INFLUENCE OF ACCOUNTABILITY ON HEALTH SYSTEM RESPONSIVENESS: A CASE OF PUMWANI MATERNITY HOSPITAL NAIROBI, KENYA

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DECLARATION

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

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DEDICATION

I dedicate this thesis to my wife Hellen and children; Eliphas, Joy, Delight and Lawi for their steadfast love and support during my studies.

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I'm thankful to Almighty God for the good health and understanding when I was undertaking this study. This thesis would not be complete without dedicated support from my supervisors Mr. Musa Oluoch and Dr. Wanja Tenambergen. I will not also forget the contributions of Dr. Kezia Njoroge who took over as HOD, Dr. John Mapesa who helped in data analysis and presentation as well as Dr. Catherine Mutinda, the Medical Superintendent at Pumwani Maternity Hospital during data collection, who facilitated and eased my access not only to the study site but also to individual study participants. My special thanks to members of faculty of KeMU, friends and colleagues who were very resourceful and encouraged me throughout the entire rigorous process of development of this piece of work. Last, but not least, sincere thanks goes to my dear wife Hellen Kisur and Children for their understanding when I was away from them. Friends, I look forward to be good to each of you and make worthy contributions to the world around. To each one of you, thank you.

ABSTRACT

Health and healthcare are essential to functioning of a society. While the government of Kenya is constitutionally mandated to ensure highest level of healthcare for all of its citizens, a number of hurdles remain on the way to realization of such priorities. To improve health system performance, accountability has been considered key to reducing abuse as well as assuring compliance with procedures and standards. The current study purposed to examine the influence of accountability mechanisms on health system responsiveness, focused on Pumwani Maternity Hospital, Kenya. The study was guided by the Principal-Agent and Complex Adaptive Systems theories. This study used correlation research design. The target populations were patients and employees at Pumwani Maternity Hospital. The hospital had a total of 206 employees at the time the study was conducted. Among the 206 employees 13 were departmental heads who were used as key informant. Yamane formula was used to get a sample of 130 hospital staff members. Primary data was collected using questionnaires, key informant guide and focused group discussions. Questionnaire was used to obtain information from hospital staff members. Key Informant Guide was used to collect data from 13 departmental heads. Focused Group Discussions (FGDs) was used to collect data from patients. Five FGDs of five patients were formed who took part in the discussions. Procedure for data collection comprised seeking permission from the National Commission for Science, Technology and Innovation through the Kenya Methodist University School of Post Graduates. A pretest was conducted at the Nakuru Level 5 Hospital. Data were analyzed both using descriptive and inferential statistics and thematic content analysis for quantitative and qualitative data respectively. The findings revealed that hospital staff involves patients in decision making. In addition majority of hospital staff agreed that they adhere to professional codes of conduct. The findings also revealed that the hospital has informal payment/user fees. From the findings the study concluded that there is a weak positive significant correlation between professional accountability and health systems responsiveness (r=.382**). In addition the study concluded that there is a moderate positive significant correlation between institutional accountability and health systems responsiveness (r=.547**).The study further concluded that there is a weak positive significant correlation between financial accountability and health systems responsiveness (r=.394**). Furthermore the study concluded that there is a moderate positive significant correlation between political accountability and health systems responsiveness (r=.572**). Finally the study concluded that there is a strong positive significant correlation between social accountability and health systems responsiveness (r=.643**). From the conclusion the study recommended that hospital should be able to collect such information on hospital practices and patient outcomes and for using those data to guide, educate, supervise, discipline, or recognize operations. It is also imperative to hold staff members accountable for tasks within their power to perform. To ensure that everyone has access to care irrespective of financial condition, the county government need to come up with policies to protect indigent patients from being detained for lack of money to pay for hospital services.

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ABBREVIATIONS AND ACRONYMS

ADR	Adverse Drug Reactions
CAST	Complex Adaptive Systems Theory
CBOs	Community-Based Organizations
CEMD	Confidential Enquiry into Maternal Deaths
CME	Continuing Medical Education
CQC	Quality Care Commission
CSO	Civil Society Organization
EEC	Executive Expenditure Committee
EMR	Electronic Medical Records
FGD	Focused Group Discussion
GoK	Government of Kenya
HENNET	Health NGO Network
HMC	Hospital Management Committee
HMT	Hospital Management Team
KES	Kenya Shilling
MCA	Member of County Assembly
MDGs	Millennium Development Goals
MNH	Maternal and New-born Health
MOH	Ministry of Health
MMR	Maternal Mortality Rate
NACOSTI	National Commission for Science, Technology and Innovation
NHIF	National Hospital Insurance Fund
P4P	Pay-for-Performance
PAT	Principal-Agent Theory
PMA	Performance Measurement and Accountability
PMH	Pumwani Maternity Hospital
PPI	Public-Private Initiatives
RMNCH	Reproductive, Maternal, Neonatal, and Child Health
RBF	Results Based Financing
SOP	Standard Operating Procedure
UK	United Kingdom

UN	United Nations
UNICEF	United Nations International Children's Emergency Fund
USA	United States of America
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

The chapter present background information, statement of the problem, study objectives, research question, justification of the study, limitation and delimitations of the study, significance of the study, assumption of the study and operational definition of terms.

1.1 Background of the Study

Healthcare has qualities of a superior good, which has led most countries to increasingly devote more resources to it, through state funding as well as a growing percentage of private financing (Marchildon & Lockhart, 2012). As a result, the United Nations (UN, 2015) observe that big strides have been made over time with regard to reducing preventable mortalities and morbidity among populations worldwide. Nonetheless, the world faces more complex health challenges stemming from growing disease burden and health risk factors than ever before in history, requiring a robust response. Consequently, accountability has been identified as a key component of healthcare reforms (Deber, 2014).

The World Health Organization (WHO, 2010) established three main goals for the health system: increasing health, improving responsiveness to the expectations of those served, and ensuring financial fairness. Importantly, WHO offers a framework for viewing the health system as a collection of six components: service delivery, health workforce, information, medical products, vaccines, and technology, financing, and leadership and governance. Accountability as a component of government and leadership is critical to the health system's strengthening and success (Brinkerhoff & Bossert, 2014). As a result, it ensures sound use of resources and/or authority, ensures

compliance with best practices, and supports service improvement through feedback and learning, resulting in a more responsive health system (Brinkerhoff & Bossert, 2014).

Accountability, as a component of governce and leadership function, is vital to health system strengthening and success due to its cross-cutting nature (Brinkerhoff & Bossert, 2014). It thus serves to ensure sound use of resources and/or authority, provides assurance of compliance with the best practice, and supports service improvement through feedback and learning, thereby making the health system more responsive (Frenk & Moon, 2013).

Globally, health services responsivess problems plague both developing and developed countries. More often than not, such problems are attributed to accountability failures. For instance, Fisher Report provides an overview of service failures in the United Kingdom, driven by desire for undue financial gain, disregard for clinical guidelines leading to avoidable patient harm and even deaths (Aiken, et al., 2018). According to Pronovost et al. (2016) between 44,000 and 98,000 people die yearly in the United States from preventable medical errors. In Italy, findings by Francese et al. (2014) indicate a Caesarean Section (CS) rates of over 50% against the normal rate of 13% suggested by WHO induced by pervert incentives of guaranteed payments from the insurer. Yip and Hsiao (2009) observe similar results in China, noting rampant wastes, inefficiencies, and provider incentives to over-provide expensive tests and services.

In the African region, Kuruvilla, et al. (2014) point out how scorecards, as accountability mechanisms, are used at all levels of the health system to track progress and identify inequities in health services delivery in Ethiopia leading to

increased utilization. In Nigeria, with 19% of the world's maternal deaths, has emraced accountability mchanisms such as mertenal death reviews as a means to reduce the maternal mortality rates (Bandali, et al., 2016). Generally, African countries still grapple with numerous accountability problems, including rampant disrespectful and abusive treatment, informal payments, misaligned incentives and refusal to provide care (Mannava, et al., 2015).

In Kenya, free maternal health services were introduced in June of 2013 in order to raise the utilization of pre-naternal care, skilled attendance at delivery, as well increase the healthcare utilization among new mothers (Nyongesa, et al., 2018). Against this backdrop, the Maternal Mortality Rate (MMR) reduced drammatically to 392 per 100,000 live births in 2014, but this rate remains very high relative to WHO target of less than 70 per 100,000 cases (Kenya National Bureau of Statistics [KNBS], 2015). Nonetheless, little in terms of empirical evidence has been offered regarding the influence of accountability mechanisms on the service responsiveness as this would help healthcare facilities raise uptake of use of and access to quality care (Abuya, et al., 2015).

Pumwani Maternity Hospital (PMH) is arguably the largest maternity and referral maternal and child health services hospital in East Africa having a bed capacity of 350 (Nyongesa, et al., 2018). It serves mainly low income clients and mainly young mothers from the surrounding Majengo informal settlement catchment area in Nairobi, but also clients from other places. It has been reported that lower social class patients often encounter poor services from providers, and are less empowered to seek services or options that are responsive to their needs (Darker et al., 2018). Thus, this study takes a closer look at a continuum of types of accountability in healthcare

facility setting, including professional, institutional, financial, political, and social accountability as a means to attend to various neglected issues and marginalized groups.

1.2 Statement of the Problem

A responsive health system is one in which individuals' legitimate needs are met or served and is thus capable of upholding their dignity, autonomy, choice, and appropriateness of care, among other qualities of safe and acceptable care (Nyongesa et al., 2018). Increasingly, the health system has become more complex with multiple actors and a multitude of institutions and organizations, each with its own immediate goals, objectives, and perspectives, roles, rules, responsibilities, interactions, and incentives (Barasa, 2017). In Kenya, mothers continue to encounter abuse, detention, egregious violations of their safety and basic rights at facilities where they go deliver their babies (Abuya, 2015). Poor standards of care in hospitals result in patients not seeking care from clinicians even when in need. This has in turn led to unmet care need and high maternal and neonatal mortality rates. Importantly, at PMH, which is the largest maternity hospital in East Africa, instances of disrespect and abuse, baby swapping or sale have increasingly received public attention (Otieno, 2018). While these problems are not unique to Kenya nor to PMH in particular, their resolution is urgent and imperative. Accountability has been touted as for its ability to transform the health sector to deliver best possible care; including through reducing abuse, assuring compliance with procedure and standards, and improving performance and learning (Hilber, 2016). Consequently, this study aimed to establish how accountability influences health system responsiveness at the facility level.

1.3 Study Objectives

The study objectives section is organized into broad objective and five specific objectives.

1.3.1 Broad Objective

The broad objective of this study was to examine the influence of accountability on health systems responsiveness at the PMH, Kenya.

1.3.2 Specific Objectives

i. To establish the influence of professional accountability mechanisms on health systems responsiveness at the PMH, Kenya.
ii. To assess the influence of institutional accountability mechanisms on health systems responsiveness at the PMH, Kenya.
iii. To establish the influence of financial accountability mechanisms on health systems responsiveness at the PMH, Kenya.
iv. To investigate the influence of political accountability mechanisms on health systems responsiveness at the PMH, Kenya.
v. To determine the influence of social accountability mechanisms on health systems responsiveness at the PMH, Kenya.

1.4 Research Question

i. In what ways do professional accountability mechanisms influence health systems responsiveness at the PMH, Kenya?
ii. How do institutional accountability mechanisms influence health systems responsiveness at the PMH, Kenya?
iii. How do financial accountability mechanisms have influence on health system responsiveness at the PMH, Kenya?
iv. What are the mechanisms through which political accountability influence health systems responsiveness at the PMH, Kenya?
v. How do social accountability mechanisms influence health systems responsiveness at the PMH, Kenya?

1.5 Justification of the Study

Efforts to improve Maternal and Newborn Health (MNH) have shifted their attention to accountability as a means of achieving transformational change (Hilber, et al., 2016). The Millennium Development Goals (MDGs) in Kenya, which aimed to reduce maternal deaths by three-quarters to 147 per 100 000 live births and child deaths by two-thirds to 33 per 1000 live births by the end of 2015, were not met (Keats, et al., 2017). At the same time, maternal death rates in facilities have remained high, with 135.3 per 100,000 live births, 52 per 1,000 live births, and 74 per 1,000 live births for children under the age of five (Ministry of Health [MOH],2014).

These figures are influenced in part by service failure, which can be addressed by effective accountability procedures. When services aren't responsive to users' needs, they create a deterrent to using facility-based labor and delivery services, resulting in increased deaths, disabilities, and problems (Mafuta, et al., 2015). As a result, the goal of this study was to emphasize an uniform accountability framework that may aid in the improvement of facility services. PMH is Kenya's largest maternity hospital, servicing an average of 800 mothers each day, and is the region's leading provider of reproductive, maternal, neonatal, and child health. (Achoki, et al., 2019). As a result, it is in a position to provide a thorough and complete examination of Kenya's RMNCH situation, which will help drive policy and programming decisions (Keats, et al., 2017). It depicts a scenario of responsiveness that extends beyond humanism of care and has an impact on other aspects of care quality, such as medication adherence, increased use of health services, the occurrence of infections, and avoidable readmissions after a hospitalization (Groene, et al., 2015). As a result, the study will give insight on how accountability works to achieve health system performance at PMH, which falls under devolved government under Kenya's new constitution of

2010, and so offers a fresh viewpoint on expanding local autonomy for administering health services (Achoki et al., 2019).

1.6 Limitations of the Study

The study faced various limitations. First some respondents were unwilling to give information freely for fear of being victimized. In addition, some respondents were reluctant in allowing the researcher collect data especially the top management. The limitations of the study were addressed by assuring all the respondents that all the information they would be provided would not be used against them. The researcher further assured the respondents that the data collected would remain confidential and be used for academic purpose only. The completed questionnaires were kept anonymous.

1.7 Delimitations of the Study

The study was limited to Pumwani Maternity Hospital, however since the health facility is one of the largest maternity facilities in the country the findings can be used to describe health systems responsiveness rate in other facilities across the country

1.8 Significance of the Study

The study is beneficial to variety of stakeholders, including the PMH board, management, and employees, the Nairobi City County government's line department and the national ministry of health. Others may include civil society organizations, but are not restricted to them. The study at PMH focused on how internal accountability strategies affect health system responsiveness in regard to the health service charter, managerial functions, administrative, and programmatic challenges. This was done in a thorough way with the goal of examining institutional accountability mechanisms and how they affect health system responsiveness.

Because it is a public hospital, the county department of health and the national MOH provide the bureaucratic linkage through which citizens and the PMH interact. As a result, the study tried to demonstrate how institutions, procedures, and mechanisms work to ensure that government fulfills electoral promises, maintains public trust, gathers and represents citizens' interests, and responds to ongoing and evolving societal demands and concerns.

Civil society organizations serve as patient advocates, philanthropic organizations, and providers of government checks and balances in order to improve government responsiveness. The main objective at PMH is to improve openness and ensure coordinated and collaborative efforts for win-win outcomes for all parties based on well-understood ground rules. Otherwise, parties that are there to benefit themselves at the expense of the patients or users may hijack the institution's mission. Furthermore, the connection does not need to be adversarial or accusatory, but rather reciprocal nurturing and constructive criticism in order to facilitate learning and performance improvement.

1.9 Assumptions of the Study

The study assumed valid and accurate responses from the study participants. To ensure this, the researcher laid out ethical guidelines that were adhered to strictly throughout the research process. This assumption was met partially as some of the harrowing stories that recently made headlines in the newspaper were merely glossed over by the staff respondents. Moreover, the study findings were assumed to reflect accurate picture of responsiveness only to a certain extent. For instance, poor and unsatisfactory services could be accounted for by resource constraints or leadership lapses that have influence on worker morale and work conditions. The study assumed valid and accurate responses from the study participants. To ensure this, the

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1.10 Operational Definition of Terms

Accountability: Refer to the procedures and processes by which clinician, hospital or health system justifies and takes responsibility for its activities.

Financial accountability: Concerns tracking and reporting on allocation, disbursement and utilization of financial resources allocated to clinician, hospital or health system, using the tools of auditing, budgeting and accounting.

Health system responsiveness: is a measure of how well the health system responds to the population's medical expectations.

Health system: Include all actors, institutions, and resources whose primary intent is toimprove health.

Institutional accountability: Refers to formalized and institutionalized processes and structures at the health facilities and health system that help ensure answerability

Performance accountability: Refers to demonstrating and accounting for performance in the light of agreed-upon health performance targets.

Political accountability: Refers to the extent to which the government delivers on electoral promises, fulfills the public trust, aggregates and represents citizens' interests, and responds to on-going and emerging health needs and concerns.

Professional accountability: Refers to shared values of technical expertise and

altruistic commitment to provide quality care to assure that health standards are being met and outcomes achieved

Social accountability: Is the term used when citizens or CSOs engage in health activities that hold their leaders accountable for health system performance.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents existing relevant literature reviewed, organized as per the study objectives. The underlying rationale between accountability and health system responsiveness is that, as Peabody et al. (2018) postulates, accountability aims to improve health system performance. Health system responsiveness is one of the performance measures of health system. Consequently, the study used complementary bases of accountability to attempt to explain linkages between accountability and health system responsiveness.

2.2 Theoretical Framework

This sub-section outlines the theoretical framework underpinning the study as well as the conceptual framework.

2.2.1 Principal-Agent Theory

The principle-agent relationship means that one or more persons known as the principal engage another person or persons known as the agent to provide a service on their behalf, either explicitly or implicitly. Jensen and Meckling developed it in 1976, and it has since been used in healthcare governance to describe the existence of a massive and complex network of obligations including government and professional regulators, accreditors, payers, managers, patients, and individual practitioners (Deber, 2014).

Because one individual, the principle, cannot directly watch or know the degree of competence or effort expended by another individual, the agent, the principal-agent interaction provides asymmetric information. Moral hazard and adverse selection are

caused by the principal-agent relationship. The fundamental goal of accountability systems is to decrease or eliminate agency problems, consequently improving system performance, reducing service delivery violations, and encouraging process development through learning (Brinkerhoff, 2016).

Moral hazard and unfavorable selection are two outcomes of asymmetric information. When the agent's conduct, or the result of that action, is only partly visible to the principal, moral hazard emerges. For example, a clinician may overuse diagnostic or therapeutic treatments or prescribe needless procedures that cost the patient extra money (Wanjama, 2018).

Adverse selection, on the other hand, results from the agent's knowledge of the principal's private information prior to coming into relations with them. Poor patients, for example, who self-select to go to public hospitals where they are not forced to pay for services, may overuse those services, increasing overall healthcare expenses. The theory is relevant in this study because it aids in the identification of methods that could be utilized to deliver more information to various healthcare actors, hence preventing or reducing agency problems. The processes may also aid in aligning the interests of the principals and agents in principal-agent relationships.

2.2.2 Complex Adaptive Systems (CAS) Theory

Rather than focusing on simple cause and effect, the Complex Adaptive Systems (CAS) theory views healthcare and other systems as being made up of multiple interconnected components with agents whose interactions and processes are dynamic, affecting and shaping the system at the same time. The theory is made up of four parts: first, self-organization and emergence, which explains how elements in a system adjust their behaviors to cope with changing internal and external demands. Second, CAS exhibit nonlinear behavior, which is defined as behavior that is

unpredictably related to input and in which small changes in variables can have small impacts at times and large impacts at other times (Barasa & Molyneux, 2017). Third, CAS exhibits behavior that is both predictable and unpredictable; as a result, complex dynamics are sometimes referred to as operating on the edge of chaos. As a result, CAS have a fourth property: they are resilient or robust. (English & Cleary 2017). Theory suits the present study because it helps explain how various accountability mechanisms can be used in the system to establish strong relationships in the system so as to effectively achieve more healthcare collective action goals.

2.3 Empirical Review

2.3.1 Professional accountability

One of the most important characteristics of professions is that the public expects the profession to self-regulate in exchange for special powers and privileges. In principal–agent models, one actor, such as doctors, works for another, such as the government, and analysis focuses on improving the relationship in the face of misaligned incentives and incomplete data (Greer et al., 2016).

2.3.1.1 Codes of conduct on health system

A code of ethics establishes roles and responsibilities within a profession, as well as instructions for dealing with ethical difficulties. The code is the cornerstone of any healthcare organization's compliance policy, as well as a vital and fundamental aspect of the organization's culture. Because of the Affordable Care Act's passage, it is now a requirement. Employees, physicians, contractors, vendors, and other stakeholders are encouraged to think about their behaviors and the consequences of their actions in the workplace by following a code of conduct (Rooney, 2019).

2.3.1.2 Licensure and accreditation on health system

When an independent, professional group recognizes that a healthcare organization has fulfilled or exceeded its criteria, it is known as accreditation. These groups are not connected to the federal government or any state governments. Accreditation is essential for the same reasons that licensure is. Accreditation's main purpose is to verify a healthcare facility's ability to meet established industry standards set by reputable bodies in their sector. This instills faith and confidence in a facility's ability to care for the patients it serves (Rooney, 2019).

The goal of licensure is to demonstrate that a professional meets a quality standard set by the industry or the state. As a result, practitioners across the healthcare sector, as well as patients, will be aware that the individual has the necessary expertise to accomplish the role's responsibilities. The exam – or, in certain cases, the degree – serves as proof that the person has grasped the key concepts required to execute the goal. It all comes down to establishing the individual as a qualified professional in the eyes of coworkers and people to whom they would provide care.

2.3.1.3 Clinical procedures on health system

A clinical procedure is any medical operation that requires a mix of unique skills or abilities and may include the use of medications, technologies, or both. Clinical processes are developed in a totally different way than pharmaceuticals and medical devices. The distinction between radical or breakthrough breakthroughs and gradual advances is useful in terms of analysis. Academic or academic-affiliated centers, where physical and professional resources are plentiful and clinical growth is encouraged, are hotbeds for radical breakthroughs.

2.3.1.4 Peer review on health system

Peer review is a significant aspect of healthcare and it is concerned with ensuring the highest levels of professional conduct. It motivates clinical and non-clinical staff to prioritize high-quality treatment, and it reinforces this effort with external ‘authority' in order to effect organizational transformation. It's worth considering why it's useful to potentially restrain individual decisions via peer review, given the value put on professional autonomy in therapeutic decisions. Professional autonomy today is defined as a freedom granted by trusting patients and acquired by a profession that demonstrates compliance with its norms, regulations, and rules. (Greenfield et al., 2010)

2.3.1.5 Continuing professional development on health system

Continuing professional development (CPD) is a strategy for maintaining, enhancing, and increasing one's knowledge and skills throughout one's career. CPD is centered on fostering successful practice, and it is better positioned to affect change than previous phases of learning since it happens when professionals are most conscious of their own needs. Individual practitioners in the practice setting can also benefit from the content and pedagogical design.

2.3.2 Institutional Accountability

Institutional accountability refers to the systems in place at the facility level to guarantee that care quality improves. Government hospitals, according to Li et al. (2015), are in the forefront, but their skills vary greatly even in first-tier cities, and they play a critical role; nonetheless, the quality of service they give has seldom been independently assessed. Effective, accessible, transparent monitoring methods and independent evaluation for remedies in the event of infractions are required for their

accountability (Sabot et al., 2013).

2.3.2.1 Service charter on health system

According to government policy and conventions, a service charter should be posted in a prominent location, such as at the facility's door. It should be written in a way that is easily visible, understandable, and accessible to clients, and it should be updated on a regular basis to reflect any facility changes. It should also provide the names and phone numbers of committee members so that members of the public can contact them if they require assistance from the health facility committees (HFCs) (Atela, 2019).

2.3.2.2 Complaint procedure on health system

An successful complaint-handling approach restores customer faith in your services, improves quality as a consequence of feedback, and keeps minor concerns from becoming major difficulties. Some concerns may be easier to address than others, depending on the exact problem and the complainant's preferences. If the complainant's preferred objective is impossible to achieve, you must explain why and provide them with alternatives. The first and most important item for a successful complaint management system is a simple way to file a complaint. Every piece of feedback, whether positive or negative, is gathered and weighed in the evaluation process.

2.3.2.3 Achievement assessment on health system

Health system performance evaluation is the process of monitoring, assessing, and communicating the extent to which various sections of a health system achieve critical goals. The major purpose of HSPA is to identify whether or not intended goals are being met and whether or not relevant activities are being carried out to help meet

those goals. The health system performance assessment (HSPA) has become an important instrument for managing today's health systems. It provides policymakers with a useful and comprehensive set of data to aid in prioritization and budget allocation in high-need areas (Norheim, 2016).

2.3.2.4 Surveillance and Audits

Public health surveillance is the continuous systematic collecting, analysis, and interpretation of data, as well as the timely communication of these data to those responsible for preventing and controlling disease and harm. Ministries of health, finance, and donors employ public health surveillance to assess the health and behavior of the communities they serve. Because surveillance can directly measure what is going on in the population, it is useful for determining the need for interventions as well as monitoring the success of treatments.

2.3.2.5 Hospital oversight and capacity

Mannion and Smith (2017) conducted a research on the role of trust and intelligence in hospital board oversight of quality and safety: a stakeholder analysis. The interviews showed a variety of narratives about hospital board control of patient safety, according to the study's findings. These went into greater detail about the importance of trust and intelligence in showing the hazards and limitations of methods to hospital board oversight that are solely focused on risk-based measures of organizational performance. Effective board supervision also necessitates the gathering and triangulation of information from both national and local sources.

2.3.3 Financial Accountability

Financial accountability, in general, refers to the ability to follow laws, rules, and regulations governing financial control and management (Brinkerhoff, 2014).

Financial incentives, like as Pay-for-Performance (P4P), which change compensation to drive providers to behave in a desirable manner, have been tested for physician services in jurisdictions such as the United Kingdom, United States, Australia, and Canada (Deber, 2014). Financial incentives may persuade doctors or patients to attempt drugs, diagnostic tests, or treatments for which there is little evidence that they improve patient outcomes (Peterson, 2014).

2.3.3.1 Budgetary tracking

Budgeting is the process of determining how to distribute resources in order to obtain the best results feasible given the available resources. A health budget, which is usually included in the general government budget, is more than just an accounting tool for presenting revenues and expenses; it is a critical orienting text, declaring the country's key financial goals as well as a genuine commitment to implementing its health policies and strategies. (WHO, 2010).

2.3.3.2 Competitive bidding

In comparison to administered charge regimes, competitive bidding for Medicare payments promises a number of benefits (Meadow, 2017). The authors demonstrate how incentives for cost reductions, quality, and access can be implemented into bidding systems, as well as reporting on a clinical laboratory industry study undertaken in preparation for a bidding demonstration. The laboratory business is characterized by varying concentration across regional markets and social and economic heterogeneity within firms. The authors argue that current bidding design alternatives and careful selection of bidding markets can accommodate these constraints.

2.3.3.3 Conflict of interest and policies

As a result of how doctors are compensated for their services, conflicts of interest arise. Despite the fact that each payment method has its own set of issues, all payment systems have problems. Self-referral practices and physician ownership of health-care facilities also pose large and widespread conflicts of interest, making it difficult for the government to monitor, reduce, or eliminate them.

The individual investigator or the commercial sponsors of research are frequently the subject of conflict-of-interest discussions. Academic institutions may also have conflicts of interest when it comes to the research that its members conduct. Medical centers and other research institutes, for example, are increasingly forming beneficial collaborations with business, and they may be able to benefit handsomely from patents and royalties generated by their research.

2.3.4 Political Accountability

Within democracies, political accountability is a critical type of accountability. Voters give their sovereignty to popular representatives, who, in turn, delegate the majority of their powers to a cabinet of ministers, at least in parliamentary democracies. Many of the ministers' powers are then delegated to civil officials or to various, more or less independent administrative entities, such as the PMH. The process of political accountability works in the exact opposite way of the delegation mechanism (Bovens, 2017).

2.3.4.1 Local monitoring /devolution on the health system responsiveness

Kenyan governance structures and processes for financing and delivering healthcare have undergone significant changes as a result of devolution reforms. Many of devolution's goals, such as community participation, responsiveness, accountability,

and increased equity, can be met using community health approaches. According to Mccollum et al. (2018) both Indonesia and Kenya faced similar issues in establishing good health governance following devolution.

2.3.4.2 Bureaucratic Oversight on health system responsiveness

Health authorities must behave themselves ethically as well as effectively and efficiently, according to bureaucratic oversight procedures. Internal or external control techniques are possible. The former is more of an accounting evaluation and is normally carried out by the target agency's audit unit. According to Slade (2018), when scientists and medical experts make mistakes, the consequences can be disastrous, regardless of how infrequently they make mistakes or how pure or impure their goals are.

2.3.4.3 Parliamentary Hearing on the health responsiveness

Parliament, arguably more than any other institution, is primarily concerned with relationships with citizens, but also with and among political parties, the executive, and individual members and their parties. In general, citizens are interested in what happens in parliament because it has an impact on the evolution of these connections as much as it reflects the authorities, laws, procedures, and resources. Through its numerous functions of representation, supervision, and legislation on behalf of its citizens, Parliament is a vital institution for tackling social determinants of health (SDH) for the advancement of health equity

2.3.4.4 Electoral Agenda

The impact of health policy on presidential elections in the United States was explored by Lambrew (2018). The researcher looked at relevant reports, data, party platforms, and policy papers. The study's findings revealed that throughout the last

century, health-care efforts have grown in scope in both parties' presidential platforms, influencing both objectives and assessments of a president's success. The ongoing dispute over the Affordable Care Act, the possibility of reversals in coverage and affordability gains, and voter concern all point to health policy having a major role in the 2020 election.

2.3.4.5 Non- Discrimination

It has been established that inequitable and discriminatory access to timely secondary care exists. Patients from low-income areas, the elderly, and women, for example, are more likely to be admitted to hospital for colorectal, breast, and lung cancer as emergencies than electives in England. Patients from low-income communities and the elderly were also less likely to receive favored surgical procedures such as breast-conserving surgery and lung cancer resection, which was inequitable (rather than just unequal)

2.3.5 Social Accountability

The right to knowledge, the freedom to speak up, the right to organize, and the right to engage in government functions are the cornerstones of social accountability (McGinn & Lipsky, 2015). According to Oyaya and Rifkin (2003), the public sector lacks proper procedures to manage the system, enforce standards, and create an enabling climate for effective participation of non-governmental parties in instilling greater performance. As a result of the lack of accountability and monitoring systems, improving system responsiveness has proven difficult.

2.3.5.1 Community Feedback

McGinn and Lipsky (2015) explored the impact of community feedback on community health workers' motivation and performance in India. The study found

that the intervention had a positive and significant effect on counseling length, but no significant improvements in case activity or number of form submissions. Providing performance feedback had a modest to significant impact on counseling times over the first six weeks, according to the study. After the intervention, these effects maintained.

McGinn and Lipsky (2015) investigated the impact of community feedback on community health workers' performance, placing them as intermediaries in complex adaptive health systems. According to the findings of the study, high-performing health workers work in ways that are responsive, fair, and efficient in order to provide the greatest possible health outcomes for clients, given the resources and circumstances.

2.3.5.2 Media and Publicity

Obtaining operational perspectives and practices from peer institutions will help you stay on top of current advancements in health services advertising. Experiential views may help design and hone advertising strategies for almost any healthcare provider. Given competitive sensitivities, gaining such insights can be challenging, but healthcare organizations are periodically required to disclose expertise in published accounts. (Kotler et al., 2008). In particular, the insights and experiences gained from Willis-Knighton Health System's vast and historic use of advertising are revealed, reinforcing the literature's experiential stories and providing operational direction for health and medical practitioners.

2.3.5.3 Community participation

Community engagement has been suggested as a strategy for social development in health promotion. These place a strong emphasis on social justice values and push for changes in social, political, and economic systems. At one extreme, community participation is seen as genuinely democratic, achieving equity and, eventually, social growth through dynamic and evolutionary processes.

2.3.6 Accountability and Health System Responsiveness

Health system responsiveness, according to Kerber et al. (2015), relates to the way people are handled and the setting in which they seek health care. It has to do with how well the care delivery method meets the needs of the patients. The eight dimensions of quality of care that concern aspects of patients' interactions with the health system and patient satisfaction include autonomy, choice, clarity of communication, confidentiality of personal information, dignity, prompt attention, quality of basic amenities, and access to family and community support.

2.3.6.1 Respect for Autonomy

The right to obtain medical information, the right to make informed decisions, and the right to refuse medical treatment all fall under the umbrella of autonomy, which is defined as "the freedom of the will." When it comes to making health-related decisions, an individual should be free to act independently. Individuals, or their agents, should have the ability to select what interventions they do and do not get when they are competent (Jones et al., 2017).

2.3.6.2 Choice of Care Provider

Choice is defined as the ability or power to make a decision that involves more than

one choice. Patients may choose to choose who offers their medical care. This usually refers to choosing between health service providers, such as separate hospitals, but it can also refer to a patient's choice of which specialist inside the hospital should care for them. Choice also refers to a person's ability to seek a second opinion and, if necessary, access to specialized care. As a result, patients should have enough information to make an informed decision.

2.3.6.3 Respect for confidentiality

Confidentiality is described as the ability to be trusted with secrets, and it is synonymous with privacy, which is defined as an individual's claim to control how personal information is collected, disclosed, and used. As a result, patients have the right to remain anonymous and have their medical records kept private. Individuals who are confident in the confidentiality of their personal health information are more willing to share important medical history information with health care professionals, which improves service quality. (Afulani, 2015)

2.3.6.4 Communication

Clarity of communication, defined as the clarity in transmitting information and eliciting comprehension, should also be a part of a responsive health system. As a domain of responsiveness, it entails that providers properly communicate the nature of the condition to the patient and family, as well as the required therapy and options. From the patient's perspective, good communication with doctors and other health workers has long been considered the underpinning of quality. It entails providing detailed explanations as well as time for inquiries (Afulani, 2015).

2.3.6.5 Respect for Dignity

Receiving care in a courteous, caring, and nondiscriminatory environment is referred

to as the domain of dignity. It refers to a health care provider's capacity to deliver services in an environment that appreciates the patient, acts with civility, and is sensitive to the requirements and circumstances of the client. Patients have a legitimate expectation that their encounters with doctors would not result in embarrassing situations, humiliation, or unpleasant treatment (Murante et al., 2017).

2.3.6.6 Access to prompt attention

The term "prompt attention" refers to care that is readily available or supplied as soon as it is required. It usually refers to the length of time spent waiting in a facility (Afulani, 2015). According to Murante et al. (2017), patients should receive prompt response in emergencies and appropriate wait periods for non-emergencies in order for services to be considered responsive. People value timely care because it can improve health outcomes and alleviate fears and concerns associated with waiting for a diagnosis or treatment (Afulani, 2015).

2.3.6.7 Access to Family and Community Support

During treatment, patients' welfare is best served if they have access to their family and other community support networks (Valentine et al., 2003). Expecting to have access to social support is not just a practical goal that may improve health outcomes, but it is also a highly valued trait (Mayumana et al., 2017). As a result, patients must be allowed to have visitors of their choice as well as communication with the outside world (Afulani, 2015).

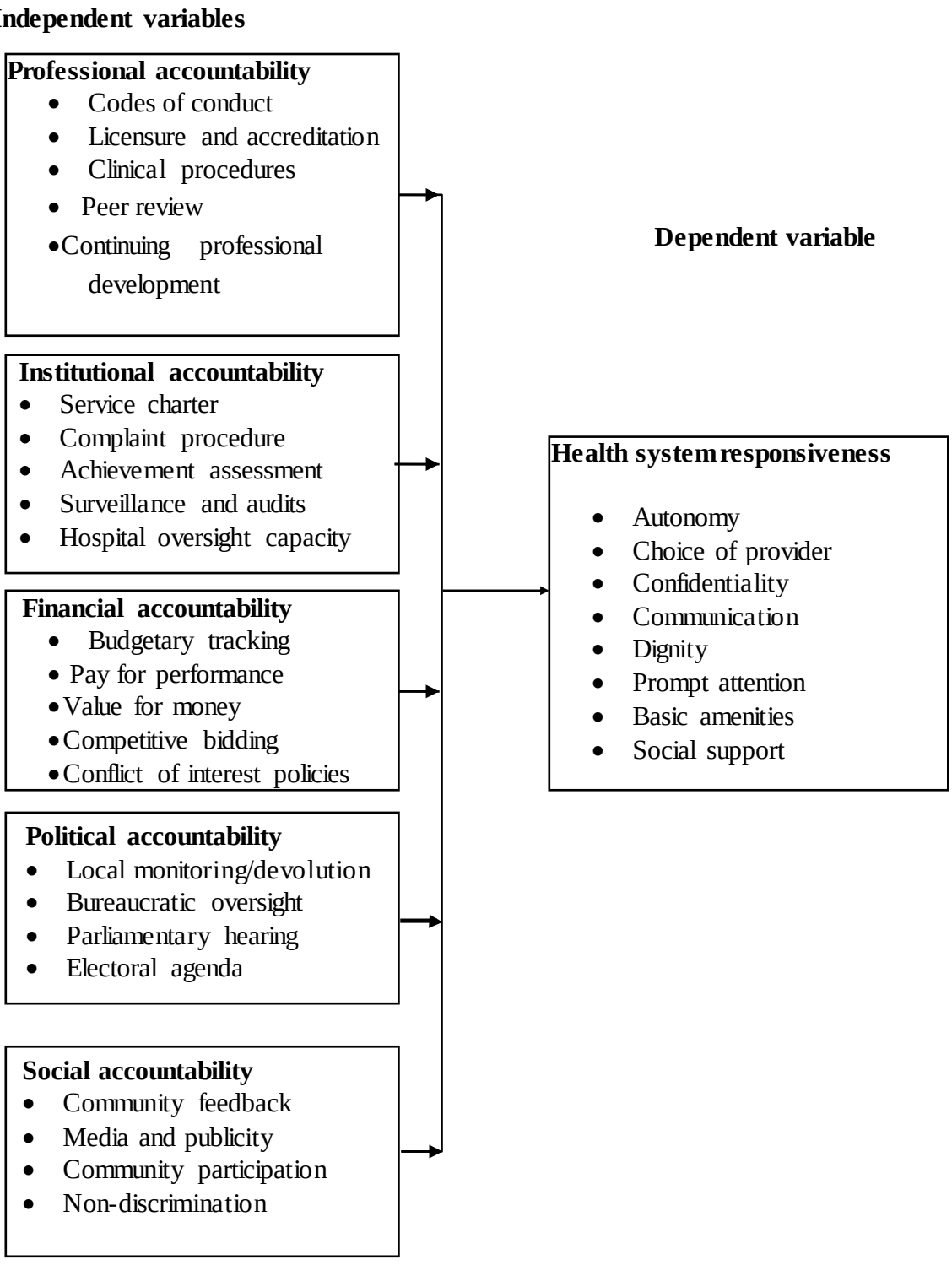
2.4 Conceptual Framework

The study had independent, intervening and dependent variables. As per the theoretical framework, the study independent variables were composed of the various elements of accountability domains including professional, institutional, financial,

political and social accountability mechanisms. These variables were assessed against the dependent variable health system responsiveness. The intervening variables included the regulations, economic performance, and managerial capacity. A schematic representation of the study variables showing the conceptual relationship among the variables is illustrated in Figure 2.1.

Figure 2. 1

Conceptual Framework



CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter explains the research design, variables, location of the study, target population, sampling technique and sample size, pilot study, data collection techniques, and data analysis procedures.

3.2 Research Design

In this study, the correlation research design was applied. Correlational research is a type of non-experimental study in which a researcher looks at two variables, understands and evaluates their statistical relationship, and does so without using any additional variables. A correlational study is a type of research strategy in which the researcher attempts to determine what kind of relationships exist between naturally occurring variables. A correlational study is a form of research design in which a researcher tries to figure out what kind of links exists between naturally occurring variables. The design was intended to help describe how the various elements of health governance affect the health system in Nairobi, Kenya (Kothari, 2009). The adopted design is also amenable to be used for answering questions involving who, what, where, how much and how many questions and for gathering and analysis of data from a cross-section of the target population.

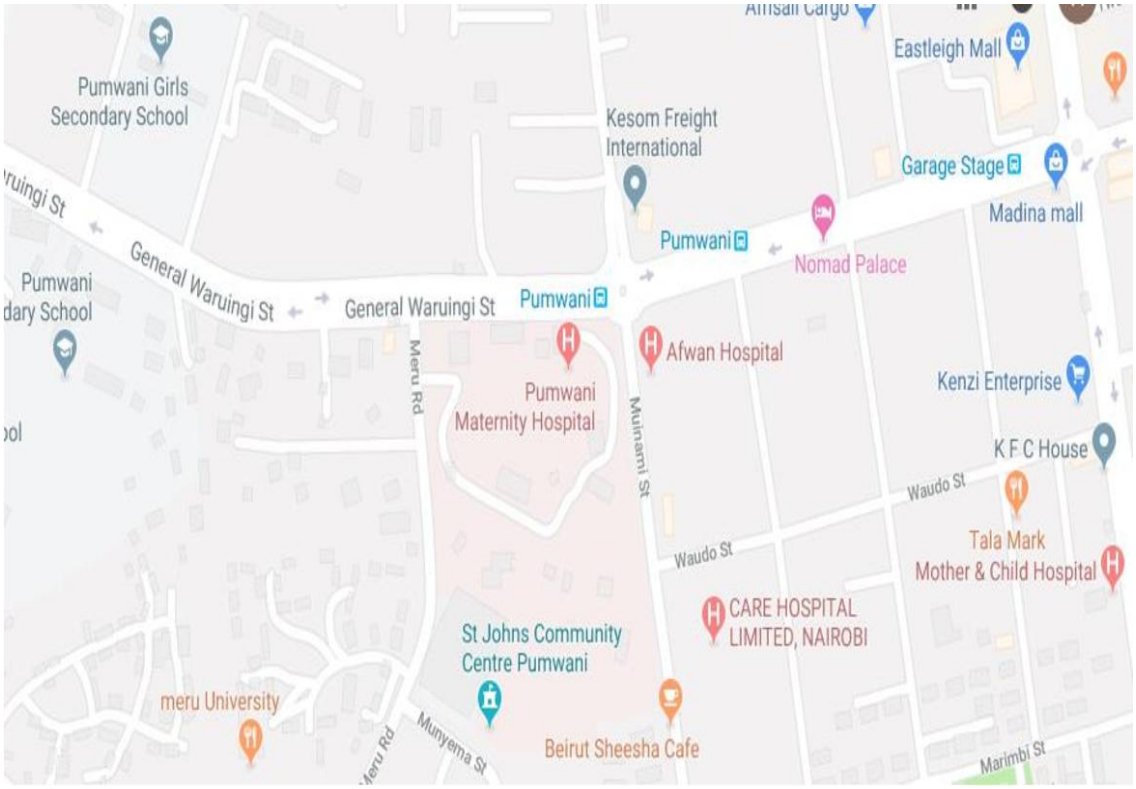
3.3 Study Location

This study was conducted in Pumwani Maternity Hospital Nairobi County, Kenya. It was intended that Nairobi County provided a microcosm of governance in Kenya, providing a broad spectrum of governance from national, sub-national and local settings and operations. The county has the highest concentration of not only health

workers drawn from various specialties but also highest number of health facilities. The county is also the seat of the various institutions involved in health service provision, regulatory and policy-making endeavors in the health sector in Kenya which was to help enrich the study.

Figure 3. 1

Map of Pumwani



3.4 Target Population

The target population were patients and employees at Pumwani Maternity Hospital. The hospital had a total of 206 employees at the time the study was conducted. This number included all cadres of PMH employees, some of whom play limited role in hospital accountability roles. The employees belonged to technical, professional, and managerial positions and therefore more intensely interacted with hospital accountability issues. These categories of staff members were therefore perceived to be able to competently be able to handle accountability and health system

responsiveness questions, besides providing other relevant information about the hospital governance. The distribution of the targeted employees is shown in Table 3.1. The study also targeted patients discharged during the period of the study.

Table 3. 1

Distribution of the Target Population of Respondents

	Number in Category	**Percentage (%)**
Top management	13	6.31%
Middle level management	33	16.02%
Professional/technical staff	160	77.67%
Total	**206**	**100%**

Source: Pumwani Maternity Hospital Health Records

3.5 Sample Size Determination

3.5.1 Sample Size of Health Workers

To determine the sample size for health workers, the researcher used the formula by Yamane (1967) which proposes that the sample size, n, is derived as follows:

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

Where n=

Sample size

N=

Population

e= Precision rate, taken as the level of significance assumed at □=0.05 consequently, n = 193/ (1+ (193*0.05^2)) = 130

Applying the formula, the sample size becomes 130 hospital staff members. The study

further used simple random sampling in picking the 130 staff members'. The sample size distribution based on the departments at PMH is presented in Table 3.2:

Table 3. 2

Sample Size Distribution at PMH Departments

Department	Frequency	Percent (%)
Newborn	21	16.1539
Labour ward	13	10
Postnatal ward 4	11	8.4615
Postnatal ward 6	16	12.3077
High dependency unit	16	12.3077
Pharmacy	13	10
Physiotherapy	9	6.9231
Health records and information	7	5.3846
Laboratory	9	6.9231
Antenatal and family planning	10	7.6923
Counseling and testing	5	3.8462
Total	**130**	**100**

3.5.2 Sample Size for Qualitative Participants

In addition, qualitative methods were used to capture data from two other groups purposively selected to complement the information generated from the employee data. These groups composed of 13 departmental heads at PMH and 25 patients discharged during the time of the study. The patients were purposively selected since they were in a position to provide information on the quality of health system they receive.

3.6 Pre-Test Study

Questionnaire was used to gather the pre-test data. A pre-test was conducted at the Nakuru Level 5 Hospital which is a comparable government owned and operated hospital. The hospital is also has the largest maternity ward in the region. The sample size of the respondents who filled the questionnaire was 13 staff members, which allowed for statistical generalization. According to Mugenda and Mugenda (2009),

including at least 10% of the sample population in the pre-testing suffices.

3.7 Reliability and Validity of the Study

Approaches to ensure reliability of the instruments to collect valid data were categorized as those under qualitative and those under quantitative methods of data collection. The concept of validity in quantitative study connotes trustworthiness, authenticity, and credibility in relation to qualitative data source. On the other hand, it refers to accuracy and appropriateness of data used in a quantitative study. Approaches to enhance ability to assess the accuracy of findings from interviews will include triangulation especially where the researcher gathered data from different sources, thereby ensuring that findings are backed by evidence from both patients and staff with a view to build a coherent justification for themes (Creswell, 2009).

In addition, in cases where the researcher makes presentations of negative or discrepant information that runs counter to the themes. To ascertain reliability of interview instruments for data collection, the researcher used cross-checking codes developed at different times during data collection and analysis by comparing them with a standard code. By cross-checking the codes derived at different times, the researcher was able to ascertain high reliability by achieving high inter-coder agreement.

3.8 Instrumentation

The study gathered both primary and secondary data. Questionnaires, key informant guide, and focused group discussions were utilized to gather primary data. The three instruments were chosen so that, in the event of a shortcoming on one instrument, the other instruments might compensate. Quantitative data was collected using closed-ended questionnaires, whereas qualitative data was obtained using open-ended

questions, a key informant guide, and focused group discussions.

3.8.1 Questionnaires for Hospital Staff Members

A questionnaire is a data collection tool prepared by a researcher with the primary goal of communicating what is meant to respondents and eliciting desired responses from respondents in order to meet research objectives (Mugenda & Mugenda, 2003). A questionnaire was utilized to collect data from hospital employees. The questionnaire was particularly useful since it allowed individuals to express themselves without fear of being judged. Closed-ended questions were selected since the researcher's response option could help the respondents understand the query content. Closed-ended surveys enhanced response consistency as well

3.8.2 Key Informant Guide for the Middle Level Managers

Key Informant Guide Key was used to collect data from the 25 middle level managers. A Key Informant Guide is a list of structured questions created to assist researchers in gathering information or data about a given topic or issue (Wellington, 2000). The researcher was able to obtain extensive information on the effect of accountability systems on health system responsiveness from middle level managers using the Key Informant Guide. The key informant guide's questions were open-ended. Such queries are adaptable, allowing for probing and the subsequent collection of detailed information (Holla et al., 2015).

3.8.3 Focused Group Discussions for the Patients

Focused Group Discussions (FGDs) was used to collect data from patients. Focused Group Discussions (FGDs) are semi-structured interviews that are guided by a competent moderator. The uniformity in FGDs was obtained by include patients who

were released on the same day. The patients felt more at ease with one another as a result of this. Five focus groups with five patients each were organized to participate in the talks. The focus groups allowed for the generation of creative and collaborative data based on group interactions. The group interactions in FGDs provided crucial insights not recorded by other techniques in the study, in addition to providing responses to questions. As a result, FGDs lasting 10-20 minutes were held utilizing a pre-selected set of questions.

3.9 Methods of Data Collection

The procedure for data collection involved, individual employees were approached to respond to the same set of questions in the questionnaire. The researcher dropped the questionnaire to the selected health workers and gave them about two weeks to fill in the questionnaires. The researcher collected the filled questionnaires after two weeks and continued following up for any missing questionnaires. After 30 days of data collection, any questionnaire that had not been returned was categorized as non-responsive.

Interviews with the key informants were conducted in the facility. The researcher started by making an appointment with key informant. On average, three interviews were conducted per day and in total key informant 13 interviews were done. Subsequently, the FGDs were held with patients who had been discharged at the facility. Since PMH has many patients the researcher sought consent among the first 6 patients who were discharged and had a 20 minutes discussion with them.

3.10 Data Analysis

All of the questionnaire were sorted and given a unique identification number prior to data entry. SPSS version 24 was used to code and enter the data. Both descriptive and

inferential statistics were used to analyze quantitative data. Frequencies, percentages, averages, measures of central tendency including the mean, and measures of dispersion, such as the standard deviation, were all examples of descriptive statistics. While inferential statistics included test of relationship between the independent variables and dependent variables. Bivariate and multiple logistic analysis were done to determine the level of association between the variables in the study. Bivariate correlation analysis was then used to assess the direction and strength of relationship between components of accountability and health system responsiveness. Further, a multiple regression analysis was performed to assess the degree to which a composite of independent variables explained the changes in dependent variable. The functional form of the model is provided as:

$$Y = \beta 0 + \beta 1X1 + \beta 2X2 + \beta 3X3 + \beta 4X4 + \beta 5X5 + \varepsilon$$

Where:

Y = Health system responsiveness

X_1 = Professional accountability

X_2 = Institutional accountability

X_3 = Financial accountability

X_4 = Political accountability

X_5 = Social accountability

B0 = Constant

β1, β2, β3, β4, β5 = Regression coefficients estimated by the model,

ε = an error term.

Thematic content analysis was used to examine the qualitative data. Glaser and Strauss proposed thematic content analysis in 1967, which used interview data to inductively build coded categories based on theoretical notions that emerged in the data (Creswell, 2009). The categories were read several times before being organized

into themes. The topics were then examined, and significant findings such as main impacts and trends, as well as a theoretical framework for conceptualizing essential aspects in the link between accountability and responsiveness, were produced.

3.11 Ethical Considerations

The National Commission for Science, Technology, and Innovation was approached for permission to gather data (NACOSTI). The Science, Ethics, and Research Committee of KeMU were consulted for ethical permission. Following the issue of the authorization letter, the researcher went on field visits to meet with the Nairobi County Director of Health Services, the County Director of Education, and ultimately the Pumwani Maternity Hospital to get an introduction and additional authorization. At the same time, provisions were made for data collecting timeliness. No damage, anonymity, privacy, and confidentiality were all observed as ethical considerations, as was each respondent's informed consent.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 Introduction

This chapter outlines how analyses were conducted and presents the results as per the objectives of the study. The study used a mixed methods approach involving explaining quantitative and qualitative findings. Thus, quantitative data were used to statistically describe the study participants, summarize background information, and draw inferences about the study variables. On the other hand, qualitative data were used to further explore the underlying mechanisms through which the phenomenon took place. Overall, the analysis and presentation of results employed statistics-by-themes/cross-comparison approach, succeeded by discussions to put the findings in broader context.

4.2 Response Rate

The study had three types of sample participants, health workers, managers and patients. A total of 130 questionnaires were distributed to the health workers and 76(58%) were received and are included in the analysis below. 13 KII interviews were done with hospital managers and 5FGDs were done with patients.

4.3 Reliability Results

From the findings the Cronbach's Alpha values of all the items were more than 0.7 which means that the questionnaires used to collect the data were reliable. This concurs with Saunders et al. (2009) standards that the instrument of study should only be used if Cronbach's Alpha coefficient value is 0.70 or higher is obtained. See summary in Table 4.1.

Table 4. 1

Reliability Statistics Results

Variable	Cronbach's Alpha
Professional accountability	0.756
Institutional accountability	0.725
Financial accountability	0.834
Political accountability	0.734
Social accountability	0.803
Health system responsiveness	0.767

4.4 Demographic Characteristics of the Respondents

The study sought to find out the demographic characteristics which include gender, experience, education and age. The categorization data are presented in Table 4.2.

Table 4. 2

Demographic Characteristics of the Respondents (n=76)

	Characteristics	n	%
Gender	Male	19	25.23
	Female	57	74.77
Experience	Less than 5 years	18	24.32
	5 to less than 10 years	23	30.63
	10 to less than 15 years	9	11.71
	Over 15 years	26	33.33
Education	Diploma/HND	42	54.95
	Undergraduate	28	35.14
	Master's degree and above	6	9.91
Age	Equal or less than 29 years	9	11.71
	30–39 years	29	37.84
	From 40–49 years	12	16.22
	50–59 years	21	27.93
	Over 60 years	5	6.31

There were more female respondents 57 (74.77%) than male respondents 19 (25.23%). This may be attributed to the fact that the maternity hospital employs its workforce in mostly traditionally female dominated roles such as nursing and midwifery. The response rate that was skewed towards female was taken to be representative of the hospital population distribution and hence did not bias the study.
The majority of respondents had worked in the hospital for 15 years or more and they were 37 representing 33.33%. This was followed by those who had spent between 5-9 years in the hospital 23(30.63%). Next were those who had been in the hospital less than 5 years 18 (24.32%). Lastly, the group that had spent between 10-14 years made up the least percentage of respondents 9(11.71%).

The highest proportion of respondents comprised those with education level of Diploma or Higher National Diploma (HND) and they were 61 representing 42(54.95%). The next highest group was composed of those who had Undergraduate degrees from university 28 (35.14%). The least group represented those with Master's degree and above 6 (9.91%).

The majority of the respondents were in the age group 30–39 years and they were 42 representing 37.84%, followed by those aged between 50-59 years 21 (27.93%), then those in 40–49 year 12 (16.22%), next was those less than 30 years being 13 (11.71%) and the least represented being aged 60 years and over 5(6.31%).

4.5 Status of Health System Responsiveness at Pumwani Maternity Hospital

The study sought to determine the status of health systems responsiveness in PMH. Table 4.3 summarizes these results.

Table 4. 3

Status of Health System Responsiveness at PMH

Dimension of Responsiveness	n	Mean	STD
Patients get care as soon as they need it	76	4.39	0.90
Patients are shown respect by hospital staff	76	4.28	0.98
Staff explain things to patients for understanding	76	4.19	1.06
Involve patients in decision making	76	4.13	1.11
Keep patient medical history confidential	76	4.18	1.20
Patients can choose the healthcare the specialist provider they are happy with	76	3.58	1.42
Avail quality basic amenities e.g. clean waiting room with TV, wards	76	3.80	1.35

Health system responsiveness was used to signify the degree to which Pumwani Maternity Hospital was able to attend to the legitimate expectations of their patients. From the findings more than two thirds of the respondents agreed that patients get care as soon as they need it, that patients are shown respect by hospital staff, and that staff explain things to patients for understanding with a mean of 4.39 and Standard Deviation (SD), 4.28 (SD 0.98), and 4.19 (SD 1.06) respectively.

Furthermore respondents agreed that staff involve patients in decision making while with a mean of 4.13 (SD 1.11), that they keep patient medical history confidential with a mean of 4.18 (SD 1.20), that that patients can choose healthcare specialist/provider they are happy with a mean of 3.58 SD 1.42), and that the hospital avails quality basic amenities e.g. clean waiting room with TV, wards with a mean of

3.80 (SD 1.35).

This is consistent with Valentine et al. (2003) assertion that perceived responsiveness is dependent on mixture of factors, including perceived need, individual expectations, and the experience of care, which inevitably lead to varied responses for nearly similar conditions of service delivery. However, from the FGD, one patient who had negative experience with service provision at the hospital made the following remarks:

"...No I was not impressed with the services, For example, the toilets were unclean, beds were congested, the mosquito net was torn and dirty, and the place was congested. I won't go there again..." (FGD 01, Participant).

According to the hospital staff, the most highly rated responsiveness item was prompt attendance to the patient while the least rated were issues related to choice. These results are consistent with Ortiz, et al. (2003) study that found out that being able to quickly receive care is the dimension that is most important to people in relation to service responsiveness. Their full list of responsiveness rating of responsiveness domains included the highest weight being attached to the domain of prompt attention (18%), dignity (14.8 %), communication (14.0%), confidentiality (12.4%), choice (12.3%), autonomy (11.7%), quality of basic amenities (10.6%), and access to support (6.3%). Hence, the study results showed similar weighting for the first four items measuring responsiveness, which comports with the patient, reported high level of responsiveness.

4.6 Status of Professional Accountability at PMH

The study sought to find out information on professional accountability mechanisms in PMH. Table 4.4 provides a summary of the results.

Table 4. 4

Professional Accountability Mechanisms in PMH

Dimension of Professional Accountability	n	Mean	STD
Adhering to professional codes of conduct	76	4.56	0.90
Meeting licensure and accreditation conditions	76	4.30	0.97
Professional association exercise of oversight	76	4.19	0.90
Use of clinical procedures	76	4.58	0.86
My work being reviewed by another professional	76	4.07	1.12
Continuous professional education/development	76	4.50	0.95

Professional accountability measured various mechanisms of maintaining professional norms and standards in service delivery at PMH. From the findings the respondents agreed with most of the statements. Majority agreed that they adhere to professional codes of conduct (mean 4.56; SD 0.90), that they meet licensure and accreditation conditions (mean 4.30; SD 0.97), that professional association exercise of oversight (mean 4.19; SD 0.09), that they use of clinical procedures (mean 4.58; SD 0.86) and the have continuous professional education/development (mean 4.07; SD 1.2).

These findings are in line with Graham et al., (2015) assertion that clinical procedures are highly valued within clinical settings. According to Brinkerhoff (2014), high rating of professional accountability measures showed primacy placed on procedural and quality standards by the providers. Thus, hospital staff tends to appreciate standard operating procedures as a means to distil and present the best available evidence in a clear and practical way for clinicians and hospital administration. As

one hospital staff remarked, professional accountability mechanisms are important since they:

"…To ensure patient safety, right thing is done at the right time and use right skill and right attitude"…. (Hospital manager; KII 04).

The most common professional accountability issue, according to the patients, related to disrespect. This was not a widely experienced problem by majority of the hospital patients; there were instances where they were mentioned in service encounters. For instance, a patient in one of the group complained that:

"…I was feeling pain so I asked a sister to assist me get attention of a doctor. Each of the sisters on duty kept on telling me to be a bit patient as the doctor was coming to see me soon. But that never happened as nurses became rude and even abusive. Some began asking me why the other nurses in earlier shifts did not attend to my issue. After four days in that hospital I had to transfer to a private hospital where there was always someone on hand to attend to me and my baby, all the time..." (FGD 06).

This kind of encounter has also been reported on by Burrowes, et al. (2017) observing that disrespect and abuse of patients, particularly during childbirth, persists, and is prevalent throughout East Africa. Furthermore, Professional accountability measures such as continuing professional education have been attributed to reduction of maternal mortality rate of 1071 deaths per 100,000 live births in the year 2000 to 383 in 2010 in Africa (Tuyisenge, 2018). These results have implications for Principal-Agent Theory as well as Complex Adaptive Systems theory. First, professional accountability measures help ensure alignment of interests where professional staff members maintain credentials with professional bodies to ensure they discharge quality clinical care and professional services within the hospital, such as

procurement of hospital supplies. This promotes resolve clinician- patient adverse selection and moral hazard problems. Secondly, professional standards are mechanisms through which staff members scan their environment and develop schema representing interpretive and action rules. This helps to ensure emergent nature of accountability to ensure improvement in health responsiveness as per CAS postulations.

4.7 Status of Institutional Accountability at PMH

Table 4.5 shows a summary of responses by PMH staff members regarding institutional accountability mechanisms.

Table 4. 5

Responses on Institutional Accountability

Dimension of Institutional Accountability	n	Mean	STD
Hospital has a service charter.	76	4.00	1.07
Complaint handling process in the hospital.	76	4.05	1.04
Achievement assessment in the hospital e.g. scorecard, benchmarking.	76	3.85	1.13
Provisions in the hospital contracts e.g. conflict of interest, dual practice, etc.	76	3.69	1.16
Hospital based surveillance e.g. maternal deaths review.	76	4.19	1.19
Hospital sanction enforcement procedures e.g. employee reprimand or dismissal.	76	3.57	1.22

Institutional accountability related to a variety of accountability mechanisms the hospital establishes to ensure that the hospital mission is achieved. From the findings most of the respondents agreed that the hospital has a service (mean 4.00; SD 1.07), that there is a complaint handling process in the hospital, (mean of 4.05; SD 1.04),

that there is a hospital based surveillance e.g. maternal deaths review (mean 4.19, 1.19), and that there is a hospital sanction enforcement procedures e.g. employee reprimand or dismissal (mean of 3.57, SD 1.22).

Over half of the respondents agreed that there is an achievement assessment in the hospital e.g. scorecard, benchmarking (mean 3.69, SD 1.16), that there is a provision in the hospital contracts e.g. conflict of interest, dual practice (mean 3.69, SD 1.16).

According to staff perspectives gleaned from interviews, the hospital has:

"…There are set systems on how the patients should be served and we have a service charter which is clear so they know when and where to get what from the hospital…" (Hospital manager, KII 03)

One notable shortcoming of such a system is that service charter lacks legal backing to make it enforceable thus rendering compliance highly erratic (Friele et al., 2013). This in turn influences the degree of hospital services responsiveness. The perspective is further reinforced by Skär and Söderberg (2018) finding that nearly 94% of patient complaints are not attended to or corrected by healthcare mostly because the issue being complaint about involves the hospital procedures over which they have no individual control. Moreover, hospitals rarely use sanctions such as warning, reprimand, suspension, and temporary work ban since, among other reasons, health workers tends more toward self-protection than self- policing (Brinkerhoff, 2014).

In regard to patient experience, there were notable inadequacies in relation to how the hospital handles patient concerns. For instance, a patient participant in the FGD observed how difficult it was to relay information about a particular issue noting that: *"…No, I didn't know where I could channel my complaints…"* (FGD 4, Participant).

Moreover, suggestion for service improvement went unheeded since it was not clear to the patients who were actually in charge and whether they would

be interested in the patients' issues. Thus remarked a patient:

"…The only problem I saw is that people give birth in the open where everybody is watching. I would suggest you have a separate room where one can give birth that can be good…" (FGD 3, Participant).

According to CAS Theory, hospital governance practices need to analyze the organizational system from a more holistic point of view in line with CAS and as such efforts can generate system-wide emergent learnings, capabilities, innovations, and adaptability (Dooley, 1997). Besides, the hospital management hierarchy, have to ensure resolution of various principal-agency conflict through various mechanisms to ensure hospital- physician integration, composition of hospital governing board, and payment design for hospital services (Jiang et al., 2012).

4.8 Status of Financial Accountability at PMH

Table 4.6 depicts responses of PMH staff on financial accountability measures.

Table 4. 6

Responses on Financial Accountability

Dimension of Financial Accountability	n	Mean	STD
Competitive bidding to encourage better prices	76	3.61	1.41
Pay for performance schemes	76	3.64	1.32
Informal payments/user fees	76	3.57	1.25
Value for money schemes such as capitation	76	3.78	1.19
Budget tracking and reporting	76	3.97	1.21
Collect and report information financial performance	76	4.07	1.17
Strict adherence to procurement procedures	76	4.13	1.26
Ensures funds are used properly and in the manner authorized	76	4.25	1.14
Comply to procedure and requirement for fund disbursement	76	4.25	1.08

Financial accountability was assessed in regard to factors that concern collection, disbursement, control and reporting of finances of PMH. From the findings over half of the respondents agreed that the hospital has a competitive bidding to encourage better prices (mean 3.61, SD 1.41), and that the hospital has a pay for performance schemes (mean 3.64, SD 1.32). Half of the respondents agreed that the hospital has informal payment/user fees (mean 3.57, SD 1.25). Most of the respondents agreed that there are strict adherence to procurement procedures, that the hospital ensures funds are used properly and in the manner authorized, and that the hospital complies to procedure and requirement for fund disbursement with a mean 4.13, SD 1.26, mean 4.25, SD 1.14, mean 4.25, SD 1.14 respectively.

Additional information from staff interview helped put these views in perspective. According to a staff member, the hospital's debt situation has contributed to less responsive services at the hospital. He observes that:

"...I believe currently we have had debt within the institution, as such it has derailed service delivery..." (Hospital Manager, KII 09).

According to Brinkerhoff (2004) such persistent debt burden and other resource constraints increase chances for malfeasance and corruption, such as procurement fraud, overbilling, and falsified staffing levels, among others. Moreover, as pending bills mount over time, the hospital finds itself in a position where it cannot procure its supplies through competitive bidding, and hospital managers are unable to control prices and quality of supplies as they have only a limited number of suppliers willing to accept their payment terms (Hilber, 2016).

According to Jiang et al. (2012), to restrain the potential hazard of agent opportunism, the hospital management needs to institute financial management measures such as

competitive tendering, payment-for-performance, and monitoring including periodic audits to ensure economic efficiency and affordability of care. Besides, in a complex adaptive system, accountability is an emergent event, where resource allocation and mobilization depends on characteristics of the social system, such as degree of decentralization and the level network with other stakeholders.

4.9 Status of Political Accountability at PMH

Table 4.7 shows a summary of PMH staff members' responses to measures of Political Accountability.

Table 4. 7

Responses on Political Accountability

Dimension of Political Accountability	n	Mean	STD
Upholds and applies the principles of equality and diversity and ensures that we are fair a open to all sections of the communities	76	4.22	1.16
Decentralization of healthcare to align with local needs	76	4.17	1.19
Provides transparent financial information for public view	76	4.16	1.03
Develop adequate internal control systems	76	4.21	1.05
Sets clear operating goals to be achieved every year	76	4.17	0.99
Fosters collaboration with other related agencies as well as other types of organizations	76	4.24	1.00

The political accountability attempted to assess the extent to which PMH fulfills emerging needs and interests of the citizens being a public facility. From the findings nearly all the respondents agreed that the hospital upholds and applies the principles of equality and diversity and ensures that we are fair a open to all sections of the communities (mean 4.22, SD 1.16), that the hospital decentralize healthcare to align

with local needs (mean 4.17, SD 1.19), that the hospital provides transparent financial information for public view (mean 4.16, 1.03), that the hospital develop adequate internal control systems (mean 4.21, 1.05), that the hospital sets clear operating goals to be achieved every year (mean of 4.17, SD 0.99) and that the hospital fosters collaboration with other related agencies as well as other types of organizations (mean 4.24, SD 1.00).

Therefore, the high rating of the items was indicative of the important place of the political factors. The higher rating was attributable mainly to devolution imperatives in line with Barker et al. (2014) contention that the rationale for health sector decentralization reform is the need to establish stronger accountability linkages among citizens, policymakers and service providers (Brinkerhoff, 2004).

However, on closer scrutiny, it was revealed through staff interviews that political accountability mechanisms present both opportunity and challenges for improved health system responsiveness. One participant surmised this view by noting that,

"...Devolution is a good thing and also it is something else..." (Hospital manager, KII 01)

This problem was also noted by another hospital staff who reiterated that:

"...But currently when things have to come from the county, there are always some unnecessary delays and sometimes you may not get the money when you really need it..." (Hospital manager, KII 12)

This view indicated that whereas devolution brought about political accountability close to where the service is offered, more hurdles have to be overcome for this priority to be effected. Part of the solution would require providing a framework for political accountability in a manner that spells out various functions and responsibilities. Accordingly, devolution has increased scrutiny in terms of how

responsive hospital services are, but this also comes with increased interference. For instance, a staff member notes that,

"*…Almost every month you hear MCAs say I'm coming to see how you treat my people. But they also interfere. Before this Linda mama came there* were *issues where MCAs did not want mothers to pay but they are not registered in Linda mama and NHIF. What that tells you is that there is interference. At the end of the day you'll lose commodities. Protocols need to be in place…"* (Hospital manager, KII 05)

From the perspective of the patients, that tension is best illustrated by a patient's contention that,

"…You know the President said Pumwani is free, and I spent 6000 there and that was the major source of complaints there. That unexpected cost made me to now have to borrow from friends…" (FGD 02, Participant).

The complexity entailed in designing effective mechanisms for Political accountability have also been rained Brinkerhoff (2004), asserting that government role in remedying healthcare market failures comprise inherent intractable tensions between economic and social decision criteria, such as equitable access and quality. As Lichtenstein et al. (2006) assert, in CAS systems, relationships are not primarily defined hierarchically, as they are in bureaucratic systems, but rather by interactions among heterogeneous agents and across agent networks. This calls for innovative ways of establishment rules that define how interactions are conducted in a manner that promotes the system mission, that health system responsiveness.

4.10 Status of Social Accountability at PMH

Table 4.8 provides an overview of PMH staff responses on Social accountability mechanisms.

Table 4. 8

Responses on Social Accountability

Dimension Social Accountability	n	Mean	STD
Client surveys	76	3.94	0.95
Citizen participation e.g. workshops, open days	76	4.01	1.02
Media publicity-positive or negative	76	3.89	1.15
Regulatory reporting requirements	76	3.78	1.18
Monitoring by civil society organizations	76	3.93	1.11

Social accountability was also assessed based on the extent to which the hospital engaged the civil society as representative of the ordinary citizens who may not have the skills and time to participate directly or indirectly in exerting accountability. From the findings majority of the respondents agreed that the hospital conducts client surveys (mean 3.94, SD 0.95), that the hospital conducts citizen participation e.g. workshops, open days (mean 4.01, SD 1.02), that the hospital conducts media publicity-positive or negative (mean 3.89, SD 1.15), that the hospital conducts regulatory reporting requirements (mean 3.78, SD 1.18) and that the hospital is monitored by civil society organizations (mean 3.98, SD 1.11).

As Burrowes et al. (2017) contends, Social accountability mechanisms, such as those that enable patients to be informed of their rights, encourage them to participate in their own healthcare. Which has the tendency to improve the overall service responsiveness.

The interview data, however, unveiled the mechanisms through which Social accountability take place at PMH to include alliance with Non-governmental

Organizations (NGOs), mainly to facilitate financing of various projects, as well as through open days and fairs. As an illustration, a staff member remarked that:

"...Kangaroo Care is supported by UNICEF, Save the Children and Afya Jijini in many ways including in staff training, renovating and expansion of the unit which is a big support..." (Hospital Manager, KII 07)

Moreover, interactions with the general public through open days and fairs were also stressed, one hospital staff remarking that such practices:

"...We usually get feedback in open air talks, they [the general public] also air what they require and do not get so that the hospital can meet their needs..." (Hospital Manager, 12)

According to patients, the various aspects of Social accountability were never mentioned. This could have been attributed to the fact that there is dearth of healthcare focused civil organizations working with patients on various fronts including payment, service quality, and patient rights, among others. However, a patient obliquely narrated how these factors affect service responsiveness when she asserted that:

"...In private hospital, you are served well right from the gate, you are given your own room, the food is good, your child is very well taken care of, you have warm water for bathing. There is always someone on hand to listen to you and see how they can assist you. But here, instead of their services improving, they are deteriorating..." (FGD 2, Participant).

According to Afulukwe-Eruchalu (2017) social accountability involving participation of civil society organizations helps empower patients, especially the poor, are in a weak position to confront this power thereby resulting in greater health system responsiveness. Importantly, reporting and use of Electronic Medical Records (EMR)

enhance dissemination of information to key stakeholders who can act accordingly to reduce abuse as well as help provide guidelines (Peabody et al. 2006).

4.11 Correlation Analysis

Table 4.9 shows a bivariate correlation analysis which was carried out to preliminarily establish the nature of pairwise relationship between accountability components and health system responsiveness.

Table 4. 9

Correlation Analysis between Accountability Components and HSR

		Pr.A	I.A	F.A	P.A	S.A	H.S.R
Pr.A	Pearson Correlation	1					
	Sig. (2-tailed)						
	n	76					
I.A	Pearson Correlation	.374**	1				
	Sig. (2-tailed)	.001					
	n	76	76				
F.A	Pearson Correlation	.260*	.408**	1			
	Sig. (2-tailed)	.024	.000				
	n	76	76	76			
P.A	Pearson Correlation	.397**	.596**	.549**	1		
	Sig. (2-tailed)	.000	.000	.000			
	n	76	76	76	76		
S.A	Pearson Correlation	.369**	.620**	.430**	.651**	1	
	Sig. (2-tailed)	.001	.000	.000	.000		
	n	76	76	76	76	76	
H.S.R	Pearson Correlation	.382**	.547**	.394**	.572**	.643**	1
	Sig. (2-tailed)	.001	.000	.000	.000	.000	
	n	76	76	76	76	76	76

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

Key: Pr.E=Professional Accountability, IA=Institutional Accountability, F.A.=Financial Accountability, P.A.=Political accountability, S.A.=Social Accountability & H.S.R= Health Systems Responsiveness

Results indicated in Table 4.7 shows relationships that are highly significant and positive correlation between Health System Responsiveness (HSR) and the various

components of accountability: thus, Professional accountability ($r = 0.382^{**}$, $p < 0.05$); Institutional accountability ($r = 0.547^{**}$, $p < 0.05$); Financial accountability ($r= 0.394^{**}$, $p <0.05$); Political accountability ($r =0.572^{**}$, $p < 0.05$); and Social accountability ($r = 0.643^{**}$, $p < 0.05$) were presented.

The significant and positive correlations indicated that improvements in each accountability measures were also associated with improvements in health system responsiveness. However, higher values, those with correlation coefficient above 0.5, were only found in relation to two accountability components of professional accountability and Social accountability. This showed that the two factors contributed more to health system responsiveness relative to other accountability factors. On one hand, it can be attributed to the fact that professional standards and norms provide the maternity hospital with a comprehensive baseline for intervention efforts to support and to improve service provision (Edwards, et al., 2014). on the other hand, since civil society organizations are involved in funding various projects at the hospital, it anticipated that through terms of contracting arrangements, these organizations are able to require the hospital to meet service and quality standards, and to report on costs as well as a variety of other indicators, thus improving Health system responsiveness (Brinkerhoff, 2004). Thus the results confirm CAS central assertion that as an emergent phenomenon, accountability components impact responsiveness differently. Thus organizational controls, such as budget, performance review, audits, and standards can provide feedback mechanisms for maintaining equilibrium (Dooley, 1997).

4.12 Regression Analysis

Since Regression analysis established a bivariate relationship between the dependent variable and each independent variable, a regression analysis was then performed to

establish the nature and strength of the relationship while controlling for other factors. Table 4.10 provides information on the percentage of total variation in dependent variable that is accounted for by the independent variables.

Table 4. 10

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.691[a]	.477	.438	.49275

a. Predictors**:** (Constant), X_5, X_4, X_3, X_2, X1

The model revealed that 47.4% of the total variation in health system responsiveness was explained by the independent variables of Professional accountability, Institutional accountability, Financial accountability, Political accountability, and Social accountability (R2 = 0.477).

Table 4. 11

Model ANOVA[a] Test

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	15.049	5	3.010	12.396	.000[b]
	Residual	16.511	68	.243		
	Total	31.560	73			

a. Dependent Variable: Health system responsiveness.

b. Predictors**:** (Constant), X5, X4, X3, X2, X1

An ANOVA test for the model fit indicated that the model fitted the data well since the F value was significant, indicating that at least one of the independent variables significantly affected the dependent variable $F = 12.396$, $p < .01$.

Table 4.12 show the nature and strength of relationship between components of accountability and health system responsiveness.

Table 4. 12

Regression Coefficients a Showing Direction and Strength of Relationships

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	1.275	.373		3.418	.001
	Professional accountability	.075	.066	.110	1.130	.001
	Institutional accountability	.110	.102	.129	1.075	.006
	Financial accountability	.068	.073	.100	.926	.008
	Political accountability	.086	.102	.114	.840	.004
	Social accountability	.356	.110	.406	3.231	.002

a. Dependent variable: Health system responsiveness

On individual accountability mechanisms, Professional and Social accountability components were found to positively and significantly affect health system responsiveness: $\beta = .075$, $p < 0.01$; and $\beta = 3.231$, $p < 0.01$, respectively. This meant that a unit increase in Professional accountability score was associated with 0.075 increases in Health system responsiveness score. Similarly, a unit increase in Social accountability score was associated with an increase in Health system responsiveness at a magnitude of 0.356. However, there was not enough statistical evidence that Institutional, Financial and Political accountability mechanisms predicted hospital responsiveness: $\beta = .110$, $p > .01$; $\beta = .068$, $p > .01$; and $\beta = .086$, $p > .01$, respectively. Therefore, the results supported the general prediction that accountability mechanisms would positively predict Health system responsiveness. However, the relationship between the other three components, Institutional, Financial, and Political accountability mechanisms and Health system responsiveness was not supported, indicating that effectiveness of the mechanisms are more likely context-dependent.

Hence, the regression equation from the results could be written as:

$Y = 0.974 + 0.465X_1 - 0.068X_2 - 0.017X_3 + 0.024X_4 + 0.343X_5$

In sum, it was found that by improving accountability mechanisms, Health system responsiveness is also improved as can be confirmed from the regression analysis. However, the two areas of hospital administrative practices and financial management practices were inconclusive in this study. They imply ongoing adjustments to management practices, while those accountability mechanisms that were detached from system approach were found to be significantly associated with improvement in hospital responsiveness. This view is consistent with Wachter (2013). Who argue that as a result, financial accountability in the hospital and institutional accountability can be seen as part of the hospital system while professional accountability and social accountability are at least not as closely linked to the hospital structures and contexts. Hence, as Aveling and Dixon-Wood (2016) surmise, accountability measures when profoundly intertwined with organizational contexts, which were typically rich in operational and managerial defects and given the prevailing cultural norms, become less effective. Thus, principal-agent relationships marked by complexities, including uncertainty, information asymmetry, and high cost monitoring requires developing incentive structures to align interests between agents and principals to prevent agents from shirking (O'Flynn, 2007). This complex environment also requires an adaptable, learning-based approach to ensure responsiveness in healthcare delivery (Lichtenstein, 2006).

CHAPTER FIVE
SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the summary of the study findings, draws conclusion from such findings, makes recommendations as appropriate, and suggests areas of interest for future studies to shed more light where the present study had some limitations

5.2 Summary of Findings

5.2.1 Professional accountability mechanisms on health systems responsiveness

According to the findings, the majority of respondents agreed that patients receive care as quickly as they require it. Furthermore, the majority of respondents agreed that hospital staff treat patients with respect. Furthermore, the vast majority of respondents believed that professionals should explain things to patients in order for them to understand. Majority of respondents believed that patients should be included in decision-making, according to the survey. According to the findings, the vast majority of respondents agree that patient medical information is kept private. Furthermore, majority of respondents stated that they receive high-quality basic services, such as a clean waiting area with television and wards.

5.2.2 Institutional accountability mechanisms on health systems responsiveness

According to the findings majority of respondents believed that following professional norms of behavior is important. Furthermore, the majority of respondents agreed that they met the requirements for licensure and certification. In addition, the vast majority of respondents agreed that professional associations exercise oversight. The majority of respondents stated that they use clinical procedures, according to the survey. The majority of respondents stated that their work is examined by another

professional, based on the findings. Furthermore, the majority of respondents agreed that they engage in ongoing professional growth.

5.2.3 Financial accountability mechanisms on health systems responsiveness

Majority of respondents agreed that the hospital has a service charter based on the findings. Furthermore, the majority of respondents agreed that the hospital has a complaint handling method. Furthermore, the majority of respondents stated that the hospital has an achievement assessment system in place, such as a scorecard or benchmarking. Majority of respondents believed that there is a provision in hospital contracts, such as conflict of interest or dual practice, according to the survey. Majority of respondents agreed that there is hospital-based surveillance, such as maternal death reviews, based on the findings.

5.2.4 Political Accountability Mechanisms on Health Systems Responsiveness

Majority of respondents agreed that the hospital has competitive bidding to stimulate better rates, based on the findings. Furthermore, Majority of respondents agreed that the hospital has a pay-for-performance system in place. In addition, the majority of respondents agreed that the hospital has unofficial payment/user fees. Majority of respondents believed that the hospital provides value for money measures such as capitation, according to the survey. According to the findings, majority of respondents agreed that the hospital should track and report its budget. In addition, the vast majority of respondents agreed that the hospital should collect and publish financial data.

5.2.5 Social accountability mechanisms on health systems responsiveness

Majority of respondents believed that the hospital supports and applies the ideals of equality and diversity, and that we are fair and open to all sections of the community, based on the findings. Furthermore, the vast majority of responders agreed that the hospital should decentralize healthcare to better meet local needs. Furthermore, majority of respondents agreed that the hospital discloses financial information that is open to the public. Majority of respondents agreed that the hospital should build effective internal control measures, according to the survey. Majority of respondents believed that the hospital establishes clear operating goals that must be met every year, based on the findings. Furthermore, majority of respondents agreed that the hospital encourages collaboration with other connected institutions and organizations

5.3 Conclusions

5.3.1 Professional accountability mechanisms on health systems responsiveness

From the findings, the study concluded that there is moderate significant and positive correlation between professional accountability ($r = 0.382$, $p < 0.05$) and health system responsiveness. The most common professional accountability issue, according to the patients, related to disrespect. This was not a widely experienced problem by majority of the hospital patients; there were instances where they were mentioned in service encounters. Professional accountability measures help ensure alignment of interests where professional staff members maintain credentials with professional bodies to ensure they discharge quality clinical care and professional services within the hospital, such as procurement of hospital supplies. This promotes resolve clinician-patient adverse selection and moral hazard problems. Professional standards, on the other hand, are processes through which employees scan their

surroundings and construct schema that embody interpretative and action rules. These findings are consistent with those of Brinkerhoff (2004), who stated that high ratings on professional accountability measures indicated that clinicians prioritized procedural and quality standards. As a result, hospital employees value standard operating procedures as a way to distill and communicate the best available data to physicians and hospital administration in a straightforward and practical manner.

5.3.2 Institutional accountability mechanisms on health systems responsiveness

From the findings the study further concluded that there is a highly significant and positive correlation between iinstitutional accountability ($r = 0.547$, $p < 0.05$) and health system responsiveness. In regard to patient experience, there were notable inadequacies in relation to how the hospital handles patient concerns. For instance, a patient observed how difficult it was to relay information about a particular issue. Furthermore, suggestions for improving service went unheeded because it was unclear to the patients who were in control and whether they were interested in the patients' concerns. Preker et al. (2006) argued that ineffective action by service providers could be hampered by weak management systems that are unable to take into account changing population health requirements and changing demands on health care providers.

5.3.3 Financial accountability mechanisms on health systems responsiveness

In addition the study concluded that there is a significant and positive correlation between financial accountability ($r = 0.394$, $p <0.05$) and health system responsiveness. From the findings the study concluded that the hospital ensures funds are used properly and in the manner authorized. The study also concluded that the hospital comply with procedure and requirement for fund disbursement. According to

a hospital employee, the hospital's debt issue has resulted in fewer responsive services. According to a staff member, the hospital's debt situation has contributed to less responsive services at the hospital. According to Brinkerhoff (2004), such persistent debt burden and other resource constraints increase chances for malfeasance and corruption, such as procurement fraud, overbilling, and falsified staffing levels, among others. Moreover, as pending bills mount over time, the hospital finds itself in a position where it cannot procure its supplies through competitive bidding, and hospital managers are unable to control prices and quality of supplies as they have only a limited number of suppliers willing to accept their payment terms (Hilber, 2016).

5.3.4 Political accountability mechanisms on health systems responsiveness

From the findings the study further also concluded that there is a highly significant and positive correlation between political accountability ($r = 0.572$, $p < 0.05$) and health system responsiveness. The high rating of the items was indicative of the important place of the political factors. The improved rating was primarily due to devolutionary imperatives, as stated by Barker et al. (2014), who argue that the justification for health sector decentralization reform is the need to strengthen accountability links among citizens, policymakers, and service providers.

5.3.5 Social accountability mechanisms on health systems responsiveness

From the findings the study also concluded that there is a highly significant and positive correlation between Social accountability ($r = 0.643$, $p < 0.05$) and health system responsiveness. The many dimensions of social accountability, according to patients, were never emphasized. This could be due to a scarcity of healthcare-focused civil organizations that work with patients on a variety of issues such as payment,

service quality, and patient rights, among others. According to Afulukwe-Eruchalu (2017), social accountability involving participation of civil society organizations helps empower patients, especially the poor, are in a weak position to confront this power thereby resulting in greater health system responsiveness.

5.4 Implications for Theory

The study had a number of implications for the theories in that there is need for a unified framework of accountability especially in a multi-actor, multi-institutional setting where clash of goals, objectives, rules, perspective and standards are inevitable. Lack of elaborate frameworks for assessing accountability issues in an institution may lead to a disjointed system of accountability efforts resulting in failure to capitalize on synergies of a diverse and multifaceted system. Linkages therefore must be made at various levels in a conceptually sound manner, such as board appointment of patient representatives or advocates through clear rules for appointment.

5.5 Implications for Practice

This study's implication for practice is that it drew on the inputs of both internal and external accountability actors to help with hospital's continuous adaptation in order to provide responsive services. The strategies, mechanisms, instruments of accountability are outlined, the actors involved and the dimensions of accountability in question.

5.6 Suggestions for Future Research

The issues of political accountability remain a highly optimistic area according to staff members, especially in light of devolution. It was established that few of the projected fruits of devolved hospital management have accrued. This has been decried

by staff members as well as by the users, and therefore, there is need to explore further on how the devolution process can be streamlined to ensure efficient running of the hospital that is focused on resolving local problems, especially in access by the disadvantaged segments of the society within the catchment.

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APPENDICES

Appendix 1: Informed Consent Form

Kenya Methodist University P. 0 Box 267-60200

MERU, Kenya

SUBJECT: INFORMED CONSENT

Dear Respondent

My names are Joseph Samich I am a Msc student from Kenya Methodist University. I am conducting a study titled: Influence of Accountability Mechanisms on Health System Responsiveness: A case of PMH, Kenya the findings will be utilized to strengthen the health systems in Kenya and other Low-in- come countries in Africa. As a result, countries, communities and individuals will benefit from improved quality of healthcare services. This research proposal is critical to strengthening health systems as it will generate new knowledge in this area that will inform decision makers to make decisions that are research based.

Procedure to be followed

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

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

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

without any consequences to the services you are rendering.

Discomforts and risks.

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

Benefits

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

Rewards

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

Confidentiality

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

Contact Information

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

Dr. Wanja Tenambergen, 0726-678020 Senior Lecturer and Mr. Musa Oluoch Department of Health Systems Management of Kenya Methodist University, Nairobi campus.

Participant's Statement

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

Name of Participant…….

Date……..Signature…….

Investigator's Statement

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

Name of Interviewer……..

Date…….Interviewer Signature……

Appendix 2: Questionnaire

Background Information

a) **Designation.....**

Gender: 1. Male [ ] 2. Female [ ]

b). **Work experience in years in the current position:**

Less than 5 years [ ] 2. 5 to less than 10 years [ ]

10 to less than 15 years [ ] 4 Over 15 years [ ]

c). **Highest educational level:**

Diploma/HND [ ]

Master's degree and above [ ]

Undergraduate [ ]

d). Age bracket:

Equal or less than 29 years [ ]

30–39 years [ ] 3

40–49 years [ ]

50–59 years [ ]

Over 60 years [ ]

Professional accountability mechanisms

As a member of a profession, you owe certain responsibility to the profession. In this section, you are asked to rate according to the level of importance. How does each of the following individual items contribute to your ability to provide patient-centered services.

Use scale: SD= Strongly Disagree D = Disagree NS =Not Sure A = Agree SA = Strongly Agree

	SD	D	NS	A	SA
Adhering to professional codes of conduct					
Meeting licensure and accreditation conditions					
Professional association exercise of oversight					
Use of clinical procedures					
My work being reviewed by another professional					

Institutional accountability mechanisms

Continuous professional education/development					

Besides the profession, you owe certain responsibility to the institution in which you work, that is the hospital. To what extent does each of the following measures influence your ability to provide patient-centered services.

Use scale: Use scale: SD= Strongly Disagree D = Disagree NS =Not Sure A = Agree SA = Strongly Agree

	SD	**D**	**NS**	**A**	**SA**
Hospital service charter					
Complaint handling process in the hospital					
Achievement assessment in the hospital e.g. scorecard, benchmarking					
Provisions in the hospital contracts e.g. conflict of interest, dual practice, etc.					
Hospital based surveillance e.g. maternal deaths review					
Hospital sanction enforcement procedures e.g. employee reprimand or dismissal					

Financial accountability mechanisms

In this section, you are going to rate how economic accountability measures of the hospital influence your ability to provide patient-centered services.

Use scale: SD= Strongly Disagree D = Disagree NS =Not Sure A = Agree SA = Strongly Agree

	SD	D	NS	A	SA
Competitive bidding to encourage better prices					
Pay for performance schemes					
Informal payments/user fees					
Value for money schemes such as capitation					
Budget tracking and reporting					
Collect and report information financial performance					
Strict adherence to procurement procedures					
Ensures funds are used properly and in the manner authorized					
Comply to procedure and requirement for fund disbursement					

Political accountability mechanisms

In this section, you are going to rate how accountability mechanisms to wider society influence your ability to provide patient-centered services.

Use scale: SD= Strongly Disagree D = Disagree NS =Not Sure A = Agree SA = Strongly Agree

	SD	D	NS	A	SA
Upholds and applies the principles of equality and diversity and ensures that we are fair a open to all sections of the communities					
Decentralization of healthcare to align with local needs					
Provides transparent financial information for public view					
Develop adequate internal control systems					
Sets clear operating goals to be achieved every year					
Fosters collaboration with other related agencies as well as other types of organizations					

Social accountability mechanisms

In this section, you are going to rate how accountability mechanisms to wider society influence your ability to provide patient-centered services.

Use scale: SD= Strongly Disagree D = Disagree NS =Not Sure A = Agree SA = Strongly Agree

	SD	D	NS	A	SA
Client surveys					
Citizen participation e.g. workshops, open days					
Media publicity-positive or negative					
Regulatory reporting requirements					
Monitoring by civil society organizations					
Provides complaints and redress mechanisms					

Health system responsiveness

In this section, you are going to rate how each of the following care goals are met by the hospital staff in general.

Use scale: SD= Strongly Disagree D = Disagree NS =Not Sure A = Agree SA = Strongly Agree

	SD	D	NS	A	SA
Patients get care as soon as they need it					
Patients are shown respect by hospital staff					
Staff explain things to patients for understanding					
Involve patients in decision making					
Keep patient medical history confidential					
Patients can choose the healthcare the specialist/provider they are happy with					
Avail quality basic amenities e.g. clean waiting room with TV, wards					

Appendix 3: Key Informant Interview Guide

1. What role does the professional association you are affiliated with play in ensuring your best clinical practice/professional career?
2. Do you believe that professional pronouncements reduce your discretion and therefore limit what you can do to achieve better professional services?
3. In what ways does the hospital ensure that there are adequate checks and restraints on the health services providers to ensure best practice all the time?
4. What constraints does the hospital face in ensuring that it is answerable, clinically, to its stakeholders?
5. Does the hospital have any procedures to deal with errors and adverse events should any occur?
6. What role does the hospital financing play in ensuring patient-centered care?
7. Do you believe that financing of the hospital makes service delivery affordable to all deserving patients, especially the disadvantaged ones?
8. Does the hospital face financial constraints that limit its ability to offer patient-centered care?
9. Can you describe the various ways community participates in ensuring accountability from the hospital staff?
10. Do you have any misgivings about the capability of the hospital, professional association or community to enforce its desired accountability measures?
11. How is the devolution affecting service delivery in the hospital?
12. What other measures can you suggest that would make the hospital more effective and responsive to patient needs?

Appendix 4: Patient FGD Interview Guide

1. Can you describe what your experience at the Pumwani Maternity Hospital was like?
2. In what ways did the hospital meet your expectations through the services they provided during the time you were there?
3. Were there instances where your expectations were not met, and what led to such expectations not being met?
4. How about the hospital charges, how were they commensurate with the services you received, in your opinion?
5. Would you go to PMH, if we were to do it all over again?
6. What would you suggest to make services better at PMH?

Appendix 5: Random Number Table (Extract from Excel)

118	61	118	21	60	135	25	106	100	105	14
87	105	180	176	200	174	159	187	175	147	58
58	188	48	60	186	54	169	6	164	8	159
14	82	26	202	26	179	131	194	205	148	169
109	105	33	50	142	149	192	53	54	81	74
9	140	122	107	5	16	162	9	46	205	28
57	166	72	144	61	200	66	107	159	57	9
57	106	176	57	89	12	10	190	118	10	23
174	104	18	29	16	52	15	71	38	65	133
163	79	79	53	99	197	33	179	104	65	183
5	101	65	109	58	150	138	179	36	131	97
5	198	124	33	41	141	179	173	124	164	65
56	40	109	104	21	199	173	45	2	24	184
9	27	138	33	132	147	204	135	177	184	57
57	63	15	126	113	7	124	133	2	56	25
90	4	134	71	109	131	45	152	24	151	7
170	1	127	64	172	156	101	53	121	106	119
118	20	7	150	13	71	168	30	126	126	194
123	163	131	191	180	113	165	164	150	155	206
149	19	84	197	197	22	206	59	197	65	144
67	98	54	101	26	127	84	188	120	154	15
77	15	4	75	205	128	200	155	176	122	77

Appendix 6: Research Letter

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

4TH DECEMBER, 2017

Joseph Kisur Samich
HSM-3-2589-2/2016

Dear Joseph,

SUBJECT: ETHICAL CLEARANCE OF A MASTERS' RESEARCH THESIS

Your request for ethical clearance for your Masters' Research Thesis titled **"Influence of Accountability on Health System Responsiveness: A Case of Pumwani Maternity Hospital, Kenya"** has been granted to you in accordance with the content of your Thesis proposal.

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

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

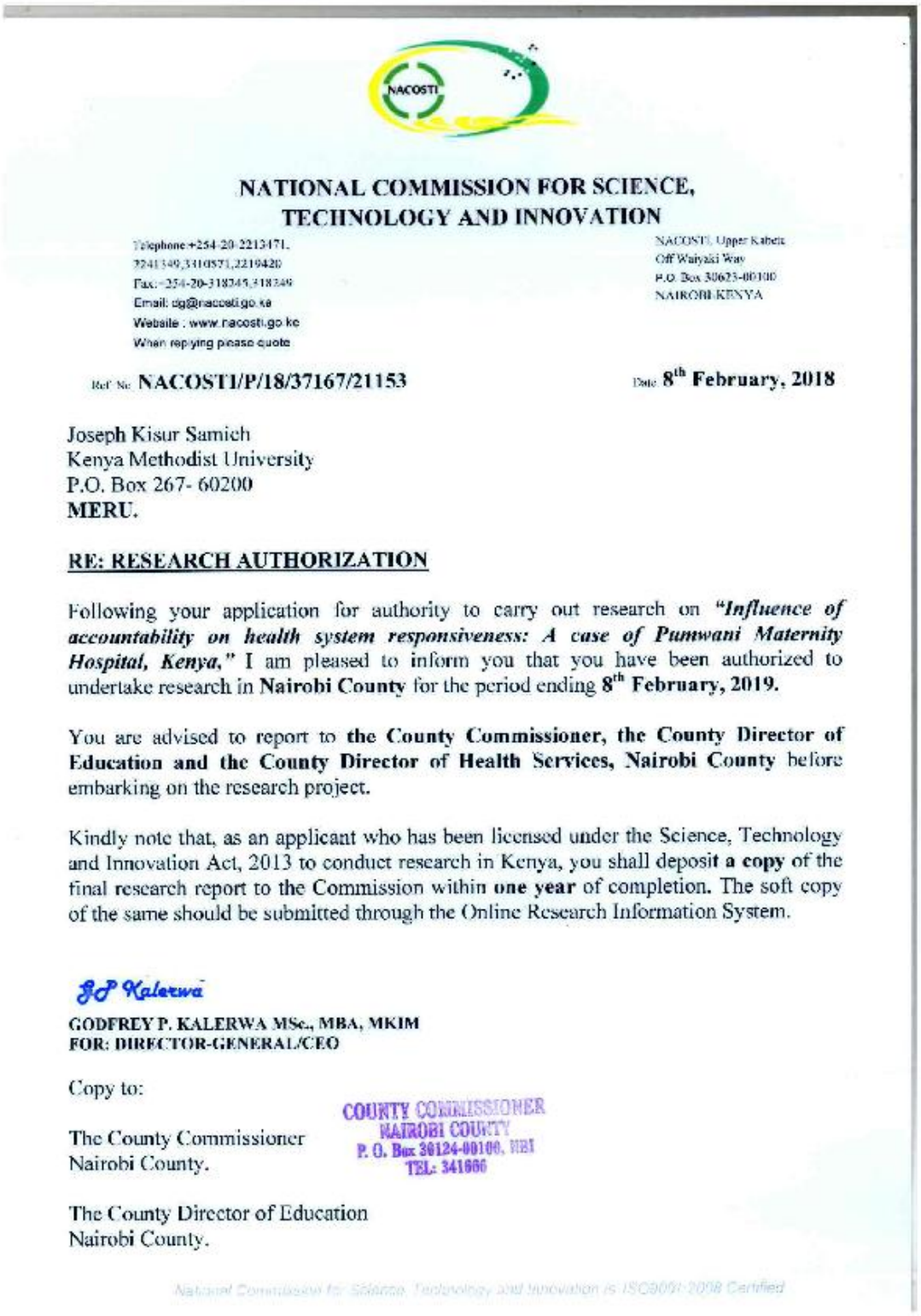
5. SERC regulations require review of an approved study not less than once per 12-month period. **Therefore, a continuing review application must be submitted to the SERC in order to continue the study beyond the approved period.** Failure to submit a continuing review application in a timely fashion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

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

Thank You,

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

Appendix 7: NACOSTI PERMIT



NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

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

NACOSTI, Upper Kabete
Off Waiyaki Way
P.O. Box 30623-00100
NAIROBI-KENYA

Ref No: **NACOSTI/P/18/37167/21153**

Date: **8th February, 2018**

Joseph Kisur Samich
Kenya Methodist University
P.O. Box 267- 60200
MERU.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ***"Influence of accountability on health system responsiveness: A case of Pumwani Maternity Hospital, Kenya,"*** I am pleased to inform you that you have been authorized to undertake research in **Nairobi County** for the period ending **8th February, 2019.**

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

Kindly note that, as an applicant who has been licensed under the Science, Technology and Innovation Act, 2013 to conduct research in Kenya, you shall deposit **a copy** of the final research report to the Commission within **one year** of completion. The soft copy of the same should be submitted through the Online Research Information System.

GP Kalerwa

GODFREY P. KALERWA MSc., MBA, MKIM
FOR: DIRECTOR-GENERAL/CEO

Copy to:

The County Commissioner
Nairobi County.

COUNTY COMMISSIONER
NAIROBI COUNTY
P. O. Box 30124-00100, NBI
TEL: 341666

The County Director of Education
Nairobi County.

National Commission for Science, Technology and Innovation is ISO9001:2008 Certified

Appendix 8: Research Authorization from the Ministry of Education

Republic of Kenya
MINISTY OF EDUCATION
STATE DEPARTMENT OF BASIC EDUCATION

Telegrams: "SCHOOLING", Nairobi
Telephone: Nairobi 020 2453699
Email: rcenairobi@gmail.com
cdenairobi@gmail.com

REGIONAL COORDINATOR OF EDUCATION
NAIROBI REGION
NYAYO HOUSE
P.O. Box 74629 - 00200
NAIROBI

When replying please quote

Ref: RCE/NRB/GEN/1 VOL. 1

DATE: 14th February, 2018

Joseph Kisur Samich
Kenya Methodist University
P O Box 267-60200
MERU

RE: RESEARCH AUTHORIZATION

We are in receipt of a letter from the National Commission for Science, Technology and Innovation regarding research authorization in Nairobi County on "**Influence of accountability on health system responsiveness: A case of Pumwani Maternity Hospital, Kenya**".

This office has no objection and authority is hereby granted for a period ending **8th February, 2019** as indicated in the request letter.

Kindly inform the Sub County Director of Education of the Sub County you intend to visit.

14 FEB 2018

JAMES KIMOTHO
FOR: REGIONAL COORDINATOR OF EDUCATION
NAIROBI

c.c
Director General/CEO
Nation Commission for Science, Technology and Innovation
NAIROBI

Appendix 9: Research Authorization from Nairobi County Health Services

NAIROBI CITY COUNTY

Telegrams: "CHO-MINHEALTH", Nairobi
Telephone: Nairobi 217131/212482
Fax: 217148
E-mail: pmonairobi@yahoo.com

COUNTY HEALTH OFFICE
NAIROBI
NYAYO HOUSE
P.O. Box 54549-00100
NAIROBI

When replying please quote

Ref: No. CM/O/NRB/OPR/VOL.1/231.8/15

COUNTY HEALTH SERVICES

14th February, 2018

Joseph Kisur Samich
Kenya Methodist University
P.O. Box 267-60200
MERU

RE: RESEARCH AUTHORIZATION

This is to inform you that the Nairobi City County Operational Technical Working Team reviewed the documents on the study titled, "**Influence of Accountability on Health System Responsiveness: A Case of Pumwani Maternity Hospital, Kenya**".

I am pleased to inform you that you have been authorized to undertake the study in **Pumwani Maternity Hospital, Nairobi County**.

On completion of the study, you will submit **one hard copy and one copy in PDF** of the research findings to our operational research technical working group.

FOR: COUNTY DIRECTOR
HEALTH SERVICES
NAIROBI COUNTY

R. K. MULI
FOR: COUNTY DIRECTOR OF HEALTH SERVICES

Cc:
Medical Superintendent – Pumwani Maternity Hospital

Appendix 10: Research Authorization from Pumwani Maternity Hospital

NAIROBI CITY COUNTY

Telephone: 020 344194
Web.www.nairobi.go.ke

City Hall
P. O. Box 30075 - 00100
Nairobi
Kenya

COUNTY HEALTH SERVICES:
PUMWANI MATERNITY HOSPITAL

PMH/DMOH/75/0067/2018

19TH FEBRUARY 2018

TO:
JOSEPH KISUR SAMICH
KENYA METHODIST UNIVERSITY
NAIROBI

RE: APPROVAL OF RESEARCH PROPOSAL

This is to inform you that the research entitled **"Influence of Accountability on Health System Responsiveness: A Case of Pumwani Maternity Hospital, Kenya"** has been approved.

You are exempt from payment because you are staff.

You are hereby allowed to collect data. We look forward to receiving a Summary of the research findings upon completion of the study.

Yours sincerely,

PUMWANI MATERNITY HOSPITAL
P. O. Box 42849-00100, NAIROBI
TEL. NRB. 6763291-4/ 6762965

DR. C. MUTINDA
MEDICAL SUPERINTENDENT