference Not Useful)		
Useful	1.46	[0.80 – 2.68]
User fee Charged (Reference KES 50 or less)		
KES >50	2.63*	[1.18 - 5.86]

*p<.05, **p<.01, ***p<.001

Data Source: Household Survey April - May 2011

As would be expected, those living more than 3 Km from their facility were 49% less likely to be aware of the HFC, compared to those living within a radius of 3 Km or less.

The quality of care as indicated by whether one was required to buy drugs from outside the facility was also a significant determinant of HFC awareness among users. Users who were required to buy drugs outside the facility after paying the requisite user fees had higher odds of knowing about their HFC (OR 1.77: p value <. 05), compared to those who were not.

Individuals who had been to a *Baraza* had higher odds of knowing about the HFC (OR 2.64; p value < .001), compared to those who had not. Holding all else constant, individuals who were charged more than the HFC set amount of KES 50 had higher odds of knowing about the HFC (OR 2.63; p value < .05), compared to those who were charged the requisite KES 50, or less. Although those who found the service charter useful had greater odds of being aware of their local HFC compared to those who did not, the results were non-significant. Surprisingly, the odds of being aware of the local HFC reduced (insignificantly so) for those facilities that issued receipts compared to those that did not, despite this variable emerging as significant in the qualitative data.

5.3 Responsiveness

Arguably, HSA should move beyond user involvement to requiring the health system to be responsive to the issues raised through participation. Responsiveness thus results from changes made to the health system on the basis of ideas or concerns raised by, or with, users through formally introduced decision-making mechanisms [79]. This section considers to what extent responsiveness was achieved in the study area.

5.3.1 Committee - Communication Processes

As discussed in Chapter 2, communication is an important element of accountability in any setting. Communication is also a two way process, rather than simply about disseminating messages and instructions. From the interviews with HFC members, it emerged that the HFCs rely on both formal and informal mechanisms to engage the community. The main formal mechanism for reaching the community was through the *Baraza*.[21] Other formal methods included health promotion/outreach forums, and in

[21] See Chapter 4 for a detailed description of a *Baraza*.

some cases school and CBO meetings. Informally, the HFCs mentioned that they interact with the community almost on a daily, individual basis given they are members of the same community and relied on the information spreading from one household to the next:

> *We rely on this technique – 'reach one, teach one'. For example if you teach me something then I meet a friend of mine, I tell him the same thing that is of importance to the community. By the end of the week or by the end of the day we shall have reached many people. We also use the headmasters of the school and that particular information goes down to the grass roots. Otherwise we mainly rely on the Baraza* (HFC Chairman, FB).

Apart from the *Baraza*, male HFC members also mentioned using local daily gatherings in market centres or at local drinking dens where they gather any information about the HF, while the female HFC members mentioned local women group development forums (merry-go-rounds) and other informal settings to reach the wider community:

> *When we have Barazas is when we meet the community and maybe there are some meetings let's say Mary-go-rounds or chamas[22], we [women] visit each other say when a woman delivers, after one week we go to that home, take tea and gift the new born. We then talk about HF issues among other development issues that affect us* (Female HFC member, FB).

It emerged from the pilot that while the HFCs felt that they were doing a lot, they were either failing to communicate their activities/successes to the community or the methods they were using were not effective. All the HFCs depended on the *Baraza* as their main method of communication with the community. The study thus investigated this medium of interaction between the HFCs and the community to understand what factors influenced these interactions and to gain a deeper understanding of the depth of engagement between the HFCs and the community.

In order to understand how the *Baraza* support HSA, the study looked at its awareness among households. Respondents were asked whether they had ever been to a *Baraza*, and if yes, whether any health facility issue was discussed at the last *Baraza* they attended. Only 32.2% (n = 329) of the respondents (N = 1019) had been to a *Baraza* in the last six months. There was no significant difference across the four clusters/facilities. However, there was a significant association between *Baraza*

[22] Small women groups where individuals pool together resources and lend to each other

attendance and gender; attendance among men was significantly higher (52%) compared to among women (21%). In fact, of the 329 who had attended a *Baraza*, 58.7% were men and 41.3% were women. A similar pattern was noted with age, occupation, income levels, the main reason for choice of treatment provider, and one's marital status. Conversely, the main reason for choice of HF for treatment, education level completed, and estimated distance to nearest HF was not associated with *Baraza* attendance. These data are presented in Table A5 Appendix of Tables. Qualitative interviews with those who had attended a *Baraza* confirmed that health and health facility issues were indeed discussed and that the forum was used as a platform for health promotion:

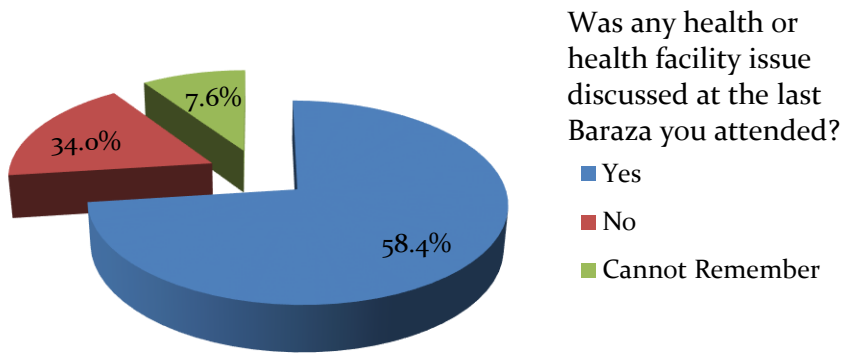
> *They [at the Baraza] talked about toilets, malaria, and use of ITNS, spraying of the houses; they told us this [referring to FA] is the nearest facility with so many services being offered. They also they talked of VCT, malaria, clinics, and to the mothers talked to majority of whom were old* (Male respondent, FA).

Perhaps underscoring the issues of fear particularly among the youths, some respondents reported that community leaders tried to dissuade them from this line of thought and to build some confidence and trust that as government officials, they are there to help:

> *They advised community members to observe hygiene at home by using clean items for their daily activities. They also encouraged people not to fear them thinking as government workers, they are there to arrest them. That they should not hide from the government officials because they may be of help but if they hide, that will not be possible* (Male respondent, FC).

Survey data showed that 58.4% of those who had attended a *Baraza* concurred (see Figure 5.3) that a health facility issue was discussed at the last *Baraza* they attended. The issues mentioned ranged from HWs' behaviour, drug shortage at HF, disease prevention and care (mainly malaria, TB, HIV and AIDS), general facility development and health promotion. Qualitative FGDs and IDIs revealed that the *Baraza* was not an effective mode of communication between the health system and the households. Community members mentioned several frustrations with the *Baraza,* especially the way it was summoned and conducted. HWs also felt that in certain circumstances, the *Baraza* was being used as a platform to wage war against the HF, rather than help restore its reputation.

Figure 5.3: Users reporting that a health/heath facility issue was discussed at a Baraza (n = 329)



Data Source: Household Survey April – May 2011

Some HWs narrated incidences where area leaders or some community members, who were unhappy with services at the HF, were reported to use the *Baraza* to castigate HWs and criticise the services offered in the HF, thereby discouraging the community from using the facility. These incidences were reported mainly in FA and FB; facilities that were seen not to be performing well. IDIs with HWs revealed that such incidences were demoralising to staff who felt they were unappreciated even though they worked so hard with such limited resources to serve the community. When asked what the main challenges to the functioning of the HFC and the HF were, the FI, at FB, reported:

> *When people go to a Baraza, they talk negatively about us, you know it demoralizes our work very much... may be you go for a break, and when they go out there, they say when you go to the hospital, you don't get service and may be that patient has just arrived and had not waited for that long anyway. You see when they just go talking, claiming that a HW stayed in break for 1 hour and it is a lie, it demoralizes us a lot* (FI, for FB).

Survey respondents also complained that the *Baraza* was not helping people to know about the on-goings at the HF and was not inclusive. The youths were particularly vocal about being excluded from discussions at the *Baraza* as the conversation in a group discussion with youths at FB below illustrates:

Facilitator:	And the Chief or councillor? Can't they address such issues [HFC members being exclusively selected and unknown to respondents] during the *Baraza*?
Res 1:	*They don't mention such things...*
Res 2:	*They do not. They talk of other agendas, other issues*
Res 1:	*in fact we have not heard of Barazas*

Res 2: *I attended a Baraza sometime back*
Res 3: *Baraza was spoilt by the Nyayo regime [referring to former government],*
Facilitator: How?
Res 1: *Because they are not open to everyone,*
Res 4: *people hate the chief*
Res 2: *it [Baraza] belongs to the old men, so what they decide is final. Do you think we youth should be attending such meetings?*
Res 1: *No it's not open for every one*
Facilitator: But why are youth not attending the *Baraza*?
Res 4: *We go, but we do not get a chance to be heard*
Facilitator: why? This is a major issue that we need to discuss openly, why are we not given a chance at the Baraza?
Res 1: *the old men [village elders] get all the time to speak and say what they want to say, when they are done the chief says one woman to speak then one man. There is usually no chance for the youth*
Facilitator: Do they mention the youth?
Res 1: *No, unless if you are somehow rich…*

5.3.2 Involvement of Users in Decision-making and Priority Setting

Two indicators were used to assess user involvement in decision-making and priority setting – user fees setting and priority setting. The study investigated what users viewed as the priority or main problems at the facility. Results are summarised in Table 5.2. Of the 1,019 individuals included in the survey, 82.9% could identify main problems they felt affected their care experience at the facility, while 17.1% either did not see any problem or could not identify any. Respondents identified three main problems that they felt should be the main priority for the HFC to deal with: drug shortage or stock outs (59.9%), few or inadequate human resources especially qualified clinicians/nurses (43.8%), and inappropriate/bad HW behaviour (15.4%).

Interestingly, though overcharging/high costs of care were identified as a major issue; it did not rank among the urgent or significant issues. The data does not compare well with HF priorities as defined by the HFCs. IDIs and document reviews reveal that most facilities considered inadequate funds, shortage of HWs, and long queues as the major problems and thus their priority. Only the HFC for FD identified drug shortage as a major issue forming a priority for the committee. HW behaviour was not mentioned by any of the HFCs as a major problem; neither did HFCs consider overcharging and/or a lack of waivers for the vulnerable groups as a problem. In essence, priorities and

perceptions of what should be the HF priorities for the two accountability stakeholders were mismatched, except for the case of shortage or few qualified HWs.

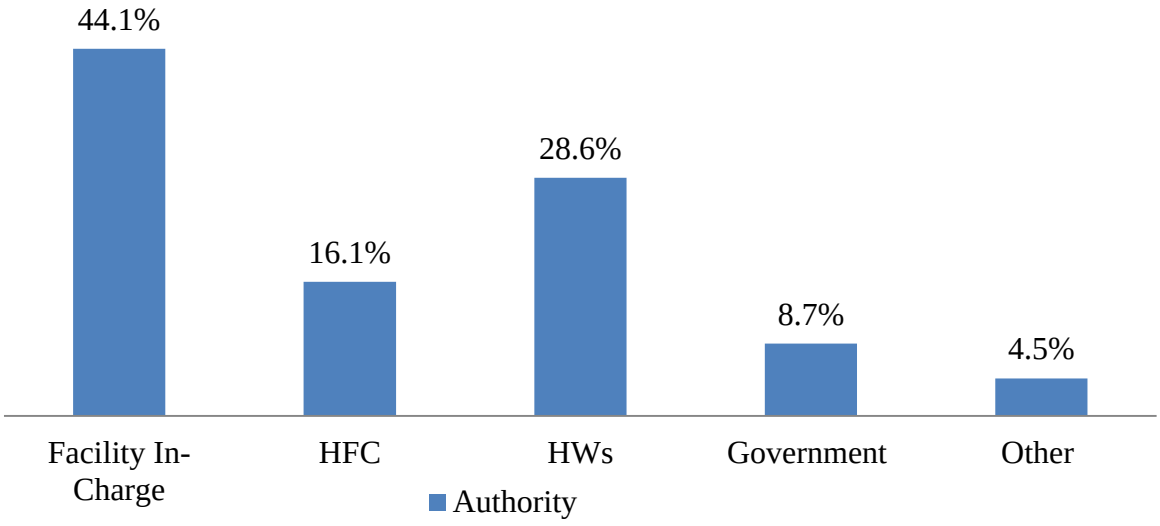
Table 5.2: Health Facility Priority Problem Areas According to Community Members (% of individuals who think a given issue is a major problem per facility)

	FA	FB	FC	FD	Total
N	225	209	171	240	845
Drug Shortage	167 (74.2%)**	135 (64.6%)	58 (33.9%)***	146 (60.8%)	506 (59.9%)
Shortage of HWs	99 (44%)*	54 (25.8%)*	62 (36.3%)	79 (32.9%)	294 (34.8%)
Bad HWs behaviour	25 (11.1%)	28 (13.4%)	30 (17.5%)	47 (19.6%)	130 (15.4%)
Overcharging/ High costs of care	15 (6.7%)	7 (3.4%)**	21 (12.3%)	32 (13.3%)*	75 (8.9%)
Health Facility Mismanagement	19 (8.4%)	15 (7.2%)	9 (5.3%)	19 (7.9%)	62 (7.3%)
Short opening hours	4 (1.8%)**	25 (12%)**	12 (7%)	14 (5.8%)	55 (6.5%)
Long Queues/ Waiting time	7 (3.1%)	7 (3.3%)	12 (7%)	26 (10.8%)**	52 (6.2%)
Inadequate maternity facilities	3 (1.3%)*	15 (7.2%)	13 (7.6%)	10 (4.2%)	41 (4.9%)
Poor referral facilities	10 (4.4%)	14 (6.7%)*	3 (1.8%)	6 (2.5%)	33 (3.9%)
Poor lab services	6 (2.7%)	6 (2.9%)	4 (2.3%)	9 (3.8%)	25 (3%)
Inadequate health facility funds	3 (1.3%)	4 (1.9%)	4 (2.3%)	2 (0.8%)	13 (1.5%)

*Significant difference between facilities (chi² test, ***p<0.001, **p<0.01, *p<0.05)
Source: Household Survey April – May 2011

On deciding/setting user fees, qualitative data revealed that the community was not involved and that this was done almost exclusively by the HFCs. Most of the community members interviewed expressed surprise when asked whether they were consulted when the fees were decided or whether they knew who set/decided on how much they were charged for the services they received at the facility. Of all survey respondents only 15.8% (161) reported to know who decides the user fee at the HF and of the 161 respondents only 1 person said the community decides (this has been grouped under 'other') and only 6 (or 0.6%) reported that they have been consulted when the user fees were being set. As shown in Figure 5.4, 44.1% reported that the FI determined the user fees with only 16.1% reporting that the fees were determined by the HFC, further showing the grey area around who exactly is the decision maker on this important aspect of accountability in the health system.

Figure 5.4: Authority that decides User Fees According to Survey Respondents (n=161)



Data Source: Household Survey April – May 2011

These claims were collaborated by data from the IDIs with HFCs members:

> *The committee decides on how much is charged at the facility. After receiving proposals from the facility in-charge, we sit down as a committee and agree on set figures and forward them to the DMOH for approval* (HFC Chairman, FC).

> *It [setting user fee charges] is done by the committee... we are being help by those running this place on a day-today basis - the facility in-charge - they give us some figures we discuss, then we agree on the limits* (HFC Chairman, FD).

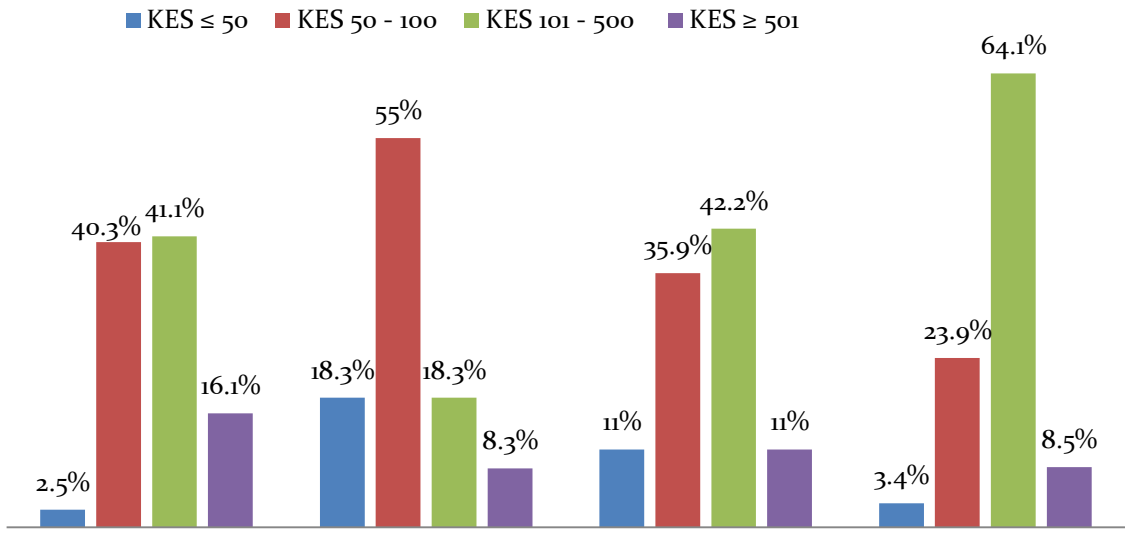
5.3.3 Role of Committee in Achieving Equity and Financial Accountability

User Fees Charges and Fee Waivers

Financial accountability emerged at the centre of discussions around HSA and was the most referred to dimension of accountability by all the stakeholders interviewed. Because the HFCs are directly in charge of the overall management of the HF, including setting user fees, managing drug revolving funds, and protecting the most vulnerable and poor from exorbitant care costs, this study investigated how the HFCs performed on these indicators but with respect to what the local populations identified as important. The main indicators were: the involvement of the community in setting and using user fees (described in chapter 4 and in section sub-section 5.3.2 above), user fees adherence, the availability of exemption schemes or waivers for the most vulnerable groups (defined as pregnant women, the poor and children under 5), and finally accounting for facility funds to the community.

The most important aspect of equity to a majority of the community seemed to be user fee adherence and the availability or lack of exemption schemes for the vulnerable members of the community. Both survey and document review data reveal that none of the facilities adhered to their user fee policy as set out by the HFC on the facility SC, neither did they have any proper exemption schemes in place for those who could not afford the charges. Of the 954 respondents[23] who had used their local facility in the last 6 months, 97.5% or 930 paid for the services they received at the HF. Figure 5.5 shows the amount paid by patients at their last visit to the facility in percentages. There was a significant association between the fee category charged and the HFs (p value =< .001). FA had the highest rate of non-adherence to user fee policy with 97.5% of respondents who visited the facility being charged more than the stipulated KES 50, followed by FD (96.6%), then FC (89%) and lastly FB which had the best user fee adherence with 81.7% reporting to have been overcharged.

Figure 5.5: Percentage User fee Charges Across all Facilities (n=930)



Data Source: Household Survey April – May 2011

Across all the clusters, users reported a 'no-money no-service' policy. Many users complained that government facilities were now being run like private clinics:

[23] Excludes 65 individuals: 35 who had no reported cases of illness in the last 6 months, and 30 (5 sought no treatment, 23 self-medication, and 5 faith healing) who used other providers for treatment

They [HWs] asked me whether I had money and I told them I didn't have. Then they informed me 'no money, no service' (Male respondent, who had gone for an anti-tetanus jab, FA).

You know even if I go to the district hospital, I must still pay, I think it's become a tradition in public hospitals, you have to pay; we have come to know these public hospitals like private clinics or pharmacies where you pay and you just leave without asking what the money is for; if you are unable to pay you leave the drugs and go your way; you know the human tendency is that if you are inquisitive you are answered back rudely (Female respondent, FA).

While many respondents reported awareness of the government's cost-sharing policy, many decried a 'money-first culture' at public facilities that they expected to cushion them from ill health if they could not afford the cost of care (see Box 2). But most worrying was the fact that the HWs in many instances denied the most vulnerable groups - expectant mothers requiring delivery, under 5s, and the poorest – services when they could not afford them. In two Facilities (FB and FD), the research team encountered two families that had lost their loved ones due to postpartum haemorrhage because the HWs reportedly denied them service without advance payment (see Box 2). In Facilities FA and FB, the HWs were reported to demand advance payment before helping with the deliveries retorting that 'they were not paid to work at night', while in FD, the HWs refused to attend to the women because it was late in the night and they were 'tired'.

In all the cases, the women lost their lives due to postpartum haemorrhage and the community turned their anger at the HFC and the HWs:

We lost a mother here, but she did not pass away here, she died at the district hospital. I was not there because it was at night. I was informed there was a delay in attending to her and in referring her to the district hospital. That mother had a problem of excessive bleeding during her previous deliveries and was informed not to deliver in a small hospital like this. It was unfortunate for all of us; we were all sorry about it. After that a Baraza was held and the blame came to us that the management was poor, that we didn't care.... Community members were warned that 'there is negligence in that hospital, don't go there to deliver your child, you will be neglected' ... such like things... now you see not only that particular staff got demoralized but everyone in the hospital (FI, for FB).

You cannot take your wife to deliver in that hospital, unless you want her to die. The HWs there do not care, what they want is money first, without money you will not be helped even if you are dying. We wish the facility was turned into a

chicken farm, we would all benefit from the meat and the eggs (Male respondent, FB).

Box 2: Health System Failing Expectant Mothers – Family Loses Expectant Mother to Postpartum Haemorrhage

Kiplimo* is a 27 year old subsistence farmer, who lost his wife due to postpartum haemorrhage, at FD. He narrates his story about how the nurses at the local facility (FD) had refused to attend to his wife because it was at night and he could not produce the KES 700 delivery fee that they had demanded. He tells his story as follows:

> They [nurses] asked me to pay the money or look for a taxi to transfer my wife to the District Hospital [about 30 kilometres away]. I did not have the money to pay for her delivery, so I wondered how I could raise the taxi fare. I pleaded with them, but my pleas fell on deaf ears. Then I rushed to look for a local taxi man I knew who could accept to help transport my wife on credit. When I arrived back at the hospital, the baby was already coming out but it was obvious that my wife had bled a lot. With the help of my neighbours and those who came to witness, we managed to get the baby out but unfortunately the mother died. I could not believe my eyes. This was her first pregnancy and our first child. In a way, I blamed myself because I could not provide for my wife when she needed me most. It pained me, but there was nothing I could do… I could not even convince the nurses to help. I was in deep shock and anger seeing the nurses lock themselves in their rooms while my wife cried for help outside in the cold on the hospital veranda. It's not in our culture to be that heartless… They have a God given responsibility to help, even if in credit…to save lives…to listen to the community they serve since they are members of this community.

Kiplimo is one of the local residents who is aware of the local HFC since one of the committee members is his neighbour. He tells us that the committee is aware of the incident but had taken no action since *'I don't think they have the powers to discipline the HWs, given the community has raised these issues with them several times but no action has been taken…, if this is the way public facilities will continue to be managed, many people will continue to suffer…, you cannot rely on them [the HFC] to solve facility issues, it's like the HWs control them rather than them controlling the HWs… I personally do not trust that they can act on our complaints… maybe people like you from outside can help, but the chief, the village elders… nothing'*.

Source: Field notes

*Name changed for anonymity

All the facilities reported to charge KES 700 or £ 5.20 for delivery; an amount the HWs felt was not enough to cover the costs associated with such deliveries but which was out of reach for the majority of community members; many of whom live below a dollar a day (see Table A2, Appendix of Tables). Concerns over high charges at the

facilities were said to lead many expectant mothers to deliver at home putting their lives in danger, a fact that was confirmed by HWs who also expressed their frustration at being expected to facilitate such deliveries without requisite equipment.

> *There are many mothers delivering at home because they cannot afford the [KES] 700, but there is little we can do because we cannot let them come for a free delivery… some even come at second stage others come at night and we don't have a pharmacy around where we can buy necessary equipment, so we just sat down [HWs] and decided to charge that amount. They say it is expensive but when we go to Barazas we always explain to them why we are doing this, we can provide deliveries for free if we are provided with the equipment* (FI, for FA).

There were no defined exemption schemes even for children under-5 despite government policy requiring under-5s services to be free. Survey data showed that only 10.6% of children under-5 were charged the HFC set KES 50 or less. One user explained:

> *When you come here [at the HF] whether you've brought a child or yourself, you must pay [KES] 50 for registration, and [KES] 100 for laboratory tests* (Female respondent, FA).

In setting user fees, only six respondents said they had been consulted, confirming the evidence from IDIs with HFC members that they do not consult the community in deciding on the user fees. Data on how user fees is set has been provided in Chapter 4.

Issuance of Reciepts on User Fee Payment

It emerged from the qualitative interviews with the community that being issued with a receipt after making any payment was as important, if not more, as adhering to the user fee policy. Respondents viewed being issued with a receipt as an indicator of *'uwazi'* the Swahili word for transparency, at the HF, i.e. perhaps an indication of an understanding of accountability that transcends what is done to include what is seen (or recorded) to have been done. It was quite surprising that many respondents were not as concerned about the amount they were charged as they were about being issued with a receipt after any payment as a sign of transparency in the way hospital funds were administered (how and for what purpose) or whether the HWs adhered to the set user fee. Some respondents explained:

> *So that you know where it (referring to the user fees) is going, in fact you cannot pay without them giving you a receipt* (Female respondent, FC, which issued receipts).

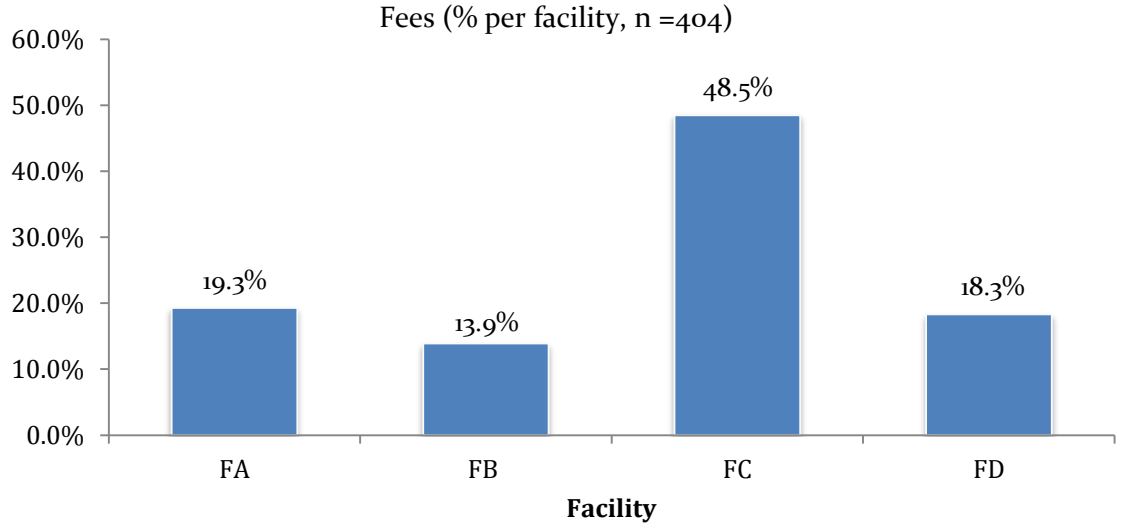
> *You know the receipt is showing transparency, without the receipt there is no transparency* (Female respondent, FA, which did not issue receipts).

Some associated the lack of receipts to corruption at the facility:

> *Now you know you may ask [for a receipt] and you may be given so many 'nini nini' [meaning excuses]. In other words you can be quarrelled 'why are you asking this?' I think it's just corruption* (Female respondent, FA).

Survey data confirmed respondents' worries about facilities collecting money and not issuing receipts for the same. As shown in Figure 5.6 below, none of the facilities achieved a 50% receipt issuance. Receipts were more likely to be issued in FC compared to the other three facilities investigated. FB had the lowest number of respondents (13.9%) reporting they were issued with a receipt after making payments, perhaps an indicator that most of the user fee collected was not recorded and thus went unaccounated for.

Figure 5.6: Respondents Issued With a Receipt on Payment of User Fees (% per facility, n =404)

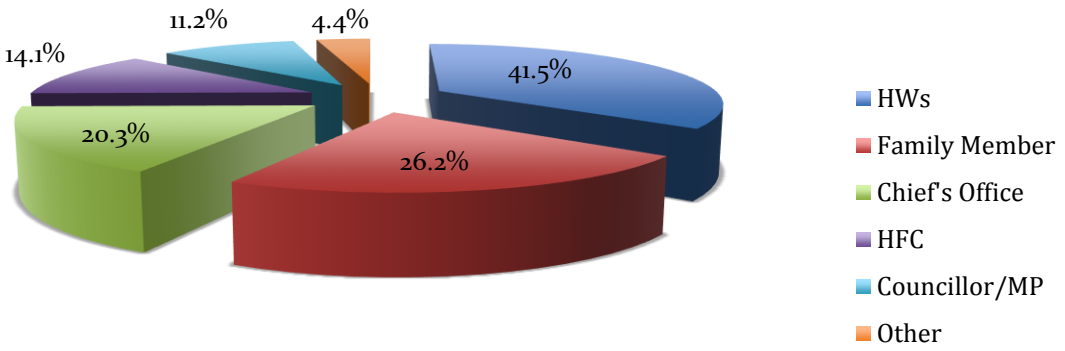


Data Source: Household Survey April – May 2011

5.3.4 User Engagement of the Committee to Resolve Facility Related Issues

In order to elucidate the role of HFCs in service provision and to understand the depth and breadth of HFC engagement with the community, the study investigated what options or persons in authority, users resorted to when they had a problem at the facility. The study further investigated which authority respondents would approach first, and why, in order to identify factors that influence the choice of a given accountability mechanism for addressing HF problems. The results are summarised in Figures 5.7 and 5.8.

Figure 5.7: Accountability Mechanism/Authority that Users would Approach to help Resolve a Problem in the facility (% per authority, n=977 in each case)

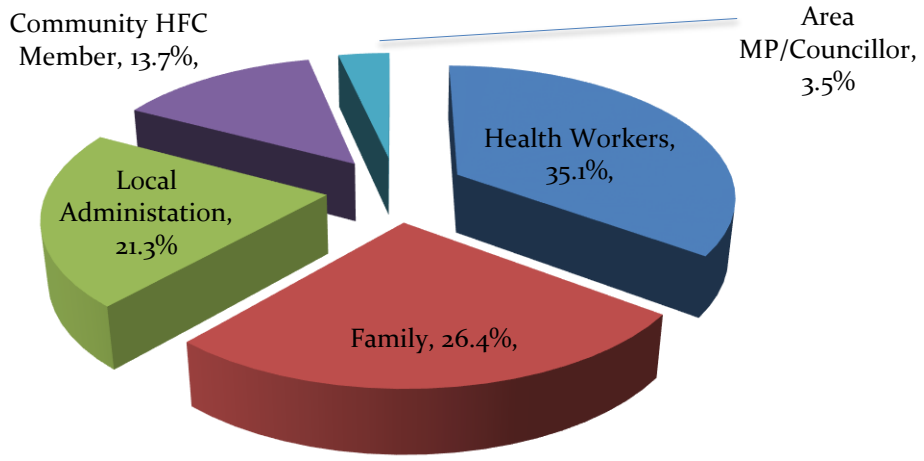


Data Source: Household Survey April – May 2011

As shown in Figure 5.7 above, only 14.1% of respondents said they would approach the HFC to resolve a HF related issue with a majority (41.5%) preferring to talk to the HWs and 26.2% to a family member.

On the subject of what authority or persons in authority users would approach first to resolve problems at the facility, the majority (35.1%) preferred to speak to the HWs first (and in particular the FI), followed by a family member (26.4%). Only 13.7% had a community member of the HFC as their first choice for problem solving, clearly indicating that the HFC is a not a preferred mode for addressing HF issues (see Figured 5.8).

Figure 5.8: Authority Users Would Approach First to Resolve Facility Problems (% Per authority, n=569)



Data Source: Household Survey April – May 2011

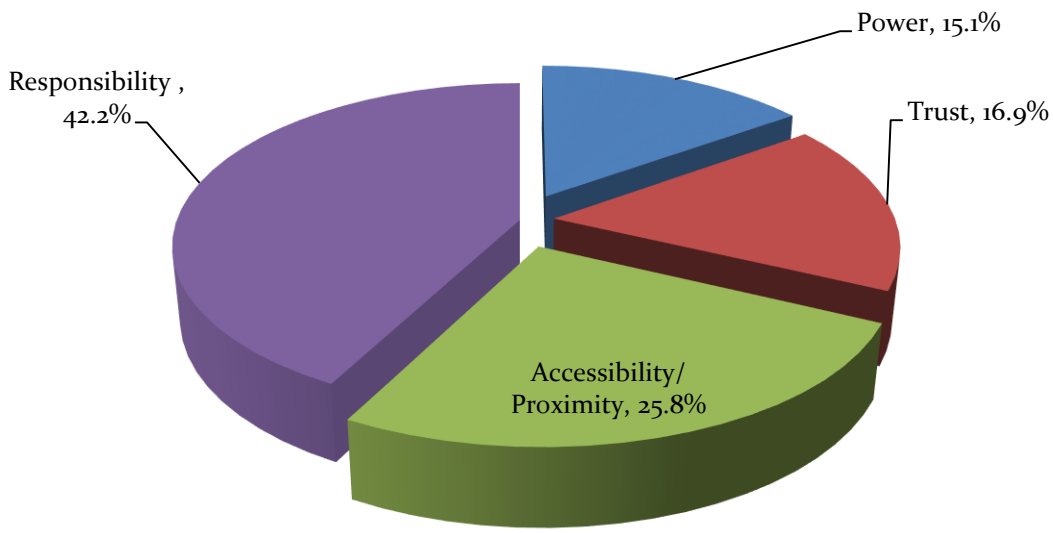
5.3.5 Factors Influencing Choice of Accountability Mechanism/Authority in Resolving Facility Problems

The study went further to try to understand the **main** reasons why respondents would choose to engage or not engage with particular accountability structures/authorities both at individual household survey sessions and at the FGDs. The majority (42.2%) mentioned responsibility (i.e. that the authority is charged with that responsibility and thus should be the one to be approached) as the main reason they would approach/use a given mechanism to resolve a HF issue, followed by proximity, or accessibility, i.e. a given mechanism being nearest to them and as such they would easily access them in case of a problem (25.8%). Some HFC members interviewed also had similar views. On responsibility, one explained:

> *Responsibility means many things: one you have to be responsible to people who elected you, to give them the support they need; you also pass the information that you think is going to help them; you are also to avail yourself when you are wanted by either those who elected you or from the people whose services are rendered within that facility* (HFC Chairman, FB).

A significant number (16.9%) also mentioned trust as a determining factor, while the least popular reason was a given office/mechanism being powerful and thus most likely to help solve the problem (15.1%). The data is summarised in Figure 5.9 below.

Figure 5.9: Users' **main Reasons** for approaching/using a Given Accountability structure/authority to Resolve a HF issue (n = 569)



Data Source: Household Survey April – May 2011

In defining trust, most respondents referred to *'ninamwamini'* - a Swahili word literary meaning 'I trust him or her'. Often, trust in this context was associated with feelings of compassion, care, understanding, friendliness and a sense that someone was genuinely interested in one's problems. These were common among respondents from FC, who reported that their FI was friendly, took his time to listen to them and thus understood their problems. They considered him to be *'mtu anayeaminka'* [someone who can be trusted] with not just their health, but also the management of the facility. Most of them did not therefore see a need to ask how the money they paid was used because most of the time they received drugs, they noticed improvements such as hygiene and income-generating activities at the facility, and whenever they complained about any HW, the FI took action to correct the problem, be it overcharging, lateness, or rudeness on the part of the staff.

Power was often cited in relation to the local politicians who community members viewed as having the means and authority to deal with HFC issues. Power in this context was seen in terms of someone having the means and willingness to help, so it was not uncommon for respondents to report they would not approach the HFC Chairman because, even though they felt he had the powers to help, in many instances they feared that he would not be willing to help. This was particularly typical among respondents using FA who referred to several occasions when they had had to rely on the area councillor to solve problems at the HF.

As shown in Table 5.3, there were significant associations between the authority/mechanism member that respondents would approach first and the main accountability markers.[24] Community members were more likely to approach: a community HFC member and the Chief's office because they perceived these mechanisms or authorities to be nearest to the them; a HW because they felt s\he was responsible or the 'duty bearer'; the area politician (MP/Councillor) because they

[24] In understanding the main factors influencing the choice of any given mechanism for redress, it is important to note that these are not mutually exclusive in the everyday life of members of this community. Its common that while one would report approaching the facility in-charge for instance mainly because of trust, that relationship could very much be influenced by the view that a facility in-charge is the most powerful of all HWs, has the responsibility of ensuring proper management of the HF, and perhaps most importantly, has access to resources such as drugs or the authority to allocate a fee waiver.

believed s/he was the most powerful person to deal with the issue; and finally, the family because they trusted them most.

Table 5.3: First Authority Users Would Approach to Solve Facility Problems and Corresponding Main 'Accountability Marker'

	Accountability Marker				
Authority talked to first to resolve HF issues	Proximity	Power	Trust	Responsibility	**Total**
Community HFC Member	35 (44.9%)**	14 (17.9%)	2 (2.6%)**	27 (34.6%)	78 (100%)
Chief's Office	70 (57.9%)***	17 (14%)	7 (5.8%)**	27 (22.3%)***	121 (100%)
Health Workers	5 (2.5%)***	39 (19.5%)*	9 (4.5%)***	147 (73.5%)***	200 (100%)
Area MP/Councillor	2 (10%)	14 (70%)***	2 (10%)	2 (10%)*	20 (100%)
Family	35 (23.3%)	2 (1.3%)***	76 (50.7%)***	37 (24.7%)***	150 (100%)
Total	147 (25.8%)	86 (15.1%)	96 (16.9%)	240 (42.2%)	569 (100%)

Significant difference between authority approached and specified accountability marker chi² *p < 0.05, **p < 0.01, ***p < 0.001
Data Source: Household Survey April-May 2011

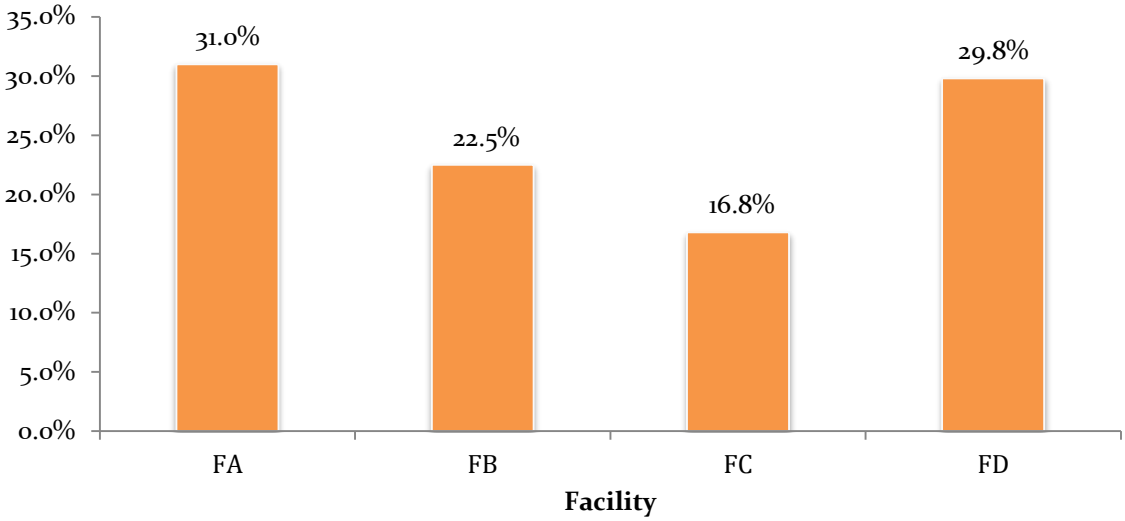
5.4 Committee Impact on Service Delivery

5.4.1 Drug Availability and Quality of Service at the Facility

The availability of drugs at the facility was an important measure/indicator of the quality of care mentioned by respondents and was inextricabley linked to HFC influence on service delivery at the HFs. Many respondents complained about frequent drug stock-outs, being asked to buy drugs from outside the facility or from a parallel pharmacy run within the facilities, and the poor quality of some of the drugs they were given. In particularly, respondents were unhappy about having to buy drugs and other treatment items from outside the facility even after paying the requisite user fees, viewing it as a failure by the HFCs to protect them from exploitation by the HWs.[25] Survey data showed that FA had the highest proportion (31%) of clients being asked to buy drugs from outside the facility while FC had the least number of users (16.8%) required to get their medication from outside the facility (see Figure 5.10).

[25] It is worth pointing out here that complaints about drug availability arose mainly when the patient was asked to buy the drugs from outside the facility after making the indicative user fees; this was not driven by a desire to receive a prescription even when from the HWs/Clinician perspective, no drug was suitable as is often the case in many care settings.

Figure 5.10: Users Required to Buy Additional Medication From Outside their Facility After Paying User Fees (% per facility, n =400)



Data Source: Household Survey April – May 2011

These results resonate with data on priority presented in Section 5.5 showing that over 74% of respondents who visited FA felt drug stockout/shortage was the most pressing issue that the HFC needed to address. IDIs with HFC members and HWs confirmed the problem of drug shortage, though each HFC prioritised this differently. The FI for FA recognised that drug shortage and inadequate maternity equipment were her major challenge, though the Facility Chairperson had other priorities:

> *I think the main priority is supply of enough drugs and maybe to equip the maternity wing so that we would be charging something small or offer free deliveries; another major problem is the committee especially the Chairman …* (FI, for FA).

Both HWs and HFC members expressed their frustrations with the drug supply system[26] used by the government drug agency Kenya Medical Supplies Agency (KEMSA). They felt that they were left to bear the brunt of patients whenever there were no drugs yet they were not responsible for supplies. HFCs members also noted that the revenue from the DRF was not enough to ensure a steady supply, subjecting the facilities to frequent stock outs and subsequently forcing them to refer patients to buy drugs from private chemists; an experience that was not taken kindly by the

[26] The Kenyan government through the drug supply agency, KEMSA, uses a push system where the agency orders drugs based on national needs estimates and then pushes the same to health facilities via the provincial and district offices. Usually this would take three months, meaning health facilities receive their supplies quarterly, but sometimes there is a longer delay. The other downside is that facilities are in most case supplied with drugs for which there is no demand.

clients. In general, HWs and HFC members felt that this was a health systems problem, which was way beyond them:

> *When you just prescribe drugs for the patients go and buy, you know … it's not a happy experience, but we have little options, you just prescribe … when supplies from KEMSA run out, it is just like that … you wait for three months …the DMOH is not helping much, they also tell us to wait and there is nothing we can do* (FI, for FB).

> *It is because at times we are supplied with the drugs we don't need and we have to store them [the drugs] until they expire and the drugs that we need are not supplied enough* (FI, for FA).

However, during FGDs, respondents claimed that they had noticed government drugs being sold in the community pharmacy, which run side-by-side with the facility pharmacy (FA), and in a nearby pharmacy to which patients were referred in order to buy drugs after visiting FB.

> *After collecting your money [user fee], they will ask you to go buy drugs from that chemist [pointing at the chemist in a local market near the health centre]. We later came to realise that when the drugs are supplied in the hospital they are taken to the chemist so that when you go you are told to buy from the chemist and the HWs benefit. The drugs are clearly marked 'Government of Kenya, not-for-sale'* (Male participant, Youth FGD, FB).

5.4.2 User Satisfaction and Committees Effectiveness

An effective accountability mechanism should result in better service delivery and protection of clients' interests. User satisfaction has been identified as a key measure of health systems performance in developing countries[139, 180][27] and as an important source of information about health care results (outcomes), and the process of care delivery [126, 181].

In order to overcome biases associated with patients reporting being satisfied by the overall care [126], the survey question was tailored to remind respondents of their answers throughout the survey, so that their response to the satisfaction question would take into consideration their overall experience with the service they received. The question was then followed by another, seeking reasons for the answers provided, in order to account for any underreporting of critical attitudes [126]. Additionally, the study drew together all the aspects of accountability investigated so far to assess the

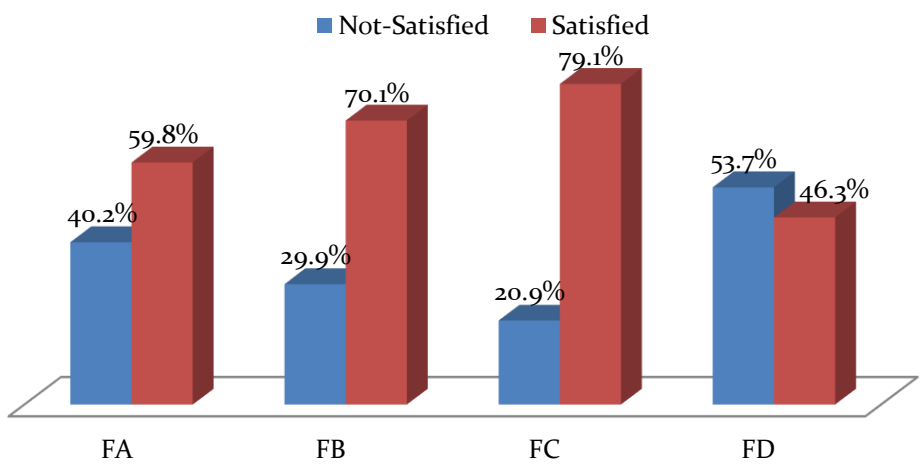
[27] This is perhaps in contrast to, the UK, where satisfaction rates are generally so high that they fail to offer anything very useful.

performance of the HFC as an accountability mechanism in ensuring satisfactory service delivery at the facility.

Community members were asked to rate their satisfaction with the service they received at the facility in a four-category Likert scale (1 = very satisfied, 2 = satisfied, 3 = dissatisfied, 4 = very dissatisfied). These responses were then recoded into a binary scale (1 and 2 = satisfied, and 3 & 4 = dissatisfied), after analysis showed no difference between options 1 & 2, and between options 3 & 4.

The overall satisfaction rates were high; 63.6% of the 946 respondents[28] who had used the facility in the last six months prior to the survey, reporting being satisfied with the service they received. This could be because, in general, the community did not want to portray the HWs in bad light despite the many challenges they opened up about during the survey. There were some variations across cluster facilities (Figure 5.11).

Figure 5.11: User Satisfaction Levels Per Facility



Data Source: Household Survey April – May 2011

Multivariate logistic regression analysis was employed to understand what elements of accountability influence user satisfaction with the service (Table 5.4). Several bivariate models were run and variables that were significantly associated with the outcome (satisfaction with service) at 10% level of significance included in the final analysis. Additionally, variables that were identified to be associated with user satisfaction during qualitative interviews were also included.

[28] Excludes 73 respondents (35 who had no reported cases of illness in the last 6 months, 30 who used other service providers except the HF, and 8 who did not respond to this question).

Table 5.4: Multivariate Logistic Regression Model for Determinants of 'User Satisfaction'

	Satisfied Vs Dissatisfied	
Indicator	**Odds Ratio**	**95% CI**
Social Demographic Indicators		
Cluster Facility (Reference FD)		
FA	2.01*	[1.13 – 3.60]
FB	2.69**	[1.46 – 4.97]
FC	2.84**	[1.41 - 5.72]
Gender (Reference Male)		
Female	1.24	[0.74- 2.51]
Marital Status (Reference Single)		
Married	1.37	[0.76 - 2.57]
Age (Reference 16 - 24 Years)		
25 - 34 years	1.07	[0.58 – 1.97]
35 - 44 years	1.18	[0.60 - 2.33]
≥ 45 years	1.71	[0.71 - 4.11]
Occupation (Reference Students)		
Agriculture	0.62	[0.27 - 1.41]
Skilled labour	0.27**	[0.11 - 0.67]
Unskilled labour	0.23**	[0.08 - 0.67]
Distance to Facility (Reference 3 Km or less)		
> 3 Km	1.17	[0.58- 2.34]
Don't Know	0.46	[0.05 - 4.50]
Education (Reference Primary or less)		
Secondary	0.75	[0.46 - 1.20]
Post-Secondary	0.42*	[0.18 - 0.94]
Income (Reference KES 2000 or less		
KES 2001 - 5000	1.02	[0.58 - 1.79]
KES 5001 and above	1.10	[0.58 - 2.12]
Health & Morbidity data		
Illness Encountered (Reference Malaria)		
ARI	0.97	[0.57 – 1.64]
Typhoid	0.34**	[0.16 – 0.80]
Others	0.59	[0.34 - 1.03]
Age of Ill HH Member (Reference Under 5s)		
Over 5 years	1.49	[0.93 – 2.37]
Given Drugs (Reference No)		
Yes	0.73	[0.20 – 2.76]
Required to buy drugs (Reference No)		
Yes	0.78	[0.50 - 1.23]
HSA Indicators		
Issued with Receipt (Reference No)		
Yes	2.23***	[1.39 - 3.57]
Use fee charged (Reference KES ≤ 50)		
KES > 50	0.66	[0.26 - 1.70]
Aware of HFC (Reference Unaware)		
Aware	0.87	[0.54 - 1.39]
Service Charter Usefulness (Reference Not useful)		
Useful	4.29***	[2.36 – 7.79]
Ever been to a *Baraza* (Reference No)		
Yes	0.80	[0.49 - 1.31]

*p < 0.05, **p < 0.01, ***p < 0.001
Data Source: Household Survey April - May 2011

The estimates presented here for each variable are adjusted, controlling for clustering and all other variables in the model. The main socio-demographic indicators

significantly associated with user satisfaction were occupation and education. The local health facility to which a respondent was clustered was also significantly associated with user satisfaction. Users clustered around facilities FA, FB and FC had significantly greater odds of reporting satisfaction with the overall service they received at the facility as compared to users in FD.

Compared to students, those in all forms of employment had lower odds of reporting satisfaction with the services they received at their local health centre, although results for those in agriculture were non-significant. A similar pattern was observed with the level of education, with those having secondary or post-secondary education showing lower odds of satisfaction, although those with secondary school education showed a non-significant result. Even though women had higher odds of being dissatisfied with the service at their local facility, compared to men, the results were non-significant.

None of the health and morbidity indicators were significant predictors of user satisfaction, even though patients who visited the hospital for the treatment of children under-5 had lower odds of satisfaction with the services that they received, compared to over 5s. Whether one received drugs at the facility after paying user fees, or was required to buy drugs from outside the facility even after paying the requisite user fees, one's awareness of the HFC, the user fee charged, and *Baraza* attendance were not associated with user satisfaction.

However, the odds of satisfaction improved with the perception of SC usefulness, with those reporting that they found the SC 'useful' having over 4 times the odds of being satisfied with the service received at their HF, compared to those who found the SC 'not useful'. Similarly, users who were issued with a receipt following user fee payment had significantly higher odds of being satisfied with the service at their local facility, compared to those who did not get the receipt (OR 2.23; p value <. 001), confirming the findings from the qualitative interviews.

5.5 Summary and Conclusions

This chapter aimed to analyse the impact of HSA mechanisms on service delivery. Two main mechanisms – HFCs and SCs – were identified as mediums for HSA. Because SCs are in many ways a sub-set of HFCs, given how they are set up and the overall

authority in their administration, they (SCs) have been used as a function of the HFC in the analysis. HFC performance has been considered by assessing the depth of engagement with their clients as evidenced in user awareness, levels and mechanisms of communication, priority setting and user involvement in decision making, financial accountability and finally user satisfaction. In terms of user awareness of HFC, all the socio-demographic indicators were significant determinants of whether one would be aware of the HFC or not. However, and surprisingly, gender and marital status were non-significant determinants of HFC awareness, even though women compared to men had lower odds of being aware of their local HFC.

Even though the *Baraza* was the main forum of communication with the community, most of the respondents were not happy with it saying it was not a neutral forum for an exchange of views and served mainly the interests of a select few. Only about 33% of respondents reported having been to a *Baraza*, a higher percentage of whom were men showing this forum alienated women who happen to be the majority users of health facilities and thus bear the direct consequences of decisions taken at the *Baraza*. The receipt and user fee adherence were identified as a significant aspect of accountability especially from the community perspective. None of the facilities adhered to their own user fee policy despite the fact that HFCs seemed to have significant powers in deciding how much users are charged and how the money is spent. In understanding user satisfaction as an end product of HFC functioning as reflected by the various socio-demographic and HSA variables, ones' health facility, their occupation, education, whether one was issued with a receipt or not, and whether one found the SC as useful or not were significant determinants of user satisfaction.

Finally, the chapter has identified four main factors – trust, power, responsibility, and proximity - that influence the performance of HSA mechanisms in this area. In the next two chapters, these factors, herein referred to as 'accountability markers', are discussed in light of field experiences and current literature, followed by conclusions and recommendations in the last chapter.

PART IV

DISCUSSION, POLICY IMPLICATIONS AND CONCLUSIONS

CHAPTER 6

INTRA-COMMITTEE RELATIONS

6.1 Introduction

This chapter draws together the findings of Chapter 4 about Intra-Committee functioning, and considers them in light of the literature on accountability in health reviewed in Chapter 2. Section 6.2 briefly summarises the evidence presented in the thesis on health system accountability (HSA) mechanisms and their role in supporting primary care in the study area. Section 6.3 compares these and other findings, with available evidence from the literature on accountability and engagement in Sub Sahara Africa (SSA). The chapter then turns to the third objective of the thesis; to examine the key factors that influence the performance of accountability mechanisms, with a focus on the role of process within the health facility committee (HFC) in Section 6.4. Four main accountability process markers – trust, power, responsibility and proximity -, are employed as thematic areas to facilitate the discussion. The Chapter is concluded by a summary in Section 6.5.

6.2 Accountability Mechanisms in the Study Area

The main HSA mechanisms were the health facility committees (HFCs) and facility service charters (SCs). Although there was a suggestion box and a patient rights charter, as reported earlier, these were only present in two facilities and were thus dropped from the main survey. The HFCs, made up of representatives of four groups (the community, health workers, government, and the local political leadership), were in charge of the general administration of the health facilities (HFs), and seemed to have significant powers over the management of the HFs. The HFCs had substantial powers over HFs finances, including setting the user fees, deciding how the user fees were spent, raising funds for the HFs operations, hiring local support staff, and setting facility priorities. An executive group within the committees, consisting of the Chairman, the secretary, and the treasurer, oversaw the day-to-day operations of the committee. The HFCs met fairly regularly.

Almost all the committees reported that their executive members had recently been trained in health facility financing and management. However, many of them also felt that they were greatly lacking skills, especially in the area of community engagement.

The HFCs reported using the *Baraza*, - a local development, law and order forum -, as their main platform for communication with the community. But the results revealed this was not an effective two-way communication mechanism. Awareness of the HFCs among survey respondents was fairly high compared to other studies in Kenya. However, there was limited evidence of the involvement of the community in the election of HFC members.

The SC was an important engagement tool between the HFs and the community. Because it is a product of the HFC, it has been used as a proxy for analysing HFC functioning. There was some variation in the type and form of information provided on the SCs for different facilities. Many respondents reported being dissatisfied with the information provided on the SC especially because the facilities rarely adhered to the user fee policy contained on the SC. Moreover, respondents felt that the facility management lacked accountability given that user fees were well defined, yet no income and expenditure data was provided as part of the charter. However, some respondents and HWs felt that it was an important engagement tool because it allowed them to voice concerns about any abuse of user fees by HWs.

In sum, HFCs and SCs were important HSA tools in the study area. The two mechanisms provided a formal forum for engagement between the community and the health system, albeit with some major challenges. However, engagement does not equal accountability. The way in which the engagement was achieved through the two accountability mechanisms is explored in this chapter.

6.3 Comparison with the Literature on Health Facility Committees

The literature did not contain studies that explicitly analyse the nature of HSA in LMICs with the household and the individual as points of focus. Nonetheless, data gathered about the functioning of HFCs overlapped considerably with many studies that described the impact of HFCs and the factors that influence their performance. This section compares those findings with Kenyan and LMICs experiences.

Just like in the study area, HFCs are almost ubiquitous HSA mechanism at the peripheral level of health facilities in Kenya and elsewhere in many parts of SSA. They

are also the most studied HSA mechanism. Other mechanisms include patients' rights charters, community groups, suggestion boxes, and in some cases, citizen report cards.

There are some common features of HFCs in Kenya; most notably their nature, roles and composition. In the coastal province of Kenya for example, most HFCs are reported to have been made-up of community representatives, facility staff, and local administration. In many cases, community representatives also served as the Chairmen and treasurers [97], reflecting the general guideline provided by the MOH Kenya. Elsewhere in Africa, a close comparison is reported in Zimbabwe, where, health centre committees (HCCs) consisted of a mix of health personnel, officials, councillors, and traditional leaders, as well as community representatives [179]. Similar setups include areas of South America, such as in Peru, where a similar structure is reported with the exception that local administration – traditional or governmental - was not part of the committees [85]. Also in Uganda, membership to the Health Unit Management Committee excluded political representatives [83]. Generally, it seems committees tend to have an apparent universal composition, their location notwithstanding.

In addition to the roles noted earlier, all the studies cited above reported that HFCs officials tended to consider certain responsibilities such as influencing the hiring of staff or drug purchases, as being beyond the remit of community representatives. Their results contrasted with the results of this study, which showed that community HFC members, to a certain extent, had some oversight, over all decisions about the facility, although experiences differed from one facility to another. In some cases, such as was in FC and FD, trust played an important role, helping committee members and staff, find mutual grounds in delimiting their roles. In FC for instance, community HFC members reported that they trusted the FI to make the right decision on both 'professional' and 'non-professional' issues. In FD, the presence of the Chairman at the facility most of the time, seemed to put staff under pressure to perform and provided avenues for consultations between the Chairman and the staff, even though this did not seem to deter the FI from reporting late to work.

The committee selection process problems reported in this study are fairly similar to those reported in other settings in Kenya, and can be said to be representative of the Kenyan health system. Goodman et al [97] reported that there were problems with

committee selection in the coastal province of Kenya where people ended up in the committee because of their status in the community and not necessarily because they were the best suited for the job. In the same province, dispensary committee members are reported to have been democratically elected [82]. It is worth noting that some of the experiences reported from these two cases (by Goodman and Sohani), were from the same district (Kwale). Since both cases involved separate external support – in the case of Goodman, the Danish government and in the case of Sohani, the Aga Khan Foundation -, the difference reported between the two highlights the impact of external interventions in general outlook of accountability structures.

In terms of the education levels of the HFC members, this study found similar results to those reported in Zimbabwe where HFC members were fairly well educated. As described in Chapter 4, some HFC members in the studied facilities had postgraduate qualifications. This contrasts the findings in other studies on HFCs [97, 128], that have pointed to low education levels among community HFC members. In the Coast of Kenya for instance, Goodman et al [97], reported that direct election, often resulted in selection of very old, often illiterate members, who, could not grasp key concepts or deal with management tasks. This contrast, could be explained by the fact that education levels in the coast of Kenya are generally among the lowest in Kenya [26], and not necessarily because HFCs tend to attract semi-illiterate members.

Comparison of how HFCs performed their roles within and beyond Kenya is constrained by the limited number of studies reporting the functioning of such committees in their normal setting i.e., without external interventions and support. That being said, there is a broader sense that the breadth and depth of HFC roles are defined in two main ways – *representing community interests to the facility and overseeing operations and management of the facility*. While the distinction between the roles is unclear, representing community interests can be seen as an effort to give the community a 'voice' in matters effecting their health [11]. Whereas overseeing operations and management of the HF can be seen to be about performance accountability [13, 16] aimed at improving service delivery. Depending on the facility, the driving forces behind the intervention, and the country, other studies report fairly similar findings with this study – that HFCs should mobilise the community, raise and

control revenue, oversee of the management of support staff, facilitate outreach and health promotion activities, and help supply essential drugs [82-84, 97].

HFC training experience are fairly similar whether committees were set up as an intervention, received substantial support from an NGO, or form part of the regular health system structure – as in the case of this study. All studies reported that committees were trained on certain aspects of health facility management. Yet in all the cases, HFC members expressed a need for regular and continuous training given the inadequacy they experienced in their everyday running of the facilities. At the Aga Khan led programme in the coast of Kenya, as reported by Sohani, committee members were also trained on consensus building and conflict resolution; a necessary skill that was lacking in the other studies. The only difference found in this study, compared to the rest of the studies reviewed - which reflect the impact and importance of external facilitation and support -, is in the involvement of women in the training. All the studies reviewed had external support that emphasised and ensured women members of the HFCs received training, thereby enhancing their depth of involvement in everyday committee operations.

At the coast of Kenya where the Danish government and the Aga Khan foundation were instrumental, women received training because, communities were encouraged to elect women to the committees and to make provisions to ensure gender parity. However, this was not the case in this study. Cultural barriers were a major hindrance to women being elected to the committees. Even when women made it to the committees, they would not be elected to the executive arm of the committee, which was targeted for training by the government and by the committees themselves. In the end, the women were effectively blocked from training opportunities. Essentially, what they had was the label 'women representatives'. The implications of this are discussed further under the section on power and committee functioning.

In summary, the evidence highlights many similarities in the structure, composition and purpose of the HFCs in Kenya and elsewhere in LMICs. However, there are some important cross-country differences in how committees function and in the process through which they structure the accountability system and the outcomes of this system. The potential for comparison with the existing literature was very limited for a

number of the study findings. For example, findings concerning the main factors impacting on committee performance i.e., trust, power, proximity and responsibility, differed between this study and others. These are closely related to the processes and context within which HSA operate, to which the discussion now turns.

6.4 Process Factors and the Functioning Of Committees

6.4.1 The Influence of Trust on HFC Operations

Trust emerged as one of the main factors that permeated HFC accountability relations. The significance of trust with respect to health systems draws on its potential to facilitate relationships that can result in positive outcomes [132]. In FC, the HFC and the community seemed to have developed a strong level of trust in the FI over time, thus giving him the authority and space to make certain decisions that would hitherto require the authorisation of the HFC. For example, committee meeting minutes showed that the FI had been mandated by the HFC to determine and implement the drug prices and charges that enable the facility to generate revenue from the drug revolving fund (DRF). Additionally, the FI was also fully in charge of the facility's IGA – the farm which generated substantial amounts of money per month (estimated at £ 150). He employed the gardeners, oversaw the sale of farm produce, and fully managed the funds (albeit with some guidance from the executive arm of the HFC). When asked, many HFC members explained that the IC had been at the facility for a long time, had shown exemplary character and integrity in managing facility resources, and had enjoyed considerable community goodwill and trust. As such they saw no need to supervise what he did at the facility. In effect, they had received no negative report that questioned his handling of facility resources. He had demonstrated, through organisational and managerial practices, values and norms that are associated with trust practices [182].

The results of this level of trust in the FI and his staff at FC were a highly motivated workforce. Their motivation was shown in the significantly high level of dedication to their duty; despite the myriad challenges facing their facility such as drug stock-outs, high demand for services against a thin workforce, and limited facility resources. The senior facility nurse explained thus:

> *Compared to elsewhere where I worked [referring to FD], here we do not have much committee interference, we enjoy good relations with the committee … a*

week won't pass without the Chairman passing by to ask how we are doing. We feel the committee trusts us with the management of the facility and is responsive when we need help. As you can see the work is demanding, just look at the queue… but at least we know we can count on the committee and the community is also very supportive… (Senior Nurse, FC).

These findings, echo experiences elsewhere in Africa, where HWs criticised public clinics for the limited control over their work place, and tended to trust their colleagues more than their supervisors [183]. Although Gilson et al [183] considered the role of trust in HW performance, the findings from this study strongly suggest a link not only between trust and HW performance, but also with the broader accountability structures supporting primary care delivery, in resource limited settings. This is because, where facility managers/supervisors (in this case the HFC) cultivate a certain level of trust in the HWs, they also create for them a 'decision space' on how, for instance, to use the limited facility resources like user fees. This could explain why the HFCs for FC and FD enjoyed good intra-committee relations as compared to FA and FB; results which are similar to findings in another study in the coast of Kenya where cordial relations between HFCs members and HWs were associated with trust [97].

The opposite was the case in FA, where there were differences that split the committee into three groups – the Chairman and his supporters, the FI and HWs and the councillor (see Box 3). The handling of facility finances – user fees and DRF – divided the committee. The FI and HWs were in charge of the user fee and the Chairman was in charge of the DRF from the community pharmacy. The Chairman saw the pharmacy as his pet project that he had 'fought hard' to have established, and had gone ahead to appoint a community member as the 'pharmacist' to sell the drugs. The proceeds were then handed over to him for banking. When asked why he runs the pharmacy this way he retorted that *'the pharmacy was my idea, besides I don't interfere with how the nurse in charge [referring to the FI] runs the user fees, why should they bother with the pharmacy money yet I have given her leeway in handling the user fees?'* However, interviews with the FI and the PHO contradicted these views and instead pointed to deep-rooted mistrust between the FI and HWs on one side and the Chairman on the other. The FI and the PHO explained that the Chairman did not trust the FI to handle finances because, the FI was not a clinician, and secondly, in the words of both the FI and the PHO, the FI *'was not from the Chairman's village and was a woman'*.

These views were also echoed by the treasurer who felt that the mode of committee selection, despite guaranteeing popular representation, did not necessarily lead to professionalism in the committee. Because the Chairman and the FI could not agree on how the facility funds should be administered, the HWs reported that they could not put up a suggestion box at the facility, nor could they provide a fully operational service charter as required by the government, further showing the implications of lack of trust within the HFC. These findings compare favourably with those of Goodman and her colleagues who report that in one facility 'HFC members were said to have demanded that all the facility's money be withdrawn from the bank account and kept at the house of the treasurer, because of a lack of trust in the health worker in-charge' [97].

The level and nature of trust had implications for processes and relations of accountability within the HCFs. First, unlike the other three health facilities, FC enjoyed an enviable level of stability and harmony that seemed to stem directly from the intra-committee relations nurtured around trust. Second, trust between committee members helped reduce process costs associated with the need to monitor performance. Situations of uncertainty can arise among stakeholders in accountability relationships. This was particularly apparent when one group of stakeholders, viewed the other as suspicious or overbearing. In many cases, uncertainty grew, when HWs perceived community HFC members as meddling in their work, wanting to know too much, simply incompetent or illiterate, and yet wanting to take on roles which could require skills beyond their education levels. Such misconceptions whether based on evidence or not, can result in friction between HWs and community representatives. This is exacerbated when HWs consider community representatives to be uneducated or lacking the necessary professional skills to supervise them. Such experiences have been reported in several studies across SSA [78, 96, 184, 185].

However, as Gilson [132] has warned, on an interpersonal level this trusting behaviour could foster corrupt behaviour when those involved in the relationship gain at the expense others. This study illustrated, an example from the land case in Chapter 4 (see Box 1), where the FI was unwilling to confront the Chairman over the facility land; in which, the Chairman allegedly acquired under suspicious conditions in collaboration

with some local council officials. In order to maintain strong intra-committee relations built around trust, the FI reported that he had tactfully avoided having this land issue discussed in any committee meetings, fearing it would tear the committee apart, and instead chose to use other mechanisms to deal with the issue.

Additionally, trust was an important tool for facilitating communication between HWs and community HFC members; a concurrent finding with results from other studies [183, 186, 187]. Interviews with members of harmoniously functioning HFCs (FC and FD) showed efficient communication and information processes, particularly among the executive committee members. The Chairman for FC explained that they were in constant contact with the FI and, that he made regular visits to check up on the facility. From observations made during facility visits, the relationship between the Chairman and the HWs was also cordial. To some extent, this was reinforced by the space the Chairman accorded the HWs and some incentives the HFC introduced, such as allowing the HWs to use income generated from the facility farm for ten o'clock tea and lunch. Thus, trust could have facilitated communications among HFC members, resulting in the elimination of information asymmetry among HFC members, which can often lead to HWs having control over committees [78]. Consequently, trust enhances the depth of engagement among HFC members, supporting the conclusion that trust and communication are mutually reinforcing process factors in the functioning of HFCs examined in this study.

This conclusion can be examined further in the converse situation provided by FA where there was conflict between the committee members. Interviews with the HWs members of the HFC and community HFC members revealed that the Chairman rarely consulted with the FI - who also doubled as the HFC secretary - and often ignored her altogether in decision-making. Instead, the Chairman relied on one or two committee members when making a decision; a situation that made the FI feel belittled, undermined and excluded. This tension stemmed from distrust between the two most important members of the HFC. The conflict spread to the community, with interviewed survey respondents showing detailed knowledge about the situation in the HFC (these experiences are discussed in the next chapter).

In one incident, the area councillor raided the facility and cut down trees for timber without consulting the Chairman because they had fundamental disagreements, despite being members of the same committee. In an attempt to resolve the issue, the Chairman overlooked the FI and the committee. When asked to explain why he decided thus, he responded that he was 'protecting her [the FI] from the community politics', since the last FI had been evicted by the same councillor – and he could not *'trust him anymore'*. The findings in this study support Gilson's argument that *'trust underpins the co-operation within health [accountability] systems that is necessary to health provision, and trust-based health [accountability] systems can make an important contribution to building value in society'* [132:1454]. In this study, the successful functioning of the HFCs depended upon the committees' internal dynamics - informal interactions between committee members' as much as formal procedures that characterised committee operations.

6.4.2 Accessibility and Internal Committee Operations

Closely linked to trust, and in many ways overlapping with trust, is the accessibility of committee members to each other. The relevance of accessibility to the working of HFCs in the study facilities is best captured by considering the views from the three groups making up the committees. Accessibility in this setting was defined both in terms of reachability (a committee member being reachable for instance when there was a meeting), and in terms of being perceived to be accessible to other members of the HFC. This latter definition mainly applied to the executive HFC members and the FI who doubled as the HFC secretary. The ability of a committee member to perform his/her role depended upon his/her commitment to the committee. This was particularly so for the executive members of the committee who in some instances spent the whole day in meetings with the DHMT, or with interested parties such as contractors working in the health facility. While many committee members reported that their work in the committee was not onerous, a review of the committee operations indicated that sometimes the opposite was true. For instance, the two meetings that the author attended lasted more than five hours. For a role that is mainly voluntary, this can be demanding.

Interviews with some facility in-charges revealed a perception that the committee members were not committed. However, given the demanding nature of some of the committee roles and functions (e.g. the long meetings), it would be difficult to expect a committee member with other personal commitments to be motivated to dedicate themselves to the administrative responsibilities at the facility as a normal part of their duties. IDIs with committee members revealed that most members of the HFCs considered their work in the committee as a way of giving back to the community, as service to God, and for some, as a chance to make a difference in the community by helping to improve the operations at the facility. But there were those like the Chief in FB and Chair in FA who perceived committee membership as a source of power, personal pride and gainful venture; where one could earn some allowance, or receive priority service for their family members. Given the poverty levels in the area, it is not inconceivable that such benefits as a seating allowance and free medical services would attract one to the committee. Nonetheless, evidence from this study strongly suggests that accessibility is a function of time and commitment on the part of HFC members and is an important factor in the development of trust and skills necessary for the HFCs to work in harmony and cohesion, and improve service delivery [188].

On the other hand, accessibility was also a function of committee internal relations and a function of how one perceived their place in the committee, especially whether they felt their contribution was valued or not. As already explained under trust, committees that enjoyed harmonious relations thrived through trust and frequent communications. This was the case in FC and FD where HFCs members were not only in frequent contact with one another, but also with the facility. For example, in FC, the committee had to temporarily replace the treasurer who had left for studies. Committee members explained that it was easy to ask the Vice-chairman to cover for the treasurer in her absence because they frequently communicated. However, this resulted in an executive committee composed only of men. Because of the good relations between the committee members, the Vice-Chairman was accessible and took on the role of the treasurer. HWs in this facility had also praised the committee members for their accessibility and approachability making it easy for them to deal with any urgent issues.

FB provided contrasting experiences. Women representatives in FB, for instance, explained that they were members of the committee by 'invitation' of the Chairman and the local Chief, and therefore, even though they enjoyed serving in the committee, they did not feel like they were 'much needed.' They explained that often the Chairman would invite them to HFC activities when he deemed fit; in essence, they were serving at his behest. Accessibility, in this case, was influenced by the agenda set by the Chairman, and whether the women representatives felt respected and treated fairly in the committee. However, the female representatives felt excluded and alienated, with little power to influence decisions in the committee. As already reported in Chapter 4, the Chairman for FB indicated that they would replace female members who they perceived to be 'inactive', for instance, if they frequently missed meetings or if they were not available for committee assignments. This begs the question, as to whom the women represent, and demonstrates the importance of considering gender in the selection of committee members.

Accessibility was also linked to approachability. This was particularly emphasised in regard to the executive committee members. Interviews with HWs and committee members showed how important approachability is to the functioning of the committee. The importance of approachability underlies the central argument that accountability is about social relations, about interpersonal engagements, and not merely a set of policy targets that ought to be achieved by bringing people into a committee. This [view of accountability] was the defining factor in separating committees where relationships were built and maintained, and where HWs viewed community representatives as part of the greater health facility system, from those where decisions were centred on specific individuals. In the later, HWs saw themselves as educated elite, who could benefit little from community representatives' perspectives. It was noticeable, for instance, the difference in body language of the Chairman for FA as he toured the facility and that of the Chairmen for FC and FD. It was not uncommon to find the Chairman for FC and FD chatting freely with the HWs in their local language. Conversely, in FA the author witnessed a visibly frosty relationship between the HWs and the Chairman. The HWs explained that the Chairman was interested in the money generated at the community pharmacy, not in welfare of the workers or the facility.

These views stemming from the IDIs with committee members underscore the significance of approachability as an important part in how HFC stakeholders perceived accessibility as an accountability marker. Accessibility was signified, first by reachability, secondly by, approachability. It is also indicative that being perceived as approachable is instrumental in enhancing the relationships within the committee and the likelihood of achieving HFC objectives. In turn, approachability, as an aspect of accessibility within the committee, helped to enhance trust and vice versa.

Finally, distance from the facility was also a major factor in determining the accessibility of a committee member. Most of the HFC chairmen resided nearby the facility, and there was a deliberate effort to have HFC chairmen elected from the villages around the facility. While this accorded them the opportunity to interact with the HWs and patients easily, it was questioned by some community members living in distant villages. Furthermore, some committee members felt that certain villages/clans dominated the committee, and by extension influenced the functioning of the facility to the advantage of the nearby villages. This highlights the tension that surrounds committees' attempt at cohesion and effectiveness. They must balance encouraging a closer interaction of the committee members and the other facility stakeholders, while at the same time upholding the principles of fair and equitable representation within the committee. Because of the important place of the committee Chairman in the functioning of the HFC and the facility, perhaps one way to resolve this is to have a rotational system where the chair is nominated from a different village at each election.

However, rotational representation could undermine the objectives upon which representational and universal participation is based - that community members have an inherent right to elect those they feel fairly and effectively represent their voices in the facility. The tensions between achieving local cohesion and adequate representation were captured in the views of many HFC members who expressed concern that although they were perceived to be inactive, their absence can be attributed to the fact that they resided far from the facility and needed commuting allowance to even attend the HFC meetings. This highlights the important question that needs to be answered if accountability and participation in such settings should

work: why would individuals commit their time and resources to serve the community without proper motivation and support in the face of the glaring economic barriers? Indeed, until the government started the HSSF system, not many HFC members attended meetings regularly; showing that economic barriers can be a major hindrance to enhancing accountability in health systems, particularly in resource scarce settings. This is partly because addressing poverty may be seen as more important thus relinquishing health care services to a non-priority issue [71].

Further, there is also the need to balance community expectations and individual commitment/expectations in serving on the HFC. IDIs with HFC members confirmed fears from community HFC members who reported that community members would be suspicious of HFC members who spend most of their time at the facility, perceiving them to be dependent on 'their' money. The treasurer for FB claimed that *'If I were to spend most of my time here, you would hear rumours and murmurs from the villagers that I am 'eating' their money'*. Such sentiments have been reported in other studies [90, 96, 99, 106, 110].

6.4.3 Responsibility, Accountability and Committee Operations

Despite the importance of having clearly defined roles for members of accountability structures [77-79, 111, 189], this study found that many HFC members were not sufficiently aware of their roles apart from the general mantra of 'overall management of the facility,' while some did not understand their roles beyond being committee members. Certain roles were emphasised more than others, while some roles were either ignored completely, or were too difficult for the committee to achieve, given the contextual factors discussed here. Many of the HFCs emphasised that they were facilitators of facility development, and were quick to point out areas where they had made significant progress. Indeed facility visits by the research team revealed that the committees were doing an outstanding job either overseeing either the fundraising for or the development of the facility infrastructure. Given these committees are not properly remunerated for such functions, it was surprising that they were entrusted with major infrastructural projects at the facilities that required handling huge sums of money, and were expected to deliver accountably to the community and the government.

It is this precarious and tempting situation that most HFCs find themselves in; being required to oversee fairly massive projects with huge sums of money at their disposal, while paying themselves small sums of money as sitting allowance. This raises important questions as to whether the accountability structures, as currently constituted, are sustainable and to what extent should committee members be expected to dedicate their time and resources in what seems to be volunteer, charity kind of work. What is certain, however, from the data gathered in this study, is that without effective leadership and deep sense of self sacrifice and financial discipline, it is almost impossible for the HFCs to institute proper financial and performance accountability structures. Perhaps it is this realisation that prompted the government to initiate the HSSF programme, whose job is partly to provide incentives for HFC members in performing their duties.

There was also, a clear disparity in the understanding of roles among the genders in the HFCs; a fact that can be explained by examining the structure and composition of the HFC. As already mentioned in the Chapter 4, none of the HFCs had a female leader in the executive subcommittee of the HFC. This situation had a direct implication for gender parity and the understanding of roles within the HFCs because all training on facility management and financing - whether by government or NGOs - were targeted at the executive committee members (see chapter 4 on committee training and roles). This effectively excluded the female representatives as none were members of this important committee, meaning that they rarely understood their roles in the committee, or lacked the skills that their male counterparts had, to effectively represent their constituency. Indeed, this point is captured by the views of the female representatives for FB who complained that the Chairman only summoned them for meetings when he needed them. It also meant the female HFC members could not question certain decisions in the committee whose origins and implications they [female members] did not understand, since they were serving in the committee at the behest of the Chairman.

Since the executive sub-committee is effectively the decision making engine of the HFCs – it becomes clear how the accountability structure in this area systematically excludes women in decision making – by denying them the chance to gain essential

knowledge and skills that can enhance their decision making capacity in the HFC. This further negates the wisdom behind co-opting women representatives in the committees since, unlike their male counterparts who easily get the lead roles, they are not helped to participate effectively in the management of the HFC through training. It was quite surprising that the major stakeholders in the health system (the DHMT, the local politicians and area administration) did not see this form of exclusion as a problem; instead they were all quick to highlight the inclusion of women representatives in the HFCs as a major achievement in bringing the voice of women to the committee. It was understandable that perhaps resources could not allow for all HFC members to be trained. To bridge the gap, the trained HFC members reported that they shared with their colleagues their experiences which were received well.

Nonetheless, this kind of knowledge sharing is not adequate and may not be reliable, given that HFCs are social institutions where there is competition for power and decision spaces. Additionally, sharing does not ameliorate the untrained HFC members' feelings of exclusion. This finding has been reported elsewhere in Kenya [97]. Also, knowledge sharing among HFC members, does not compensate for the value of impartial external facilitation and support; which has been shown to be important in successful case studies elsewhere [77]. In South Africa, for instance, a facilitation process by a university department is reported to have helped clinic staff and community members overcome difficulties and tensions as they arose [190]. Meanwhile while in India, three professional local NGOs provided training to 620 VHCs on areas like project management and adopting VHCs activities to the needs and capacities of the local population, thus significantly helping the VHCs improve health care coverage and outcomes [191]. It becomes clear that unless attention is paid to the quality of training process, the women members will continue to be excluded from decision-making even when they are physically present in meetings.

Interviews with some of the most experienced HFC members supported the argument that clarity and consensus on HFC roles and authority can significantly help to reduce tensions such as those reported in FA and FB. The treasurer for FA, also a qualified professional accountant, offered useful comparison between the HFC and the school management boards for which he served. He argued that the health sector could learn

from the education sector, where boards consisting of properly trained members, with adequate support from the education ministry to manage schools. However, it should be noted here that school boards in Kenya tend to attract qualified members are well funded. Additionally, schools in Kenya are annually ranked by the government based on their performance in the national examination, a factor that can push the boards to ensure their schools perform well. All these factors are incentives for better performance and accountability.

The clarity of roles and functions is also a key aspect of accountability if considered from the angle of answerability and sanctions [13]. Brinkerhoff identifies three main purposes of accountability in the health system from which a clear understanding of one's responsibilities in the HFC can benefit: to control the misuse and abuse of public resources and/or authority - this relates directly to *financial* accountability; to provide assurance that resources are used and authority is exercised according to appropriate and legal procedures, professional standards, and societal values - this relates to financial, performance, and *political/democratic* types of accountability; and, to support and promote improved service delivery and management through feedback and learning - the focus here is primarily on *performance* accountability. However, these three functions cannot be achieved in an HFC where few or none members are equipped with important skills to understand their roles.

A final way to understand responsibility as an accountability marker is to consider HFC members' motivation for serving in the committees. Several HFC members argued that they felt obliged to serve in the committee as a way of giving back to the society, and as a way of serving God. The Chairman for FB (a university lecturer) argued that the society had invested so much in him, and that he felt he could use his skills to serve the community by guiding the development at the HF. Meanwhile the women representatives FA (all private practising nurses) argued that they felt that they could use their skills as nurses to help improve services at the facility, (although it emerged from the interviews with other committee members and the community that there were competing interests at stake since the private clinics run by these HFC members competed for clients with the HFs they served). One of the women admitted that she saw several patients who were referred to her practice by the HWs at FA.

Responsibility was also largely viewed as 'God given'; many HFC members argued that their participation was a way of serving God. This finding echoes the evidence in the literature underlying the role of spirituality as a motivating factor in resource poor settings, such as: among volunteers serving poor orphaned nurseries in Malawi [192], among lay volunteers in tuberculosis-control programmes in south Africa [193], and among other community carers in similar programme elsewhere in Africa [194, 195]. Only two interviewees admitted to joining the committee for prestige, power and the allowance. Data from IDIs with HWs and community members also pointed to some benefits for HFC members' families, such as free care and medication, (although it was difficult to examine the evidence, as these were not formally recognised or outlined). In essence, HFC membership provided both tangible and intangible benefits, most of which were not comprehensively articulated. Nonetheless, it was not difficult to notice the altruistic motive given the compensation for the workload in the committee did not match the work the HFCs do.

6.4.4 Power and the Functioning of Committees

One of the most important process determinants of HFC functioning in the study area was power and its application in everyday HFC members' relations. Power encompasses the way on which actors manage to control or direct the actions of others, and in some instances, how people are able to resist or subvert such control [196]. Power matters to implementation and policy outcomes [133] because it is at the centre of every health policy process [117], and is important to sociological investigations of the provider-patient relations [197]. Yet power is rarely explicitly examined in the health policy process especially in LMICs [129, 198]. Power, combined with patterns of patronage and cultural hierarchies, defined the operations of the HFCs' priority setting, decision-making processes, and service delivery at the HFs. The evidence shows that, like in the HFC-Community relations discussed in the next chapter, the intra-committee relations were often marked by deep suspicion, a lack of trust, and a silent but powerful struggle permeating the boundaries of age, gender, professional and clan membership to the committee. Additionally, power seemed to revolve around two centres – the Chairmen and the FIs -, whose basis of power presumably lay, and was negotiated, around, the different facility resources which they controlled.

While women had representation in the HFCs, their representatives did not seem to wield significant power to influence decisions or perform their functions. This was perhaps due to the manner in which they were selected to join the committees – e.g., by invitation in some HFCs. Even then, their title of women representatives seems to imply that they represent only a section of the community they serve; a situation that may have implications for their participation in committees issues, for the amount of power they wield, and for their self-image as HFC members. Whereas accountability and engagement assume equal and fair representation of voice and presence, when one is 'invited to join the committee' as a 'women representative,' this could potentially limit her contribution more than it could enhance it. As already shown in earlier sections of this chapter, women representatives in FB complained that their participation in their HFC was limited by what contribution the Chairman felt they could, as evidenced by their limited knowledge of the committee operations.

The same seemed to apply in FD where the depth of involvement of the female HFC members was evidently limited. In one of the HFC meetings that the author attended, the female representatives were passive in their contribution. The Chairman and the FI (both male) seemed to run the HFC by making important decisions on behalf of the committee. It was difficult to tell whether the women were comfortable in the HFC meeting and in agreement with the decisions being made, or were simply observing the meeting's proceedings. This dynamic further indicates that their presence in the committees does not necessarily translate into effective participation. It also shows that even with the new government guidelines on HFC membership that require at least three out of five community representatives to be women [199], issues impacting women and children will not be automatically voiced, at least not until the cultural traditions that limit female participation are dealt with.

Nonetheless, there was a unique case that warrants mention. Unlike in FA, gender did not seem to disfavour the FI for FB. Evidence from attending the HFC meeting for FB, showed that the FI was fully in charge of the operations of the facility, and in some instances seemed to have usurped the powers of the committee. In one instance, the committee was discussing hiring a new tea lady and a facility cleaner. The Chairman suggested having the committee interview the applicants. However, the FI overruled

him, arguing that the committee would be overstepping their mandate. Instead, she insisted on recruiting the needed staff with the support of the PHO (also a woman), and informing the committee of her choices in the next meeting. Despite prolonged arguments, and the Chairman receiving support from other community HFC members, she stood her ground and ensured that her demands were granted.

Many studies in LMICs have linked committee domination by HWs to their education levels *vis-a-vis* that of community representatives, who in most cases, have been reported to be semi-illiterate [77-79, 84, 90, 97, 110, 128, 200]. This generalisation cannot be said to hold true for this study, given that almost all the community HFC members studied were well educated, some having postgraduate qualifications (see Chapter 4 for HFC members description). Therefore, another explanation was sought to elucidate these tensions. A review of the committee minutes and of evidence gathered from attending the HFC meetings, indicate that a complex web of factors, enveloped in power, undermine the performance of women in the HFCs. Plausibly, the lack of clearly defined roles among the women representatives - which is linked to inadequate skills or training - is one explanation, and is linked to the previous point on male domination through culture and traditions. Since none of the female representatives were members of the executive, they missed out on the training offered by the government. It is therefore arguable that they lacked the 'brevity' that comes with training, and which has been shown in other settings to be an important ingredient in determining the exercise of power within committees [84, 97, 128].

The male cultural hegemony within the study community reflects the gender disparity in training and subsequent power relations within the committees. It has already been noted in Chapter 4 that none of the committees had a female chairperson, and that the only female member of the FC committee had left for further studies; meaning none of the executive committees of the HFCs had a female member. The inadequate female involvement in the committees can be traced to the election process. Women, like the youths among this study population, tended to shy away from the *Baraza* where HFC elections ought to take place. When asked why, the answer was almost the same everywhere *'mzee wangu ananiwakilisha, lazima nipate ruhusu kwa mzee ndipo niende na mara nyingi hawapatikani nyumbani'* translated to mean 'my husband represents me

at such forums, I must get permission from him in order to attend and most of the time he is away from home'.[29] This was a common theme across the study population. Moreover, the culture of the study population limits the contribution of women in general since they are not expected to speak freely in front of men. The majority of the female HFC members, including the FI, expressed their fears that they would be seen to be bringing *'fitina'* (a Swahili word for 'bad politics') to the committee if they questioned how things were done, or to demanded a voice in committee affairs simply because these were frowned upon in their culture.

Surprisingly it was the women in this community who frequently interacted with the HF as they found themselves taking a sick child for treatment or attending regular clinics. It is therefore a case of a health system designed with the main target group (women, the poor and vulnerable, the youth, and children) in mind, but that fails to provide avenues for these groups to take control of their health in the ways envisaged by the policies that drive accountability and engagement. It further negates the very principles behind accountability - especially from the western perspective as espoused by the WB and donor community – that stakeholders will have a voice in matters directly or indirectly effecting them, without which they should have options for 'exit' [11]. Without 'voice' and 'exit', stakeholders effectively lack the power to influence accountability relations, a fact that was apparent in the study area.

The situation was made worse where the ex-officio members of the HFC happened to be male (as was the case in this study). This phenomenon was readily seen in the HFC–community relations, and is discussed further in the next chapter. Therefore, even with proper education, if the cultural practices as anchored in the daily power structures are unresponsive to accountability processes, accountability structures are unlikely to meet the expectations of supporting primary care, especially in expanding services to

[29] The term *Mzee* as used in this community has a different connotation from regular Swahili - 'an old or elderly person'. Since independence the Kenyan form of the term *Mzee* has been used as a euphemism for 'a wise revered person', in many cases referring to a male. It is an earned title often used by cabinet ministers or politicians to show awe and respect for the president. It is in this context that it should be understood in the study population as the women are expected to revere their husbands to the point that they should not 'unnecessarily' appear at the *Baraza* without the husband's permission. As explained below, unlike some other Kenyan communities, the *Baraza* among the Kipsigis was surprisingly male dominated. For a visitor, it could easily qualify as a males' club where they meet to make decisions on behalf of the community.

the vulnerable in the community. The case studies (of intra-committee relations) provided here illustrates this point.

Over and above power application through cultural and gender dynamics, individual understanding of the powers and roles in the committee also had important implications for the functioning of the HFCs. In all cases, putting up accountability structures (the HFC) also meant releasing power from the centre to the local structures (the HFCs), with the provisioning of extra resources and authority over how such resources were to be spent. In some facilities this process (of handing over more resources and regulatory powers to local HFCs) was also seen as that of giving individuals or groups of individuals a chance to apply themselves in determining the use of facility resources in a manner that did not necessarily enhance accountability and engagement within the committees and with the community. The result was a mismatch between the powers of the chairpersons and the powers of other committee members (particularly HWs and female representatives), and the poor marginalised communities that they sought to represent.

This was particularly the case in FA whose HFC was headed by an activist for a local teacher's union who did not differentiate between his role as trade unionist and as the HFC chair (see Box 3). In leading the facility committee, he took an activist approach. Two cases illustrate this. In the first instance, the committee had to decide where to construct staff houses within the compounds of the facility using money donated by the local council and constituency development fund (CDF). All committee members and the DHMT were in agreement except the Chairman who then viewed this opportunity to apply his activist skills, and demonstrate that he wielded the power within the facility.

Box 3: Power, Trust, Responsibility and Gender Struggles in a Committee

FA served the largest and most populous divisions within Kericho district. Its HFC operations were characterised by wrangles that almost halted the operations of the health facility. The Chairman, age group 45 and above, is a local primary school head teacher and also the chair of the national teachers union, local branch. The facility in-charge is a female Kenya registered nurse, contrary to government requirement that a clinician head such a facility. Several events in the operations of the committee illustrate this:

- **Community pharmacy set-up and management**: According to interviews with the DMOH, the

HFC members and record reviews, the pharmacy was set up using funds from the CDF. The pharmacy runs parallel and adjacent to the government-funded pharmacy dispensing government drugs. During the interview, the Chairman claimed that the pharmacy was his idea, and one of his most successful projects for the facility. According to him, it followed that he should be fully in-charge of pharmacy management. To achieve this, he hired a local girl, without consulting with the HFC, to run the pharmacy. The lady reported to him with daily collections, which he claimed, he banked. He also decided what medicine to stock, depending on sales. The manner in which the pharmacy was run and the management of the funds it generated was a source of conflict and tension between the Chairman and the HWs led by the FI. The HWs felt that since the pharmacy was a community project, its profits should have been used to support the facility. The FI claimed that they were unable to put up a suggestion box and a proper service charter because the Chairman was holding on to the funds, despite the HFC having approved the project. While acknowledging this claim, the Chairman informed us that he expected the user fees to be enough to cater for such needs, *'after all, I don't ask them where they take or how they use daily hospital collections'*. The FI also complained about the community pharmacist being rude to her, and about her lack of power to discipline the pharmacist, who solely reported to the Chairman.

- **Conflict over timber**: On the day the research team visited the facility the second time in April 2011, the local councillor, an ex-officio member of the HFC, had raided the facility trees for timber, without consulting the HFC or the local administration. The councillor was very popular with the community, and was viewed as their main voice in the committee. In handling this matter, the Chairman decided to bypass the FI, instead gathering together a few committee members who he said were *'closer to me'*, and the district administration. When asked why he by-passed the FI, who is the official government administrator of the HF, he retorted, *'I wanted to protect her from community politics, you know, being a woman she could be in deep problems if she was to get involved. This councillor is a beast; he has evicted a FI from this facility before. So it was in her own interest.'* When asked whether the FI shared his sentiments and had asked for his protection, he answered, *'some decisions you have to take as the Chairman, and I didn't see the need of involving her.'*
- **Facility bank accounts**: FA recently had its FI transferred. The law therefore required that the new FI is, added to the list of signatories to the facility bank accounts. However, the FI informed the research team that the Chairman had refused to do this, claiming 'he cannot trust a woman with facility bank accounts.' In the Chairman's words, 'that woman [referring to the FI who had just walked in to the facility at the time of the interview] is not a qualified doctor; we are waiting for the government to post a new FI before we make the changes.' The battles within the HFC spilt over into the community, with many respondents supporting the area councillor, who they argued had their *'interests at heart and is the only person we can trust to solve facility issues.'* A respondent who had been disappointed with the services commented, *'I wish the place [referring to the facility] could be turned to chicken farm, at least we can get eggs from it'*. The residents were also aware of lack of a qualified 'doctor' at the facility. The majority of men reported that they stopped using the facility since *'there are only nurses,'* and besides they would not *'trust women from this village to treat men*

and observe patient confidentiality'. This led to many residents seeking treating from a nearby mission hospital and at the district hospital; a situation confirmed by the DMOH who noted, *'the district hospital has been recording rising numbers of patients form the area served by FA.*

Data source: Field notes

He then lobbied some community members from his clan and also managed to convince some committee members to change their minds. In the end, the committee voted and the Chairman's group successfully carried the day. It later emerged that his opposition to the initial suggested place was not based on any rational consideration; instead he was opposed to it because apparently it was the local councillor's suggestion, and there were conflicts between him and the councillor (who is an ex officio member of the HFC). Because the Chairman had also convinced the FI to support his course, the councillor held a grudge, against the FI, whom he later led the area residents to evict from the facility on claims of non-performance.

The second instance arose when the committee had to decide on the usage of some money left from a donation by the CDF committee. Instead of convening the committee to decide on the use of these funds, the Chairman went alone to the then DMOH, and convinced him to approve the use of the funds to start a community pharmacy to run in parallel with the government provided facility pharmacy. While this initiative later gained favour with the community, HWs and the other HFC members, it was the manner in which the DRF from the pharmacy was administered that irked the community, HWs and other HFC members. The result of these tensions was that the facility could not put up a suggestion box or a service charter since the Chairman held on to the money. The results of all these power games were service interruptions, low morale among HWs, and a generally disenfranchised community that avoided the facility for other facilities (see Box 3).

These two incidences illustrate the intricate power struggles that had significant ramifications on the HFCs performance and impact on service delivery and representation (albeit less explicitly in the other facilities). What was meant to help the community by improving services ended up damaging the quality of care they received since the facility suffered serious drug shortages due to mismanagement of the drug revolving fund. Additionally, the fragmented manner in which the facility funds were

administered (separately by the Chairman and the FI) meant that important accountability structures such as a suggestion box and the facility Service Charter could not be provided since each camp saw this as the role of the other. Essentially, an accountability structure that was meant to support the effective functioning of the facility ended up disrupting its operations, and by extension, the service that the community received, mainly because of the manner in which power was personalised and applied.

A final positive point about power within the HFCs is that when it was applied well, it aided the raising of funds for committee operations by lobbying the local politicians and NGOs who viewed the committees as legitimate. It was indeed amazing the work that FC and FD had achieved through local fundraising efforts, either because their HFC members - especially the Chairmen - had important connections with the local politicians and councils. FC had received several equipment donations from the local Walter Reed offices, thanks to the connections provided by the Chairman, while FD had their facility revamped by the Japanese government, thanks to strong lobbying by the Chairman and the Treasurer.

6.5 Summary and Conclusions

In this first part of discussion, four main accountability process factors were identified as underpinning the performance and functioning of HSA in the study area. These factors were: power, trust, proximity, and responsibility. Given the social nature of accountability and its complex form, the four factors (also referred in the analysis as accountability markers) were a function of committee internal relations; determined by how one perceived his/her their place in the committee, especially whether he/she felt valued. The four process factors were not mutually exclusive, and in many ways influenced interrelations in the committee and in turn, while those relationships intern influenced the power of the factors.

These complex interactions (of process issues and accountability stakeholders) produced an inherent tension between upward accountability (HFC being accountable to the government through the DMOH and politicians), downward accountability (HFCs being accountable to their electorate), and horizontal accountability (HFCs finding their accountability spaces within the HF in contestation with HWs).

Downward accountability is considered in the next discussion chapter. It is also important to emphasise that without due attention to the clarity of roles and functions and the delineation of HFC powers vis-à-vis DMOH authority in the design of HFC operations, these mechanisms risk failure, especially due to multiple lines of accountability. The discussion presented above highlights the fact that the area of responsibility and lines of accountability among the various committee members were far from clear, undermining the legitimacy of some the their decisions.

One further point can be drawn from the discussion above on the understanding and interpretation of power among committee members, vis-à-vis their responsibilities, and how these translate into better services for the community. Power and its interpretation among the committee members particularly the Chairmen and the FI, had a major impact on the functioning of the committee, especially due to its gendered perspective. Female committee members in some of the HFCs were reduced to spectators, underscoring the point above, that unless attention is paid to the quality of process (in this case in regard to power), people (women) can be excluded from decision-making even when they are physically present. As shown in the cases analysed above, an accountability structure in some HFs that was meant to support the effective functioning of the facility, ended up disrupting its operations and by extension the service that the community received, mainly because of the manner in which power was personalised and applied.

If harmonious operations of the HFC can be achieved, one would then expect that the community should benefit from the services offered by such operations, and would report better levels of patient satisfaction. The following Chapter takes the discussion further by bringing in the perspectives from the community and their interactions with the HFCs and the SCs.

CHAPTER 7

COMMUNITY – COMMITTEE INTERRELATIONSHIPS

7.1 Introduction

Having considered the main accountability markers in intra-committee relations, this Chapter moves the discussion to the second level of HSA interrelationships –inter-mechanism relations - as defined in the conceptual framework by bringing in perspectives from the community. The four main accountability markers (power, trust, responsibility and accessibility) that defined intra-committee relations were also present in the inter-mechanism relations, albeit at different levels, and are considered in this Chapter under various thematic areas. This Chapter focuses on how the four main accountability markers influenced community-committee relations, thus providing a perspective into how the two interact.

Section 7.2 discusses process issues and the depth of engagement between the HFCs and the community, including the representativeness of the HFCs. Section 7.3 is a discussion of the nexus between the HFC, facility users, and the facility Service Charters. Section 7.4 contextualises accountability experiences in the study area by looking at the health system and cultural context within which the HFCs operate. Finally, the Chapter is concluded by a summary of the main points, setting the stage for the final chapter of conclusions and recommendations.

7.2 Process Factors and the Depth of Engagement with Committees

7.2.1 Committee Awareness and the Functioning and Performance of Committees

Three main indicators were used to assess the level of respondents' awareness of the HFC: reported knowledge of HFC, knowledge of HFC selection criteria, and knowledge of a member of the HFC. Although comparison with other studies across SSA is very limited because of design and context issues, the level of awareness in the study area (55% of respondents reporting awareness of the HFC in their area), is high, compared to two other contextually similar studies [84, 97]. Goodman et al [97], reported an awareness level of 44.8% in the coast of Kenya, and Loewenson et al [84], a level of 59% in rural Zimbabwe. However, these two studies reported on HFCs that had benefited from significant funding from donors, and as such, should be compared with caution.

Bivariate analysis showed that age, occupation, distance from the facility, income levels, and marital status were significantly associated with knowledge of HFCs. When multivariate analysis was performed, all the socio-demographic indicators were still significantly associated with HFC awareness, except for gender and marital status. The insignificance of gender is a surprising finding, because women use the facility services most frequently, and would thus be expected to have higher awareness levels. Qualitative data pointed at an intricate and complicated interaction between health system structure, and cultural practices that stifled women's engagement in health related issues affecting their health. The complicated interactions were almost impossible to understand at surface level.

Interviews with key stakeholders (DHMT) showed that government policy expected women to fully participate in facility issues, and assumed they would do so through the *Baraza*. But as noted in Chapter 6, since the *Barazas* were male dominated, it did not facilitate female engagement in the health system, nor did it allow them to hold the system accountable. In any case, cultural norms did not expect/encourage women to speak at the *Baraza*. Many female respondents reported having to seek permission from their husbands in order to attend a *Baraza*. Bivariate analysis confirmed that men were significantly more likely to attend a *Baraza* compared to women.

The women relied on their husbands/fathers to handle facility matters on their behalf. Even within the HFCs, where there were female representatives, tradition still dictated that women should go through their husbands as intermediaries to reach members of the HFCs when they had a problem. Because the culture expected them to be passive, few women would take such action, instead preferring to suffer silently. During interviews, some women noted that the HFCs *'hawako karibu nasi'; meaning* that the HFCs were not accessible to them. Similar sentiments on accessibility were expressed about the service charter, which some felt was written in a language they could not understand, and about the area Councillors who many felt were only accessible to the rich and to men. To some respondents, accessibility issues resulted from being physically distant from the facility, (which was also significantly associated with HFC awareness). This is expected since the farther a person is from the facility, the less likely they are to maintain regular contact with the facility, let alone the HFC.

However, to a majority, the distance between the HFC and the households was 'artificial' and was mainly about accessibility (approachability and how reachable) HFCs were. This could be an indication that users - particularly women, young people, the poor, and the vulnerable - need mechanisms that they can easily access to improve their engagement with the health system.

Nonetheless, respondents were more likely to approach a community HFC member, and the Chief's office, because they perceived these two to be closer to them, not because they trusted them, or saw them as responsible for facility issues, or because they perceived them to be the ones with power to handle facility problems. This finding indicates that user-friendly and accessible mechanisms are needed, for accountability to work. Scrutinising the sense and feeling of distance among the women showed that a majority of women preferred to talk to their husbands, family members, close family friends, or associates in women's groups to discuss facility issues, rather than talk directly to HFC members. This was because many felt that these categories of individuals/groups were closer to them, and thus generally accessible. Proximity was also linked to trust, which is discussed below.

Because most decisions about the HFC are made at the *Baraza,* and at meetings which tend to limit female participation, it is likely that women's issues, such as user charges and maternal health services, would be dealt with differently were they fully involved. Findings on user fees and priority setting presented in Chapter 5 confirm this assertion. Nonetheless, the insignificant difference in HFC awareness between the genders could be explained by the fact that women frequently interact with the HF, thereby improving their knowledge of the HFC existence. This may also explain why women, as compared to men, had higher odds of being dissatisfied with the service at the local facility. Women's perception of service quality at the facility can be a good indicator of the general performance of the HF, and by extension of the impact of an HFC since they regularly interact with the health system more than their male counterparts.

Based on qualitative data, age disparity in HFC awareness was closely linked with gender. The finding that HFC awareness tended to improve with age is an indication that the health system has not properly integrated and engaged the young. Discussions

with the youth revealed a disillusioned group who felt that their voices were not being heard in decision-making about the facility, and that their health needs were not properly addressed. Like women, young people did not have a strong voice in the *Baraza*, as they rarely attended. This, they explained, was because the elderly were given priority within the *Baraza*. Many of the young people also feared that if they were seen raising many issues about the facility at the *Baraza*, they would be targeted for service exclusion since they were already known to the HWs. Further investigations also revealed that youth tended to avoid the *Baraza* because of the negative connotations associated it. From its origin in the colonial time, the *Baraza* was associated with law and order issues, and in the past, perceived offenders were severely punished. This instilled fear among residents who view the chief as a government agent for law and order, and not responsible for health issues. Indeed many respondents (especially young and female groups) were surprised when asked whether any health or HF issues were discussed at the *Baraza*.

Proximity was also evident in the regression results, which showed significant variations in the level of reported HFC awareness. Respondents who used facilities FB, FC, and FD were more likely to know about the existence of their HFCs compared to those attached to FA. Two main factors could explain this: FA covered a huge area and large population, making it difficult for the chief to reach all areas whenever a *Baraza* was held. It is also possible that many households were not involved in the committees' selection, making it unlikely that they would know about their existence. It is also possible that the greater distance between HFC members and the community could limit the interactions between them. Secondly, compared to other facilities FA suffered an acute shortage of drugs, forcing many patients to seek services at a local missionary hospital, or to look elsewhere entirely. Interviews with households revealed a general disappointment with the facility, and many respondents expressed surprise that the facility had a functional HFC.

7.2.2 Committee Selection and Engagement to Resolve Facility Problems

The performance and impact of HFCs in the study area was also largely a product of their selection, role definition and community dynamics. Data from the household survey revealed that the process by which a committee was initially formed

significantly influenced its success, and legitimacy in the eyes of the community. Awareness of committee selection criteria was very low among survey respondents. Only 18.8% of those who knew about the committee reported awareness of its selection process. Although it is quite encouraging that a majority of the 18.8% reported 'election by community members' as the mode of HFC selection, this number is still quite low, and is an indication of poor community engagement. However, this problem is not unique to the study area, and has been reported in Zimbabwe and Tanzania [84, 90].

Bivariate analysis, FGDS, and other data sources all showed that gender was significantly associated with knowledge of HFC selection criteria, with more men than women reporting knowing how their local HFC was selected. Just as with the case of intra-committee relations, the male-directed bias surrounding knowledge of selection criteria indicates that the committees generally failed to consider the voices of the majority that they should serve: women, children, and those in the lower income category. The gender disparity in HFC selection awareness is further explained by looking at the central role of the *Baraza* in this important committee process. Few women attend the *Baraza* because of cultural barriers. Their lack of or limited participation had serious implications in that they had to rely on men to discuss and decide on pertinent issues, such as maternal and child health. Perhaps more worrying, is that the health system expected the committees, as constituted, to effectively capture the voices and needs of women and children, to formulate and to implement policies that could improve their lives, without necessarily giving women a say in those processes. It is therefore not surprising that few, if any women made it to the HFCs and that instead, women had to wait to be nominated as female representatives. Similar dynamics occurred between age groups with older community members more likely to know about committee selection methods, compared to the younger respondents.

It is likely that *Baraza* attendance is the main variable that influences the knowledge of HFC selection. However, ignoring other process issues such as power and patronage, accessibility and trust, and a sense of who is responsible for HFC issues limits an understanding of the complex factors influencing HFC performance and impact.

Attending a *Baraza* would help one to know about HFC selection, assuming it is discussed during that *Baraza*. Nonetheless, the fact that younger respondents in the age group 16 – 24 years reported less knowledge of HFC selection is a reflection of feeling disenfranchised or being ignored when decisions are made about the running of the facility. Discussions with this group revealed a sense of alienation from the general management of community affairs, which tended to be handled by the elderly perceived to be more experienced. The youth tended to avoided the *Baraza* altogether and thus gradually developed a sense of powerlessness in determining who goes into the HFC. In effect, they could not trust the available structures to listen to them in matters of the HFCs. Sentiments such as, 'it is not our responsibility', or 'it is their responsibility', 'I don't trust that they would listen to us in the *Baraza*', 'we are not empowered to change the status quo', or 'the Chief is too powerful to be challenged' dominated and permeated the FGDs and IDIs responses from both women and those aged 16 – 34 years.

A majority of community members and community HFC members did not believe the HFCs represented community voices in the facility. Both groups saw the HFC as responsible for the general management of the facility; which is certainly a key role of the HFCs. However, the community still expected the HFC to represent them. Data from the IDIs and FGDs revealed a deep understanding of HFC roles among respondents. The majority of respondents mentioned issues such as ensuring waivers to the poor, implementing user fee policy, ensuring drugs availability, ensuring HWs performed their duties, holding HWs accountable for facility finances, and protecting the facility users from rude HWs, as key roles that the HFCs should perform. As discussed later in this chapter, community members viewed being issued a payment receipt as more important than the amount they had paid to the facility in user fees. In their understanding, these broad issues constituted community representation, and are what they expected the HFC to account for.

On the other hand, HFC members saw themselves as administrators of the HFs, and fundamentally as agents of development of the local facility; a role they played quite well. As already highlighted in Chapter 4, it seemed that HFC members in some instances did well in mobilising funds for facility development, and in managing

infrastructure activities. It could be that their level of dedication was purely out of goodwill and commitment to community service. Few HFC members saw themselves as representing community voices in the facility, highlighting an important shift in understanding of accountability among different stakeholders. For example, HFC members reported when interviewed that they expected the FI, with the help of the DMOH, to supervise, and thereby ensure HWs performed their jobs (because the DMOH had overall authority over the HWs appointed by the MOH at the district level). While acknowledging that the HFC could not effectively supervise HWs, the DMOH indicated that the committees were at least expected to take up complaints about HW behaviour through regular meetings, and thereby ensure the HWs were accountable to the community through the HFCs.

Therefore fundamental questions remain about where and with whom the responsibility for accountability, and the power to impose sanctions lay. Perhaps the lack of clarity over the roles of the HFC, the inherent feeling among community members that HFC members were 'distant' from the community, inaccessible, in some cases either unwilling to help or lacked the powers to influence meaningful change at the facility, and therefore could not be trusted altogether, explain community members choices of where to seek help when faced with a problem at the facility. The majority of respondents (35.1%) preferred to talk to HWs (the majority singled out the FI), as their first choice, followed by a family member (26.4%), and the area chief (21.3%). Only 13.7% chose a community HFC member; showing that many people do not see the committee as appropriately representing their problems or suited to handle issues of the HF. The majority of respondents reasoned that the HWs, especially the FI, being the 'duty bearers', were also responsible.

7.2.3 Committee – Community Communication

In order to achieve accountability to the larger community, it is essential that communication mechanisms are carefully considered in the process of setting up the HFCs [79, 97]. Communication mechanisms best ensure accountability when they are dynamic and reciprocal. For the study area, HFC relied almost entirely on the *Baraza*. As already noted in Chapters 4 and 5, the *Baraza* in the Kenyan setting, is an administrative forum convened by the local administration (usually the Chief's office)

to discuss issues affecting the community. However, the main users of the HF who could benefit from the decisions made at the *Baraza*, (i.e. women and youth), were less likely to attend these forums. Data presented in Chapters 4 and 5 showed that men and those in the age bracket 35 and above were more likely to attend a *Baraza* as compared to women and those in the age category 16 – 34 years.

The reasons for the variations along age and gender have already been highlighted in this Chapter, and are closely linked to the four main accountability markers already identified, namely: accessibility, power, trust, and responsibility. Data from the IDIs and FGDs help shed light on how these four process markers interact to influence accountability of the HFC to the population via communication. In terms of accessibility, the majority of women and the younger respondents (irrespective of gender) lamented that the key stakeholders at the *Baraza* (the area chief/village elders) were not easily accessible to them, and that they would need permission from their husbands/elders to approach them. Even if they asked for permission, their issues must be judged by the men to be significant and worthy of the attention of the chief. Additionally, women and the young particularly, may not have felt free to raise confidential issues with the elderly in this community.[30] Therefore, they lacked the trust that is fundamental for accountability mechanisms to be effective.

Secondly, the community in this area still considered the *Baraza* a law and order forum. Many respondents expressed surprise when asked whether any HF issues had been discussed in the last *Baraza* that they attended, wondering aloud that 'health issues were not the responsibility of the chief.' The community did not see the chief/village elders as responsible for health or health facility issues, highlighting a failure by the government in reforming the *Baraza* to make it suitable for its new role as a community development forum where issues such as health can be dealt with.

[30] A case in point is the new government policy of provider initiated testing and counselling (PITC). Since many people do not volunteer to take HIV tests because of the stigma associated with disease, this policy is meant to help detect new cases of HIV, and to put those infected on medication. During FGDs with the age group 16 – 24 years, we learnt that this group was being denied services if they did not accept to be tested for HIV. While many reported to be happy to take the test, they reported that they faced two main barriers. Firstly, the staff hired by the HFC to run the VCT centres were local females, and were reported not to keep confidentiality (as they supposedly would talk to other community members about those they found positive and warn peers against any sexual engagement with the victims). Secondly, they queried why HIV testing was now linked to other services and why it had become compulsory.

Lastly, the power dynamics within the *Baraza* in this setting did not favour or provide an environment conducive for women and youth participation. The current set up of the *Baraza* still borrows heavily from the traditional African practice perfected by the colonial British government where community elders convened meetings to deal with communal issues, such as conflicts, family disputes, land disputes, security, among other issues - more of an instrument for pacifying the communities and ensuring law and order. The remit of such meetings were unlimited, but it is important to note that within the African traditional setting, such meetings were embedded within the patriarchal societal practices and, as such, the *Baraza* in many communities was male-dominated. Subsequent Kenyan governments reformed this important communal institution but in a way that served the interest of the ruling class.[31]

Little has changed in the community of study. In fact, experiences from the field strongly suggested that the institution of the Chief in which the *Baraza* is anchored is associated with corruption, nepotism, harassment, punitive actions levelled against perceived offenders or lawbreakers, and in some cases extortion from would be clients. It has been applied like a kangaroo court of some sort, often avoided by the youths - mainly due to fear - who view it as a platform for the *'wazee'* to discuss community issues. Comments from the FGDs pointed to why young people in the study area avoided the *Baraza:* age difference, the discussion of irrelevant or unappealing issues, the mode of conducting the meetings with the chiefs viewed as being unfriendly, and the lack of perceived benefits from attending such meetings. It is therefore difficult to see how the women and young people would contribute effectively in such forums, let alone hold the HFCs accountable. As was the case with HFC elections, the HFCs in many cases failed to find the proper communication mechanism that was necessary for ideal engagement with the community, resulting in a breakdown of accountability.

[31] For instance, the *Baraza* was to be summoned and conducted by the area chief (an administrative position under the office of the president meant to facilitate development though ensuring law and order), supported by village elders, representing clans or '*milango*'. Under the one party state (which lasted till 1992) the position of chief, as the 'eyes' and representative of the president at the local level, was an exceptionally powerful institution, and was easily abused by the holders. It is until recently with the promulgation of a new constitution in August 2010 that the provincial administration was reconstituted requiring the central government to reform the institution of the chief, a factor that has further weakened the *Baraza* as a mechanism for facilitating accountability in the health system.

7.2.4 Responsiveness - Engaging Users in Priority Setting and Decision Making

An important facet of an accountability mechanism is its ability to ensure efficient use of resources, and effectiveness in implementing programmes that meet the community's health needs [201]. Results from this study showed that HFC's decision making and priority setting processes influenced whether users perceived them as responsive or not and whether users would report satisfaction with the services they receive. This study evaluated HFCs responsiveness based on three main indicators identified during the pilot: equity (user fee charges), quality of service (drugs availability and financial accountability) and involvement in priority setting.

There was little evidence that the HFCs ever consulted with the community when deciding on the amount of the user fee, even though government policy required them to do so. Instead, IDIs with HFCs members across all the four facilities revealed that the HFCs decided on a figure (KES 50 across the board) - based on the recommendation of the FI, and with the approval of the DMOH. This partly explains why the level of awareness on user fee setting was very low among survey respondents. Generally, the committees felt that having been elected, they represented the voices of the community, and as such it was unnecessary to consult the community. To many of the committee members, this would amount to a 'failure in/of leadership in the eyes of the community'. Additionally, committee members mentioned that the community was not consulted because it was so difficult to organise a forum where community members could share their views even though the *Baraza,* however ineffective, already existed.

However, both quantitative and qualitative data produced a surprising finding; users were not as much concerned about the level of user fees paid, as they were about adherence to the user fee policy. Additionally, users were more concerned about the HFCs inability to account for the funds they collected, and to provide some form of waivers for the poorest, rather than how much they were charged. None of the HFCs had a clear exemption scheme for users who were unable to pay. Those mostly effected were pregnant women who could not deliver at the facilities due to the high costs, and children under 5 who, despite the government policy of total exemption, were in some

instances being charged more than the HFC's own prescribed fee of KES 50.[32] Additionally, non-adherence to clear and explicit fee arrangement engendered mistrust, because many users, having accepted that services will likely have some costs, questioned why these were not explicit. In cases where fees were explicit (on the facility service charters), they questioned why the HWs did not adhere to their policy.

In the regression analysis, adherence to user policy i.e., whether one was charged the right amount, was a significant determinant of HFC awareness. Those who had been overcharged were more likely to know about the existence of the HFC, showing that users associated user charges levels with the HFC. The finding that best captures users' perception of HFC responsiveness is from the regression showing that those who had been issued with receipts on user fee payment had higher odds of reporting satisfaction with the general performance of the facility. It is imperative to note that the amount one paid, whether it adhered to the set user fee or not, was not a significant determinant of user satisfaction. Additionally, HFC awareness and income levels were also not significantly associated with user satisfaction, indicating that users valued certain aspects of accountability; and in this context, being issued with a receipt was a key indicator of accountability. Indeed overcharging at the facility was ranked at number four by respondents when asked what priorities they wished addressed by the HFCs.

On quality indicators, users were particular about drug availability at their facility and linked this with user fee payment. Whether one received drugs during their last visit was not a significant determinant of user satisfaction in general. However, those who received drugs in their last visit to the facility had higher odds of being aware of their local HFC. One explanation is that users linked quality service as indicated by drugs availability to the HFC, and expected to get at least the basic drugs after paying user charges. Qualitative discussions showed that in facilities where there were frequent drug stock-outs, users pointed a finger at the HFC as being irresponsive to their needs especially when they had to pay user fees and then buy drugs from outside the facility. There were also reports of corruption where users claimed that government drugs were

[32] During the survey, the research team encountered two families who had lost their loved ones because they could not afford the requisite KES 700 which two of the facilities FA and FB charged for HW supported delivery at the facility. This is highlighted in Chapters 4 and 5.

being sold to them at private pharmacies owned by the HWs. Availability of drugs was identified by the respondents as the main problem that needed addressing by the HFCs. This was followed by staffing and HWs behaviour.

A spot check at the facilities during the both the pilot and the main survey found that the facilities suffered drug stock-outs, for which the HWs blamed the government push system; which in most cases sent facilities drugs they did not need. It was not possible to verify how the facilities used the drug revolving fund (DRF), which accrued from sales of drugs. Of users' priorities for their facilities (drug shortage, staffing and HWs behaviour), only staff shortage matched those of the HFCs. It was only in FD that drug shortage was a priority. This difference in priorities could be explained by the fact that HFCs rarely consulted with the community in their facility priority planning processes. But it could also be an indication of a breakdown in the overall processes that sustain accountability: committee selection, the understanding of committee roles, communication, and a lack of willingness among various stakeholders to actively engage and be held accountable. In the same way that centre powers (in this case MOH) are expected to be devolved and eased into the hand of local units (the HFCs), these local units must also be ready to relinquish some of their powers to those they serve. Local units are expected to communicate their priorities and to accept that for accountability to work, an open communication process must be sustained between the duty bearers and the public.

HFCs have a duty to their electorate to maintain communications without becoming complacent. In return, the electorate are expected to actively seek information and demand accountability from the HFCs. In a culture where open conversation is not the norm, and certain members of the community are not expected to freely engage with the authorities, a constant nudging might be required to build and encourage ownership of the HF just as it is with the schools. Only then can a genuine process of accountability can be achieved. On the side of the community, there were those who were eager to engage, but were limited by numerous barriers such as a fear of being 'marked' and denied service at the facility, or being viewed as polemic in a community where people frequently mentioned relying on God to punish irresponsibility.

7.3 Community, Committees and the Place of Facility Service Charters

No previous studies were found that had evaluated this mechanism for accountability in health, showing that it could be a relatively new idea especially in LMIC settings. For this study, the SC was considered an independent variable in the analysis of HFC functioning since the HFCs are directly involved in setting up a SC. The HFCs are also expected to ensure that commitments on the SC are met. None of the SCs in the facilities met the standard set by the government in terms of the information provided to facility users. While all of them had provided a list of services offered and the corresponding costs, the information was fragmented. It was generally hard to understand whether the information provided on the SCs were a genuine commitment to accountability by the HFCs, for example, for the service they gave their clients.

Bivariate and multivariate analysis showed that one's cluster facility, occupation, education level, income, and whether one received drugs at facility or was required to buy drugs outside the facility were all significant determinants of perceived SC usefulness. These associations notwithstanding, there were three main ways in which the SC facilitated and influenced accountability relations at the facility. Firstly, it provided users with a voice to curb potential overcharging (though the study found only one case where a user had relied on the SC to query the amount he was charged). Secondly, it provided useful information about the services offered and their costs. Finally, many uses felt the SC helped them plan their medical expenses before coming to the facility for service, while others felt the SC was a sign of transparency or *'uwazi'* in Swahili as they referred to it. Even though the research team identified only one case in which a client had queried the amount he was being charged after reading the information on the SC, this mechanism has a potential for enhanced accountability that can supplement the *Baraza* and other modes of communication between the HFC and facility clients.

A number of factors lead to this conclusion. First, over 80% of the study population can read basic English and Swahili, meaning that if the information was provided in a user friendly manner, many clients would benefit from it. Second, a majority of respondents expressed a desire to have financial accounts displayed as part of the SC commitment. The logic, they argued, was that it's often difficult to bring facility users

together for a meeting to share this information, but that it would be easier and cheaper to print it and display the accounts on a public notice board at the facility. In fact both pilot and survey data reveal that the majority of respondents expected this to be the practice, and were disappointed that none of the facilities ever provided information on how they spent the money they collected, despite that the user charges were clearly shown.

The challenges associated with displaying such information, though, would be the sensitive nature of the information, especially in a poor area where majority still live below poverty line, and the extra human resources that would be required to put together this information given the HWs are already overburdened by the huge number of patients they have to attend to. A number of studies have reported that HWs and administrators were reserved displaying financial information openly as a source of possible security risk to HWs and the facility, especially where their security cannot be guaranteed [99, 106]. Nonetheless, evidence from this study such as HFCs disagreeing on who should handle which funds, suggests far more might be going on beyond the superficial explanations about security and sensitivity of the data. In actual fact, one of the major challenges to achieving financial accountability particularly in the study facilities was staff shortage. The FI did not have enough time to monitor how the support staff (facility clerks) handled the finances. These challenges are not unique to the study population and have been reported elsewhere [96, 110]. With the new HSSF programme currently being introduced, there is hope that this level of accountability could be achieved when facilities are provided with professionally trained staff to handle finances.

7.4 Contextualising Process Issues in Accountability Mechanisms

In developing the conceptual framework that guided this study, it was hypothesised that the functioning and performance of accountability mechanisms (in this case HFCs) would be influenced to a greater extent by the overall functioning of the health system i.e. the context within which the mechanisms find themselves (see figure 3.1 chapter 3). This is because health systems not only produce health care and directly impact health, they also can shape wider norms and values around which the care is received [12], and provide a site from which to contest accountability spaces [14]. It is

therefore imperative to see the functioning and performance of HFCs in Kericho district as part product of Kenya's primary health care system, and also of the cultural environment within which the HFCs operate.

At the time of this study, there were some policy changes that were being introduced but whose impacts on the HFCs could not be immediately evaluated. Examples include the implementation of the Kenya community strategy which sought to give more powers to the communities in managing their own health, including recognising the household as one of the levels of care in the health system [202], and the direct funding of facilities through the HSSF [199]. This study thus provides important baseline data for future comparison on the impacts of the new programmes.

Prior to these programmes, Kenya had implemented a decentralisation programme anchored to the concept of PHC where lower rung facilities are managed by HFCs under the supervision of the DHMT. In the study area, the DHMT through the DMOH had significant control on the affairs of the HFCs, which according to the team, 'ensures accountability of the HFCs and protection of the interest of users'. Apart from being in charge of the health system in the district, the DHMT had certain key roles and powers in relation to the HFCs, such as: approving any charges proposed by the HFCs, presiding over the election of community HFCs members, facilitating staffing of facilities, and maintaining an overall supervisory role over staff. In fact, the line of accountability of the HFCs to the DHMT was much clearer as compared to HFC-community accountability. There were however strong points and grey areas which we now turn to.

7.4.1 District Health System Leadership

Two cases illustrate the impact of health system leadership structure on the functioning and performance of accountability mechanisms in the study area. First, Kericho district had a DMOH who developed an excellent relationship with the HFCs, HWs, and the community. His leadership style seemed to endear him to the local community and his staff, and therefore was largely trusted. The effect of this trust was that they supported his decisions, and did not assume he was interfering with their activities, even in cases where he clearly overstepped his mandate. A case in point is FA, where the DMOH ordered that the local community pharmacy at the facility be

shut and merge with the government pharmacy after disputes between the HFC Chairman and the FI on management of DRF proceeds. Although according to the HWs this was the right decision-since it meant that they could now consolidate facility finances and ensure improved drugs supply--some members of the committee saw this as usurping of HFC powers, especially because the DMOH did not involve them in the decision to close down the pharmacy. This resulted in the one side of the HFC represented by the FI feeling victorious, and the other side led by the Chairman feeling wounded. The decision also received praise from community members who felt that the pharmacy was a moneymaking venture by the Chairman, since they had to buy drugs from it even after paying the regular user fees.

A second case in point comes from the HFC elections. By law, the HFCs are required to hold elections every three years. This exercise should be organised by the DHMT and presided over by the DMOH and the area DO to ensure fairness and effective participation by the community. Since the chief is an ex officio member of the HFC, the elections ought not to held at a *Baraza* that he convenes to avoid any conflict of interests. During the time of the fieldwork, the HFC had outlived their three year terms but could not hold elections because they had not received authorisation from the DMOH. Instead, the HFC members and the DHMT confirmed that the DMOH postponed the elections until the facilities received the first batch of HSSF funds from the government. The DMOH explained that since the funds required signatories, two of which should be community members, it was not possible to hold the elections. However, community members felt that they did not have powers to influence important processes such as HFC elections, and identified this as a case in which the centre intentionally refused to release power to the local level.

These cases highlight the four main issues discussed in Chapter 6 namely: responsibility, power, trust and accessibility in the operations of the HFCs. The cases also show the significance of understanding accountability as a function of complex processes, and not merely of structures and outcomes, as is portrayed in most of the literature and donor-funded projects. In terms of responsibility, it is important to clearly define lines of accountability and associated roles and responsibilities in order for mechanisms to function optimally. In the cases highlighted here, while the DMOH

may have been acting in good faith to close the pharmacy, it resulted in further division within the committee thus failing to achieve the intended purpose. It did not help that the HFC Chairman for FA took personal liberties with the pharmacy to the extent that it almost was a private enterprise. Further still, while postponing HFC elections may have been the appropriate action to ensure the facilities did not miss out on funding, the manner in which it was done portrayed the DHMT as overstepping on their roles and powers, and thereby causing disquiet within the HFC's and the community.

Moreover, these cases also show the complex interplay of power within accountability structures. As shown in the literature review, policy makers rarely expect such complex interactions[65, 129, 198], but instead tend to assume that the HFCs, like clinical aspect of care provision, will be devoid of politics of power and power struggles. This assumption is a major oversight on the part of policy makers, at least based on the experiences reported in this study. Accountability in the health system, the level notwithstanding, involves human relations around scarce resources. Whether they are intended so or not, such interactions and relationships will be about who gets what, when and how, and that implies the politics of power and power struggles, however subtle. Therefore, the government would do better in developing the capacity of HFCs and the DHMT to deal with conflicts that arise from these accountability relations. Particularly, it is important to build trust among committee members through continuous training, role clarification, and supportive supervision which can reduce the personalisation of power and facility resources.

7.4.2 Socio-Cultural Context of the Local Community

Finally, the cultural context within which the accountability mechanisms are meant to work is equally as important as the context of the health system [5, 35, 203-205]. The mechanisms themselves are an articulation of particular cultural values, and as such, it is important to consider to what extent these 'fit' the wider cultural context. For this study, the culture of political patronage, male dominance and inequality served either to hinder or promote accountability and engagement. The role of cultural context becomes clear when looking at the accountability-based decisions and options that users have for recourse whenever they feel the health system is failing them, and the

reasons behind those decisions. Respondents in this study were asked to discuss their options when dealing with the health facility and the facility committee. For example, respondents reported that they would consult a certain authority (family member, community HFC member, local administration, HWs, local politician) mainly because they felt the authority was responsible (42%), nearest to them (26%), trustworthy (17%) and because they were powerful and could deal with the issue (15%).

Investigating these choices further through FGDs and IDIs revealed deeper, but hidden reasons behind the choices that were linked to Kipsigis culture. As already mentioned elsewhere in this Chapter, most women were likely to choose a family member, most probably the husband, to help resolve any problem at the facility. This, they reported, was because they were nearer to their family member (accessible) and they trusted them. On the contrary, most men would approach the local politician (councillor or MP) to deal with facility issues because they believed they were powerful and could handle facility problems. Again, compared to women, men were likely to have easy access to the local power wielders. Chapter 4 narrated a case in FA, where the councillor mobilised local residents to evict the FI who was perceived to be underperforming without involving the DHMT or the local HFC. Similar cases--of local politicians or elite taking control of HFCs--for personal or insinuated community gains have been reported in other studies across LMICs [82, 206, 207]. Most men clustered around FA reported that the councillor was their best choice in dealing with poor performance at the facility, noting that the Chairman and his team had failed to listen to them or were not powerful enough to bring meaningful change to the facility.

Interviews with community leaders pointed to a cultural issue that went beyond the HFC and its members. Generally the Kipsigis community tend to shy away from confrontation, and as such they do not question the community HFC members on matters of the facility fearing that it would be seen as *'fitina'* or 'bad politics'. Closely linked to the 'fear of confrontation' and *'fitina'* is the place of religion in everyday lives of the Kipsigis. Many respondents pointed to God as the ultimate judge of people, and as the ultimate holder of the 'accountability stick'; used to punish those who do not perform their roles in the community. Responsibility was linked to the perception that it is human to serve and ones' duty to perform to their best of ability. God would be

the one to deal with you should you fail. Perhaps this is what Dowden has referred to as *'a clear evidence of the humanity of Africans, rooted in traditions of duty and deeply-felt religion'* [208]. Rather than take accountability actions or sanctions as envisaged in the literature, most community members felt they would leave this to God as 'responsibility is God given, and it's our duty in service to him to perform our roles, failure to which it's him to punish.' Many ideas about accountability of the HFC were actually embedded not only in the wider social structures, but ultimately on beliefs about the cosmology.

There is also the 'strong African man syndrome', where power and institutions tend to be personalised, and any attempts to challenge underperformance would be seen as an affront on the person holding the position of authority. It is therefore difficult to see how HFCs as mechanisms of accountability can function effectively with all these caveats enveloped in socio-economic and political hierarchies. This is perhaps best exhibited by the comment of the HFC Chairman for FA in reference to the FI, and in response to a question asking why he was sidestepping the FI in committee decisions; *'I am protecting the woman from local politics'*. Several studies [96, 108, 188] have reported similar experiences in other parts of Africa.

But the silence was much pronounced among the women who society did not expect to openly engage without the permission of their husbands. Therefore most women relied on their husbands to represent them at the *Baraza* where facility issues were discussed. Indeed during the researcher's interaction with the female respondents it was not hard to notice their timid nature, with most of them commenting that *'mzee wangu [my husband] is better placed to answer that,'* even after the research team emphasised that the interviews were personal and confidential. In both cases (of the cultural and health system context) the problem was not so much that the patients/community members were disengaged/did not want to engage with the system, but rather that the providers/HFCs and the health system was not always vey engaging. The story in Box 4, illustrate some of these issues.

Box 4: Culture, Health care Costs, and Engaging the HFC to Resolve Facility Problems (FB)

Claire* has five children aged eight, six, five, three, and one. Given her young age of 25 years, it's clear that she must have been married early. As we get into the details of the interview, Claire's eyes change and her jovial mood disappears. She begins to narrate to us her predicaments since her husband left for work in the coastal city of Mombasa. She reveals that her last three children have been ill for the last three weeks. From their hospital records, one was diagnosed with malaria, typhoid and the youngest a mild cough. She says she couldn't afford the cost of care at the hospital and after the diagnosis, she was denied medication because she couldn't produce the KES 500 that the HWs had demanded. She narrates how the health facility (FB) had *'become like private where one cannot get treatment unless you part with specified amounts of money'*. The only difference between private and public facilities, she says, is on the quality of care given. Most of the times *'the HWs would still ask you to buy drugs from the private pharmacy outside the facility even after paying the requisite user charges'*.

Claire tells us that she got to know about user fees from the facility service charter, but that most of the time, users end up paying more since each window or department at the facility will demand some money before helping. To cope with the high user charges, Claire sometimes opt to buy drugs directly from the pharmacy when the illness is not severe, arguing that it made no economic sense to visit the HF, pay user charges, but not get the drugs. She also tells us that sometimes she would visit a private clinic in the local market where she can get treatment on credit since the proprietor is a local and knows her circumstance. She would then pay latter when she got the money. At times she would also use local traditional herbs and other times resort to prayer for healing.

At this point, we ask Claire about the whereabouts of her husband and she tells us that, *'since he left for Mombasa about six months ago, he had not returned, but had called the other day to say that he had found a second wife, a Luo, and that he will be bringing her home'*. She adds that *'men in this village resort to additional wives or extramarital affairs, once they get some extra money, leaving their wives to shoulder all family burdens*'. She tells us how she is struggling to cope with high costs of care, finding food for the children and ensuring they can go to school. Claire thinks that cost sharing is not a bad thing; but that the charges at the facility are too high for the poor and that despite government policy for free care for under 5s, she is always charged even when she goes for regular immunization.

Claire is aware of the HFC and knows some of its members. She tells us that the community including herself, have complained several times to the committee, *'but nothing is changing; I gave up on putting my hopes on them [the HFC], if I can't afford it, I stay home or seek help elsewhere, otherwise they will accuse you of petty politics, that you are full of "fitina" [bad politics]. It's not unusual to be accused of spreading gossip, especially for me being a woman and my husband is away; they would say I am idle…you know such kind of talk'.* Claire tells us that she leaves it to God who is in charge of everything.

Source: Field notes

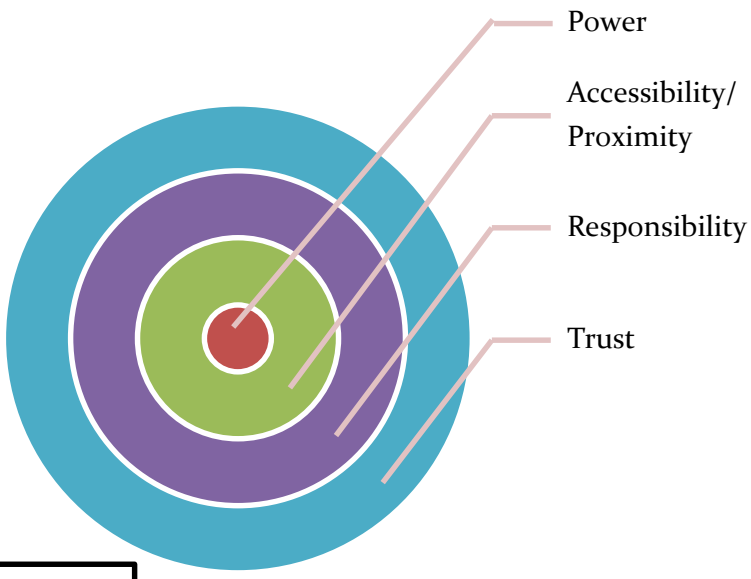
**Name changed for anonymity*

7.5 Summary and Conclusions

The discussions presented in these two chapters point to the fact that health systems are complex socio-political institutions, and not merely delivery points for bio-medical interventions [132]. Though four main accountability markers identified (trust, power accessibility and responsibility) form the main dynamics influencing the performance of accountability mechanisms, and represent a complex web of factors that either enhance or undermine the performance of accountability structures in the study area. All the four factors were closely interlinked, serving to illustrate the fact that accountability in health is not a linear process. Instead, it is constituted of much more complex processes that involve determination and human and policy interactions. It is rarely a simple cause-and-effect relationship as current policy envisages, but instead chains of factors, potentially quite long, which cause and are embedded in multiple interactions. It is therefore impossible to separate aspects of power from trust, responsibility and accessibility or proximity.

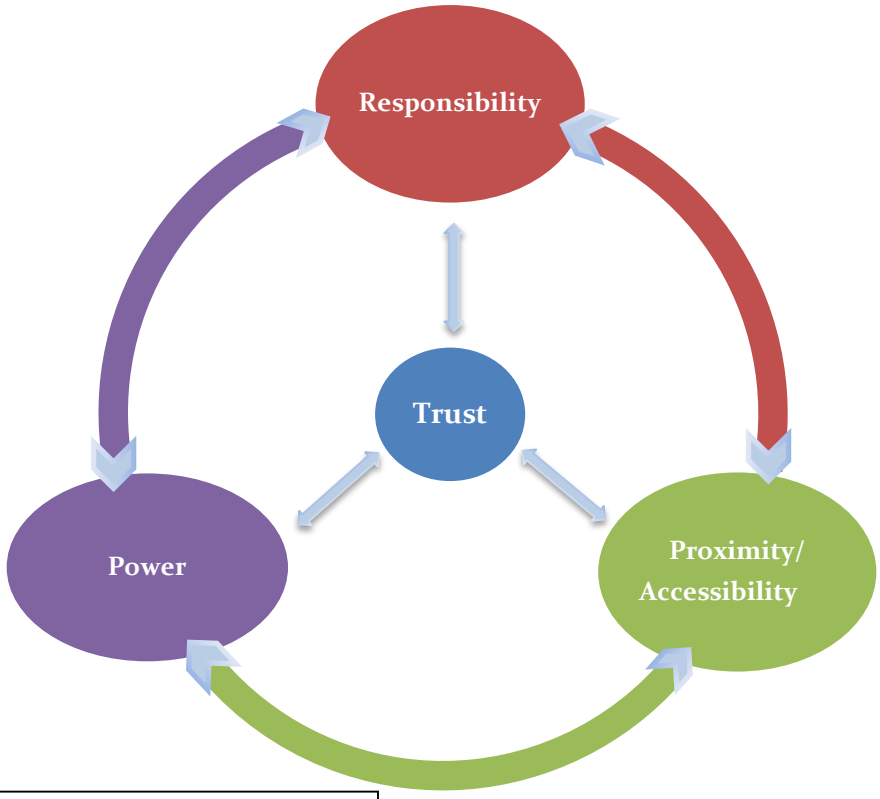
Comparison of the study findings with other literature on accountability and engagement in health, though limited, revealed some similarities on the functioning of HFCs in Kenya and elsewhere in Africa. There were also some differences. For instance, unlike in other studies where the level of education in the community was reported to be an important influencing variable in the functioning of committees (i.e. that low education levels among community HFC members and HF users tends to undermine accountability relations), this study found that this did not hold entirely in the study area. Instead, power relations, trust within HFCs and with the community, accessibility of HSA mechanisms, and an understanding of responsibility of HSA structure members were important explanatory variables. Within committees, power was at the centre of stakeholder relationships (Figure 7.1), while the committee-community interrelationships were largely revolved around trust, which influenced how stakeholders understood their responsibility, applied their powers, and actualised accessibility (Figure 7.2). These factors were accentuated by cultural values and practices, and the health system context within which HSA was applied. The interactions of various forces caused the difference between what policy had envisaged for HSA, and what committees and health workers implemented, and what users experienced.

Figure 7.1: Accountability Markers Characterising Intra-Committee Relations



Source: Author

Figure 7.2: Understanding committees - community interrelationships



Source: Author

A final conclusion that can be drawn from the results and discussions above is that context matters in understanding the performance and impact of HSA mechanisms. For instance, it seems that the committees studied here were quite successful in

bringing in women as representatives in the committees. In fact, it would seem that they had overcome the representation challenge and met the government policy on gender inclusion [199]. But that was just about it; co-opting women in the HFCs to achieve gender balance did not result in more female issues being articulated or prioritised, nor did it result in their male counterparts opening up any 'decision space' so that they [women] could influence policy in the HFCs. Perhaps it represents the 'naïve position' that more participation equals more accountability, and that HSA are devoid of politics of power since they handle health, which has traditionally been perceived as a non-political issue. However, evidence discussed in this study point to the need to understand that HFCs are made of complex human beings engaged in a web of interactions, motivated by a range of different financial and non-financial incentives, and that accountability relationships are deeply hinged in cultural and professional value systems.

The following Chapter takes these points into consideration and provides some policy options for addressing some of the issues that arose from the study.

CHAPTER 8

CONCLUSION & POLICY IMPLICATIONS

8.1 Summary of the Study

Drawing on existing theoretical and empirical research, and a pilot study to contextualise the practice of accountability to the study location, this thesis has examined the factors that impact the functioning and performance of health system accountability mechanisms (HSA) in rural Kenya. In particular, the study primarily focused on the process factors that influence the health system accountability. Following a mapping exercise that identified the main HSA mechanisms in the study area, health facility committees (HFCs) and facility service charters (SCs) were identified as the predominant HSA mechanisms in the study area, present in all the HFs studied. Further, SCs were found to be part of the broader function of HFCs and, as such, were analysed as a determining variable (sub-set) in the operations of HFCs. The analysis presented took a two pronged approach, where accountability within HFCs was considered, followed by an analysis of HFC-Community relations, thus providing a holistic picture of the practise of accountability that has hitherto been lacking in the literature, as most studies focused primarily on either the HFCs or the community perspectives on HFCs [77].

The importance of understanding the factors impacting on the performance and effectiveness of HSA mechanisms flows from a sustained international emphasis on accountability in health, especially in LMICs where health systems are struggling to effectively allocate scarce resources in the face of growing demands for PHC [12, 58, 119]. Also important is the realisation that involving people in planning their health is a human right in itself, besides the other possible benefits which may include: raising additional resources for facilities; reducing the impact of medical costs through waiver schemes; and generally promoting equity and reducing poverty in the health system, in the wake of the devastating effects of HIV/AIDS, malaria and other infections in LMICs.

Using data from a household survey in a rural Kenyan district, this study sought to: describe the range, nature and composition of existing HSA mechanisms supporting primary care in peripheral health facilities; analyse the perceived impact of the above

mechanisms on PHC delivery through an assessment of their depth of engagement, responsiveness, and effectiveness; examine the key factors that influence the performance of the above mechanisms with a focus on the role of process; and to identify policy implications for improving HSA at the peripheral level. The study systematically reviewed the available theoretical and empirical literature on HSA and PHC service delivery and developed a multi-factor conceptual framework that incorporated aspects of various theories on accountability in health and pilot data from the study location which led to the gathering of a rich mix of data. To examine the factors impacting the performance of HSA mechanisms, mixed methods analysis was employed ranging from univariate, bivariate and multivariate statistical tools using IBM SPSS software, complemented by qualitative thematic approaches.

8.2 Study Limitations and Attempts to Overcome Them

Although much care was taken in designing and implementing this study, no research is without limitations and some of these are highlighted below:

- The study relied on user satisfaction with services received at the HFs as one of the measures for responsiveness and quality of care. Despite being considered an important measure for understanding the quality of care from users' perspective [126, 209], patient satisfaction as a construct is subject to many biases since it reflects people's expectations in addition to their experiences [210, 211]. To overcome this weakness, the questionnaire was designed to allow users to explain their answers, which have then been used to further, explain the results.

- The study was conducted among a population from a single district in rural Kenya, limiting the applicability of the results to the district of study and perhaps other areas with similar sociocultural and economic context. Nonetheless, the study is a much-needed addition to the empirical evidence on the functioning of HSA and can be a major contribution to policy. Further, the focus allowed for in-depth accounts that give insight into processes that are more generally relevant.

- Regarding the methods, the study relied on a cross-sectional survey raising concern as to whether this was enough to fully understand the functioning of HSA mechanisms. The three months within which the study was conducted was not

enough to allow a richer and fuller understanding of users' experiences, which might have been best captured through a longitudinal survey, but which was not possible due to time and financial limitations. Attempts were made, however, to learn as much as possible from the operations of the HFCs by reviewing their minutes over several months prior and during the study period and incorporating this in the analysis. Additionally, the study adopted a multi-methods approach, relying on different kinds of data in order to produce a more holistic account of the functioning and performance of HSA mechanisms in the study area, than qualitative or quantitative sources could, on their own, provide.

8.3 Key Findings

The following key findings summarise the complex nature of health system accountability practices in the study area:

Four accountability mechanisms provided linkages between the users and the health system in the study area. These were: HFCs, SCs, suggestion boxes and patients' rights charters. Of these, HFCs and SCs were the main mechanisms in use and were present in all the facilities surveyed. The HFCs were hybrid in composition and structure, drawing their membership from community representatives, government administrative representatives, health workers representatives, and area political representatives.

On the SCs, there were several similarities across all the facilities. These included information about the types of services offered (consultations, laboratory tests, drugs available), the user fees charged for each service, and the facility working hours. None of the facility SCs met the minimum standards provided for by the government.

Four main accountability markers – power, trust, responsibility and accessibility - were identified as the key influencing factors on the performance of HSA mechanisms in the study area. The markers mediated relationships between users and those administering health, in formal and informal ways in the system producing both negative and positive results. Formally, the government with the DMOH and DHMT being in charge of implementation defines the roles and powers of the HFCs. But even then, these relationships were not clearly defined and in many instances different

stakeholders had to find innovative ways to overcome challenges of accountability in the system. For instance, while the government user fee policy for services at the health centre level is KES 20, the HFCs had to review this upward to KES 50, with the approval of the DMOH, in order to raise additional resources to keep the facility running. However, none of the HFCs could effectively implement this policy and evidence presented in this study show that users were, in many instances, overcharged. Many users saw this as corruption, pointing to the failure of the HFCs to ensure accountability in the facility, with negative consequences for the majority of the poor users and equity in general.

Further investigations revealed that the HFCs could not hold the HWs accountable since they were not the appointing authority. These realities lend themselves to the argument that informal HSA relationships, anchored on political leverage, competing interests, and ambiguity of roles, can distort regulatory mechanisms in ways that obstruct service delivery [131]. The case of HFCs raising the user fee charges beyond the official government guideline, and then failing to implement the new fees, is an indication of formal hierarchies of power being ineffective in dealing with problems affecting the local population, which led many people to lose trust in the mechanism.

Related to how power was understood and applied among HSA stakeholders, and the role of trust in building effective HSA mechanisms, was the finding that fees charged were not a significant determinant of user satisfaction with service; instead, a significant determinant was whether one was or was not issued with a receipt. Unlike what has been reported in many other studies on cost-sharing of PHC costs (in the form of user charges), in that most populations report resentment to charges, this study found a unique response to such charges. Despite their high levels of poverty, most respondents were not against the cost-sharing scheme. Instead, the majority of the community in the study area recognised and accepted that services will come with some costs, but expected that such costs should provide, in return, value for their money.[33] They expected the funds to be accounted for in the form of open financial information at the facility and issuance of receipts upon each payment. This

[33] Though value was equated to a number of different things and dimensions that users felt were important to them such as 'medication' and 'intervention', these expectations were not out of the ordinary and could be judged to be well within what the HFCs should account for.

conclusion is supported by another important finding in the study: that whether someone received drugs/treatment items or not, and whether they were required to buy additional medication from outside the facility after paying requisite user fees, was significantly associated with user satisfaction with service received, and with perceived SC usefulness, and not with awareness of the HFC.

Closely linked to power relations within HFCs was a lack of *clarity of roles* among HFC members. HFCs members perceived their main role, rightly so, as that of the overall management of the HF. This is intriguing, given almost none of the HFC members interviewed mention representing the community or community interests as part of their key responsibilities, again illustrating conflict between formal and informal accountability relationships. This perception of HFC role [as being one of management of facility] significantly limited HFC members' level of engagement with the community since they did not think they were answerable to the community. Instead, most of them envisaged an accountability relationship defined by one partner (the community) playing the election role and the other (HFC members) playing the information-giving role. This limited view also impacted the relationship with HWs, particularly in FA and FB where supremacy wars and conflict concerning management of finances and hiring of support staff dominated.

Among the key findings of this study was the contrast between quantitative and qualitative data on links between *gender* and *HSA mechanism experiences*. Save for gender and marital status, all the socio-demographic indicators were significantly associated with HFC awareness among the study population, even though women, compared to men, had lower odds of being aware of their local HFC. The same held for overall satisfaction with service where women had higher odds of being dissatisfied with the service at their local facility compared to men, though the results were non-significant. However, further analysis of qualitative data revealed how the health system systematically excluded women and young people (age group 16 – 24years) from participation in matters affecting their health. This is despite women and young people, representing the demographic groups with the greatest need for PHC and being the majority users of the HFs.

From the set-up of HFCs, to how they are run, to the information provided on SCs, the study found a health system insensitive to the needs of the neediest demographic groups. In some cases, women representatives were invited to attend HFC meetings at the behest of the Chairmen who also handpicked them to join the committee. In the committee meetings they faced frustrations and could not question certain issues since they needed to show allegiance to the Chairmen and the Chief who appointed them to the committee. Yet, their attendance was still classified as involvement and representative of women issues in the HFCs. These findings support and are related to evidence presented elsewhere in India and Uganda on local politics [212-214]. It is therefore inconceivable to think that through regular election at three year intervals, the poor and vulnerable, women, and young people will have a voice in the decision-making processes of HFCs, when clearly they have very little or no input between those elections. Because electoral and elections systems often reproduce themselves over time, unless genuine efforts are made to correct their anomalies, often, they end up marginalising women, minorities and vulnerable groups [214].

The problem of getting community voices into decision-making and priority setting was not just limited to the poor and vulnerable groups, even though they were the most affected. This study found that HFCs and community members often held different priorities; an indication that even if the community selected the HFCs, they were unable to capture user needs in their decisions/policy choices, reflecting little relationship with the desires of their clients. The system assumed that HFCs, having been elected, were able to assess the detailed needs and priorities on behalf of those they represent and that HFCs' decisions would reflect users' needs.

Linked to the *Baraza* and financial accountability, was the finding that *communication strategies* used by the HFCs to reach out to the community were ineffective as evidenced by the fact that those who had attended a *Baraza* were more likely to know about the HFC compared to those who had not, and that very few respondents had ever been to a *Baraza*. It is indicative that the HFCs failed to communicate their successes and challenges to the community, leaving many community members either unaware of their existence or altogether questioning their usefulness. Findings

presented in this study point to the significance of communication as a tool for building trust within the HFCs and between the HFCs and the community.

The results presented in this study showed that the majority of the community HFC representatives were well educated unlike the current literature that point at low *education levels* as a major problem for HFCs in SSA. This is very encouraging and needs enhancing by providing the much-needed incentive to attract the best skills in the community to the HFCs.

The research has shown that *socioeconomic status* was a major influencing variable impacting the performance of HFCs especially on depth of engagement, and knowledge of HFC members. Socioeconomic status reflected in reported monthly income was significantly associated with perceived SC usefulness, awareness of HFC, and user satisfaction. Quantitative findings also pointed to the divide between the poorest in the income category KES 2000 or less and those in the higher income categories who had higher odds of knowing about the HFC and reported less concerns with the user fees charged at the facility. Because the HSA mechanisms are primarily a tool for achieving equity in health service delivery by putting in place mechanisms such as waivers, credit facilities and encouraging healthy lifestyles, it is clear that HFCs in the study population are failing the neediest among them.

Finally on SCs, analysis showed that user perception of SC usefulness varied depending on one's occupation, cluster facility, income, and whether a facility provided drugs or not after user fee payment. Some respondents reported that the SC provided them with a useful platform to challenge perceived 'acts of corruption' and therefore was an important tool for ensuring accountability at the facility. The SC was also seen by some users as having useful information that ensures that they do not waste time when they visit the facility, including finding the right amount of money for specific services before they reported for treatment. Therefore, the SC was an important tool for planning one's medical budget and as a signifier of transparency at the facility.

8.4 Significance of the Findings

Findings in this study confirm the initial hypothesis that features of process are critical to the functioning and effectiveness of HSA. While previous studies have focussed

mainly on the HSA structures and their outcomes, and their impact on PHC delivery, the evidence obtained from this study suggests a critical need to understand the structure-PROCESS-outcome interrelationships that underpin performance of HSA mechanisms as a first step in HSA evaluations. Although there may be merit in looking for outcomes of HSA, especially where donors and governments are keen to justify certain policy actions, a holistic assessment is nevertheless important. As this study demonstrates, it provides a better understanding on how process issues combine with other variables such as socio-demographic characteristics, context specific accountability indicators and the health system context to produce the outcomes reported in many studies. In addition, a focus on process reveals that there are a number of relevant outcome issues in addition to the usual metrics of health outcomes, for instance, issues of continuity, gender, power distribution, and trust among others.

This study has also disproved the common logic in the literature that more participation necessarily equals enhanced accountability or responsiveness to users' needs (especially the poor and vulnerable). This study supports the understanding that there cannot be accountability without some level of participation – but that this does not equate simplistically with numbers of people, and reinforces previous findings in other LMICs, which generally concluded that decentralisation efforts, though producing more participation and increased representation, ended up proving little in the way of empowerment or enhancing equity [76, 213-222].

In sum, this study has added important knowledge about the functioning of HSA mechanisms with special reference to SSA and Kenya in particular. More importantly, the focused analysis on HSA processes adds much needed detailed description and analysis in this field. The use of mixed methodology in both data collection and analysis contributes significantly to bridging the gap in lack of robust methods for studying the complex relationships of accountability.

8.5 Policy Implications

A number of policy implications arise from the findings of this study:

- The findings lend support for initiation of programmes and policies that takes into account user perceptions and calls for full involvement of users in designing such programmes.

- There is a strong case for a review of the HSA mechanisms in the study area to provide for and strengthen processes by which the community can filter through their needs to decision makers. These could take the form of patient report cards, suggestion boxes (SBs) and public consultation meetings at the facility, to seek user views about what they wish done. Given the success of biweekly health talks at the facilities targeting breastfeeding mothers, such initiatives can be expanded to include consultation with the rest of the community on their health needs and how best they can be tackled. Users were particularly keen on having SBs placed in facilities that lacked them. This was especially so because suggestion boxes were seen as providing a safe and anonymous platform for airing views given the fear of victimisation among users if they were to directly confront HWs or HFC members with some of their concerns. It is encouraging that two of the facilities that lacked SBs were in the process of setting them up following feedback from the research team.

- It is important for HFC members to be offered continuous on-the-job training on important accountability areas such as conflict resolutions (both within and outside of the HFCs), financial accountability, community representation, and engagement. Particular emphasis should be placed on how to mobilize and get community members to be actively engaged in the running of HFs. Perhaps the government could borrow a leaf from the education school boards system as recommended by treasurer FA, to institute continuous seminars bringing together HFCs from different settings to facilitate learning and sharing of best practices.

- There is an urgent need for the Kenyan government to revamp the HFCs selection process with a view of opening the process to capture more women and young people. This study has shown that the *Baraza*, as currently constituted, does not address the needs of these two groups and as such the government should consider using forums which attract women and young people's participation such as school

meetings, religious gatherings, community groups, public notice boards, and women self-help groups *(chamas)* as election platforms for the HFCS.

- It would be important for the government to revise the HFC selection process in order to ensure that special groups such as the poor, youths and women are not only represented, but also supported to achieve effective engagement in the committees. Special provision for their nomination can be a beginning point, but ultimately it is giving these groups a voice in the committee decision making process that counts.

- Related to the selection process is the need to reconsider the role of the provincial administration through the local Chiefs and VEs, since this study found that they tend to scare away young people and women from openly participating in HF and HFC issues. While this could be partly due to traditional cultural values and practices, whether Western or non-Western, which are often not ideal to the principles of accountability, one option can be to completely separate HF issues from the law and order arm of government. This is because many respondents continue to associate the Chief's office with law and order issues, rather than with issues concerning health. In fact this study found that the *Baraza* was causing more damage than help to the HFCs as they were politicized and tended to attract competing political interests who used the HF problems as a platform to achieve their own agenda. Importantly, the government would do well to discourage politicisation of HF issues at the *Baraza*.

- Also requiring special attention is the need to deal with deep-rooted cultural norms and practices among the Kipsigis that tends to mark out community leadership positions as the preserve of the elderly people. A targeted health promotion programme including information about the benefits of getting women and young people involved in the management of their own health could help the community overcome some of the cultural barriers. Discussions with all age groups during the fieldwork showed that, in many cases, it was not a case of the community members not wanting to be involved, rather it was the health system failing to engage the community and to mobilise their efforts into supporting the HFs.

- The government should take advantage of the positive attitude of the community in the study area towards cost-sharing, not just to mobilise resources for the health system, but also to help community-based accountability structures to maximise the use of resources so that people are not disenfranchised and led to withdraw their support for the HFs. Particularly, there are several opportunities such as the use of social media, mass media and open forums to engage community members on why it is important to support the health system and also to help HFCs reach the community with information about facility funds and how these are used.

- The HFCs and the HFs need to be supported to provide publicly accessible information on important operational areas such as the resources they have, how they are used, and how services are being provided. This should help build trust among various accountability stakeholders in the health system.

- In addition to strengthened community oversight, the government should consider institutionalised mechanisms such as audits of HF books of accounts as recommended by the treasurer FA and supportive regularised supervision by the DHMT to ensure that the HFCs operate within their mandate without interfering with their autonomy. There should be standardised procedures that allow for professional audits and oversight on matters of finance at the HFs without compromising the strength of local voices and independence of HFCs. Perhaps, professional audits could be linked with supportive supervision and institutionalised and specialised mechanisms put in place to check that HFCs are performing their roles. As it is now, the line of accountability to community is vague and fraught with fear, mistrust, and power politics.

- Finally, incentives for members of HFCs should be a priority for the government if it is to attract the most qualified community members to serve in the committees. With the new HSSF for HFs, tailored along the lines of free primary education programme, now being scaled up across the country, it should be possible to attract some of the best brains in the community to serve in the HFCs albeit with some incentives like enhanced allowances and facilitation for serving in the committees, like is currently the case with schools.

8.6 Recommendations for Future Research

This study has relied on a cross-sectional survey design to generate data on the functioning of HSA mechanisms. However, the results presented here show HSA as a complex social process that brings together several stakeholders and involves multilayer interactions and interrelationships. As a result, recommendations for future research are based upon this conceptualisation:

- Such relationships can be best understood through a longitudinal methodology that allows for accountability mechanisms to be followed, and studied, over a long period of time, to enable a richer documentation of their experiences and changes over time. Based on the researcher's field experience and the evidence presented here, it is strongly recommended that future studies consider a longitudinal methodology that can generate qualitative and quantitative data, with strong descriptive and analytical elements.

- The results presented in this study were from accountability mechanisms receiving no external support or facilitation. This significantly limited the level of comparison with the current literature since all other studies were based on experiences with externally supported projects. Therefore more studies of the kind presented in this thesis are recommended in order to generate enough scientific data that can lead to some epistemic consensus around the functioning of HSA in a 'normal' or 'natural' setting void of external intervention. The alternative could be case control studies looking at HSA mechanisms operating at 'normal' health system structure *vis-a-vis* those receiving external facilitation and support. This latter type of study presents the opportunity to identify areas that need improvement for HSA mechanisms in normal health system settings, and could present more, and perhaps varied, useful policy data compared to the current case where studies compare supported HSA mechanisms with those facilities without any accountability structure.

- This study found that many HFCs members did not expect any significant monetary incentives in order to serve in the committee despite the fact that they were in charge of comparatively huge sums of HFs monies and oversaw projects worth thousands of shillings. Discussions with most of them pointed to a religious

angle to their commitment, though this was not an objective in this study. Many reported that they felt they were giving back to the community and in that way serving a higher calling by God. In the health sector, several studies have been done on the motivation factors for staff especially those serving in rural and resource scarce settings with low pay. However, there is very little on the motivating factors for those serving in non-professional voluntary positions such as HFCs, yet such information could significantly shed light on why accountability mechanisms involving voluntarism perform as they do. This is therefore an important research area that future studies should incorporate.

- Finally, this study was done among the Kipsigis of Kericho district, Kenya, using a customised conceptual framework. In order to provide cross-culture comparative analysis, there is need for similar studies to be carried out among different cultural groups and perhaps countries, adopting and adapting such a framework. Data from such studies can provide useful comparison of differences as well as similarities, and sharing of best practices. Fundamentally, there is a huge methodological challenge in researching accountability necessitating continuous sharing of information and frameworks among researchers in order to isolate and apply what works best, where and how. It is hoped that the framework presented in this study can be seen in this light.

8.7 Final Conclusions

There is a renewed interest in health system accountability as a means for enhancing health system performance and the delivery of services especially at the primary care level. However, the evidence on the practice of accountability, especially on the factors influencing the performance of accountability mechanisms, is to date very limited. While there is considerable literature on conceptions of accountability and, to some extent, on the impact of accountability mechanisms on service delivery in some LMIC settings, primary analysis of the process factors that influence the performance of HSA mechanisms is largely missing. This study has combined available literature on conceptions of accountability, pilot data, and data gathered from extensive fieldwork to offer a holistic analysis of the concept and practice of HSA in Kenya. While the thesis findings have immediate relevance to the improvement of the performance of

HSA mechanisms in Kenya, it is hoped that the concepts and methods employed will be of use in expanding our knowledge of the structure, process, and outcome of developing country health systems accountability and accountability in health care delivery initiatives generally.

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