INFLUENCE OF DIRECT GOVERNMENT HEALTH FUNDS ON SERVICE DELIVERY IN PRIMARY HEALTHCARE FACILITIES IN MERU COUNTY, KENYA

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A THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE REQUIREMENT FOR THE CONFERMENT OF MASTER OF HEALTH SYSTEMS MANAGEMENT DEGREE, KENYA METHODIST UNIVERSITY

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DECLARATION

I declare that this thesis is my original work and has not been presented for a degree or any other award in any other university.

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DEDICATION

I dedicate this to my beloved wife and my loved children who have really encouraged and supported me throughout the period I had to juggle with time to complete the research.

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I would like to thank the Almighty God for His mercy and grace that have enabled me to complete this thesis. My sincere gratitude goes to my very abled supervisors Dr. Wanja Mwaura-Tenambergen and Dr. James Mwitari for their guidance, dedication and enormous support they accorded me throughout my research period and completion of this thesis. I wish to extend my appreciation to the Meru County Executive for agreeing to my request to conduct this research in the County and particularly Mr. Peter Wangombe who ably led and facilitated the data collection team. Were it not for his tireless effort and perseverance this research would not have been a reality. I wish to thank the dedicated team that I worked tirelessly throughout the period of the research, undergoing through the toils of distributing and gathering the questionnaires and conducting the interviews. Am grateful to the health workers from the health facilities that were visited and interviewed for sacrificing their valuable time to provide responses despite the demanding nature of their work, some who were even called to attend to emergencies during the interview. Also, the facility management committee members who took time to provide us with invaluable information that helped us to put together the knowledge that we sought during the time we were in the field. Finally, would like to express my heartfelt gratitude to my family for their unwavering emotional support.

ABSTRACT

Health care financing is a worldwide issue that affects all governments, including those in developed countries. In third-world countries with faltering economies and competing demands for financial resources, the problem is exacerbated. This has had an impact on citizens' healthcare access. In Kenya, there has been a scarcity of research to inform policy formation and practices in healthcare funding. The focus of this thesis was on Meru County's Direct Government Health Funds. The study's major goal was to determine the impact of direct government health funds on service delivery in Meru County's basic primary health facilities, because of the significant diversity of distribution, the study area it was excellent for the investigation. The study aimed to draw concrete conclusions about the study's main objectives. Determine the quantity of funds received and their impact on primary health facilities service delivery. To determine the impact of existing funding modalities on primary health facilities service delivery. To determine the impact of health facility committee functionality on service delivery in primary health facilities. Statistical Packages for Social Scientists was used to analyze the data (SPSS Version 28) to assess the interrelationship between the study case variables, descriptive and inferential statistics were used. In this study, multiple regressions and bivariate logistic analyses were used to analyze the relationship between the study variables. The study discovered and concluded that the amount of funds, funding modalities, and the influence of the health management committee had a significant impact on service delivery in primary health care institutions. The R value represented how the independent variables in the study influenced 56 percent of service delivery at primary health facilities. The results showed that the government health funds had a positive impact in service delivery at primary health facilities. With a significance value of 0.001 and 0.002, respectively, at a 95% level of significance, the amount of funds and funding mechanisms had the greatest impact on service delivery. Furthermore, the significant value of the health management committee's influence was 0.004. The government funding had aided health facilities in Buuri in becoming more effective and delivering services to a larger population. The study recommends that, more government funds should be allocated to aid primary health facilities, facilities should have plans in place for how they would use the allocated funds, more community involvement in the management of the facilities, more training and seminars.

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LIST OF ABBREVIATIONS AND ACRONYMS

BRAC: Bangladesh Rural Advancement Commission

CAS: Complex Adaptive Systems

HSSF Health Sector Support Fund

DFF: Direct Facility Funding

DHB: District Health Board

DHS: District Health Systems

DHMB: District Health Management Boards

HFMC: Health Facility Management Committees

KHPF: Kenya Health Policy Framework

MoH: Ministry of Health

NHSSP: National Health Sector Strategic Plan

PHC: Primary Health Care

SES: Socio-Economic Status

STATA: Software for Statistics and Data Science

WHO: World Health Organization

PSR: Public Service Reforms

MOPHS: Ministry of Public Health and Sanitation

PETS: Public Expenditure Tracking Survey

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

The most important building blocks for a healthy health system are governance and financing, according to experts (World Health Organization [WHO], 2010). Governments around the world are grappling with how to effectively fund their health-care systems. Financing of health care systems continue to pose a big challenge even in among the most developed countries. Providing proper fiscal allocation for the healthcare system, for example, continues to pique political and societal attention in the United States of America.

Many rural health facilities in America are still underfunded, despite states like Illinois voting to raise funding in order to enhance healthcare quality. A report on German health system performance shows a number of areas that are in need of improvement compared to similar developed countries (WHO, 2010). The system was determined to have a low satisfaction rate as well as difficulties with healthcare quality.

According to a report published by United States Agency for International Development (USAID, 2019). Health systems in Sub-Saharan African countries remain poor. Low per capita income, poor domestic revenue mobilization capabilities, and high disease patterns are all complicating the situation. Countries that employ only 2% of the global health workforce and spend only 1% of global health expenditures are unable to adequately respond to their health systems. Large gaps still exist between the available and the needed resources despite increased external assistance.

While the Kenyan government funding for the health sector and the ministry of health has increased in absolute terms over the last three fiscal years, the health ministry's budget as a percentage of the overall government budget remains small and fluctuates. As the ministry

took on the role of supporting the piloting of universal health care, its proportional allocation grew from 3.8 percent in FY 2017/18 to 5.1 percent in FY 2018/19.

The boost in the ministry of health proportional budget allocation, however, was only temporary, as it fell to 4.8 percent in FY 2019/20. County governments boosted their health budget allocations to 27.2 percent (or Ksh 121 billion) of total county budgets in FY 2017/18, up from 27.0 percent (or Ksh 105 billion) the previous year. Although this change reflects county governments' improved commitment to health, the allocation remains below the predicted pre-devolution levels of 35 percent. Elgeyo Marakwet, Laikipia, Kiambu, Tharaka Nithi, and Machakos were the top five counties that allocated the most money to health. Mandera, Bomet, Turkana, Tana River, and Wajir were the bottom five. However, between FY 2017/18 and FY 2018/19, 18 counties raised the percentage of their budgets dedicated to health. (Ministry of Health [MOH], 2019)

However, in order to ensure the scarce resources are properly utilized at health facilities the government seeks to engage participation of local communities who are essentially the health service consumers. Moreover, studies have shown that most communities are not aware that they have any role to play in the performance of the rural health facilities. In Kenya the requirement for public involvement in public development programs is now a constitutional requirement. The public participation aspect is regarded as a key ingredient in improving governance of public resources and service delivery.

The government initiative to introduce the Direct Facility Funding Program (also known as Health Sector Support Fund) for health facilities and the establishment of health facility management committees was aimed at improving health service delivery especially at the primary health facilities (MOH, 2019). Kenya's budget contribution to the health sector is still falling short of the government's own 15 percent target. To make the health sector a

priority, the MOH's part of the national budget should be boosted significantly from the existing 4.8 percent. The Ministry of Health and the Ministry of Finance must collaborate to improve and expand domestic funding for the health sector. Meanwhile, the Ministry of Health needs to do more to link resource allocation with policy priorities, particularly when it comes to funding critical national priority programs.

In addition, the Ministry of Health must improve its technical and advocacy efforts in order to facilitate effective budget talks during the planning and budgeting process. The system was not only inefficient but also denied health facilities operational funds.

Inadequate funding coupled with weak governance capacity adversely affected delivery of healthcare services especially at the primary health facilities where majority of Kenyan population get health services. Direct facility funding therefore envisages improved delivery of health care services that are responsive to the local needs, create sense of ownership by the local communities and increase utilization of primary health services at the primary health facilities (Ministry of Public Health & Sanitation [MOPHS], 2019).

In order to promote good governance, accountability and transparency of direct facility funding (HSSF) program emphasis has been placed on stronger community participation through the health facility management committees. Despite the implementation of a direct funding program and the formation of a Health Facility Management Committee, research reveal that complaints about the quality of health care services continue to be prevalent. This puts the direct government funding program in jeopardy, threatening primary health care facilities, which serve around 80% of Kenya's population.

In developing nations, there is a recognized need to increase the quality and utilization of services offered by public primary health care facilities. By fostering direct community engagement in health facility activities, health facility management committees are seen to

be one strategy for leveraging such health system change. HFMCs were first implemented some decades ago in many developing nation settings as part of a larger redesign of the health system based on concepts of decentralization, community engagement, and inter-sectoral collaboration. The creation of structures that are closer to service consumers, as well as the inclusion of community representatives in those institutions, would be beneficial.

Since independence in 1963 Kenya has had a predominantly tax-funded health system but the Government has kept on formulating a series of policy changes geared towards introducing different financing models. For example, 'user fee' or 'cost sharing' was introduced in 1989 but due to concerns on social justice it was abolished only to be re-introduced again in 2004 due to budgetary constraints. This model however impacted negatively on access to healthcare for citizens resulting in catastrophic out of pocket expenditure on healthcare.

According to Kimani and Maina (2015), 11.1 per cent of households in Kenya experienced catastrophic health spending up from 10.3 per cent in 2003. In 2013 the government declared free healthcare services in all primary health facilities apart from a token registration fee of ten and twenty shillings. In its place the government provided nearly USD.7 million for compensation to primary health facilities. According to the World Bank (2019), Kenya's national domestic product (GDP) was estimated at USD.98.84 in the financial year 2020. Allocations to the health sector as a percentage of the total government budget climbed from 7.8% pre-devolution in FY 2012/13 to 9.1% in FY 2019/20.

Government health spending increased somewhat as a percentage of GDP over the same time, rising from 1.9 percent to 2.2 percent. As county budgets grew over time, so did the MOH budget, which jumped by nearly 50% between FY 2017/18 and FY 2018/19, bringing total government health allocations to 9.5 percent of the entire government budget. The

increases were aided by new allocations for conditional grants to level 5 hospitals and additional financing for universal health coverage-related projects. Despite increased allocations to health system Kenya is still dependent on donors with about 57 per cent of the health development budget estimated to come from the development partners. African governments made a historic vow to contribute at least 15% of their annual budgets to the health sector. (Kagwanja et al., 2020)

The Abuja Declaration was born out of this pledge. Despite significant increases in health-related budget allocations, current trends still fall short of the government's pledged aim of dedicating 15% of the overall national budget to health, as indicated in the Abuja Declaration of 2001.They also fall short of the government's own promise to health, as outlined in the ruling Jubilee Party's Manifesto, which calls for a 12 percent reduction in health spending by FY 2018/19. (Government of Kenya [GoK], 2014)

In order for the Ministry of Health and counties to effectively carry out their health sector tasks in FY 2019/20; the Kenyan government needs to mobilize an additional 5.9% of the overall government budget. The Kenya Health Strategic Plan 2014-2018 indicates that over half of the Kenyan healthcare facilities have old infrastructure that do not meet the Ministry’s norms and standards with respect to the expected staffing, infrastructure and equipment. This has been found to compromise the quality of healthcare services.

Since the commencement of Kenya's health policy in 2014, the country's second strategic plan, 2014-2030, has been developed. By 2030, a policy that envisions Kenya as a rich nation with health levels and distribution comparable to a middle-income country. The Kenyan health policy states that the goal is to reach the maximum level of health possible in a timely way. The right to high-quality, accessible, equitable, and responsive care, as well as the right to emergency and reproductive care, is enshrined in Kenya's 2010 constitution.

According to a review of the literature, a small study evaluated the impact of direct government funding on service delivery at Meru County's basic health institutions. According to various research, many policy improvements fail due to insufficient formulation or implementation. On this basis, the researcher proposes to conduct a study to examine the influence of direct government funding, funding modalities and functionality of health facility management committees on service delivery at Meru County's primary health facilities. (GoK, 2013)

1.2 Statement of the Problem

Globally Governments are faced with the challenge of adequately funding healthcare services to improve service delivery to citizens amidst competing demands for scarce resources from other priority sectors. Tulchinsky (2014) averred that accessibility of good primary healthcare services depends not only on methods of raising funds but to a larger extent on the healthcare financing methods. Globally, however, the dwindling governments' financial allocations to health systems have had negative implications on the provision of healthcare care services. For example, in the United States of America about 83 rural hospitals closed down between 2010 and 2017 due to incapacity to provide healthcare services arising from inadequate government funding (Gilson et al., 2017). Most of the rural hospitals affected are those that had not renewed their Medicaid prescription. The situation was worsened by the Congress decision to slash budgetary allocation to public hospitals. In Australia healthcare services at state and territory public hospitals continue to experience a crisis following the government decision to reduce funding to those hospitals from 9% to 4.5%. In Zambia there was remarkable improvement in health indicators following adoption of a new model of financing health facilities WHO (2015). According to Lukwago (2016) in Uganda most primary health facilities experience shortage of drugs equipment and general

poor service delivery attributed mainly to inadequate and irregular disbursement of funds to the facilities.

In Kenya, the introduction of direct government health funds also known as Health Sector Services Fund (HSSF) initiative was to provide a direct and reliable source of funding to improve healthcare service delivery at primary health care facilities. The aim was to promote access and utilization of health care services at primary health facilities which serves about 80% of the population of Kenya. In order to enhance prudence management of the fund and achieve the intended results the fund policy integrated local communities in the fund management through the health facility management committees. This was envisaged to create a sense of ownership among communities, influence better management of the facilities and lead to improved healthcare service delivery and increase utilization of services (MOPHS, 2019).

Despite the government allocating direct financing to primary health care institutions and forming management committees to improve service delivery, concerns about the low quality of healthcare services delivered at these facilities continue to be voiced by service customers Only 22% of the beneficiary health facilities were assessed as satisfactory in the Fund's performance audit report (Kiplagat, 2015). For example, in Meru County which is among the major recipients of the government health fund due to the high number of health facilities, the County Government Development Plan (2019/20) indicates that delivery of quality health services is still facing major challenges despite the direct government health funds. This scenario is contrary to what the fund envisaged as improved delivery of health care services in primary health facilities. This scenario could lead to collapse of the direct government funding program whose objective was to improve delivery and utilization of healthcare services at primary health care facilities, and hence affect service delivery to approximately 80% of the Kenyan population who gets services from them. In Meru County,

the reported deterioration of healthcare services as reported by the County government report is likely to adversely affect patients in the rural areas of Meru who mainly receive services from the rural government health facilities. Consequently, if this scenario is not addressed it is likely to increase disease burden among the rural residents of Meru. It is not therefore clear whether the government direct funding translates into better service delivery as envisaged. This study therefore intends to unravel the influence of the government direct funding on service delivery at the primary health care facilities in Meru County. Various interacting factors could be contributing to this scenario including the amounts of funds disbursed, the existing funding modalities, functionality of health facility management committees and the oversight role of the County Health Management Teams which the study will focus on. On this basis, the researcher proposes to conduct a study to examine the influence of direct government funding, funding modalities and functionality of health facility management committees on service delivery at Meru County's primary health facilities.

1.3 Objectives of the study

1.3.1 General Objective

To explore the influence of direct government health funds on service delivery at the primary health facilities in Buuri sub-county.

1.3.2 Specific Objectives

The specific objectives that will help to achieve the study's overarching goal are as follows:

i. To determine the effect of the amount of government funds received on service delivery at Meru County's primary health facilities.

ii. To determine the influence of the funding modalities on service delivery at Meru County's primary health facilities**.**

iii. To determine the influence of health facility committee functionality on service delivery in primary health facilities**.**

1.4 Research Questions

i. What is the effect of the amount of government money received on service delivery at the primary health care facilities in Meru County?

ii. What is the influence of the funding modalities on service delivery at the primary health care facilities in Meru County?

iii. What is the influence of the functionality of facility management committees on service delivery at the primary health facilities in Meru County?

1.5 Justification of the study

The Government through the Ministry of Health has been disbursing government health funds to selected public health facilities to enable them to meet their operational costs and enhance healthcare service delivery. The Ministry also established facility management committees whose role was essentially to manage the health funds on behalf and for the benefit of local communities. However, information is scanty on the studies that have been previously carried out to determine the influence of the government health funds on service delivery at the beneficiary public health facilities. It was envisaged that the success of the government health funds system will immensely contribute to reduced pilferage of the funds and lead to more funds available to improve health care services. The success of the system will however be realized if decisions are made based on the available data on what is working and what is not working. This study is therefore imperative as it is intended to

gather data and research evidence that will reveal information on how the government health funds system is performing towards achieving its objectives. The research findings will also enable the Ministry of Health to formulate policies and guidelines that could better improve the management of direct government funding of primary health facilities programs in Kenya. The findings will also contribute to the existing knowledge in the field of Health Systems Management and also provide information that could be used to strengthen and increase the level of involvement of local communities in the management of direct government funding programs in Kenya and particularly in the County of Meru.

1.6 Limitations and Delimitation of the study

1.6.1 Limitations of the study

The respondents for this study were chosen using a purposive selection method. As a result, the information gathered reflected the opinions of the respondents.

Some respondents initially were concerned of exploitation if the information was released, and hence hesitant to share details regarding the case study. To soften the blow, the researcher assured the respondents that the research was solely for educational purposes and that any information they provided would not be exploited. The respondents were instructed on how to categorize the data they gave. They were assured that the information they submitted would only be used for educational purposes.

Some respondents were unable to complete the questionnaire due to the nature of their work at public health facilities. The researcher circumvented this by visiting the facilities at break periods i.e. lunch, tea, after the workers had concluded their regular routine. The researcher made certain that the questions in the questionnaire were straightforward and concise, thus saving them time to filling them out.

1.6.2 Delimitation of the Study

The study took place at five public primary health care facilities in Buuri Sub County, Meru County, that are funded directly by the government. The study's purpose was to see how the amount of funds available, the funding modalities, as well as the health facility management committee, affect service delivery at the facilities. Only persons above the age of 18 and those who had lived in the catchment areas for more than four years were included in the study.

1.7 Significance of the Study

This study will provide data and research evidence that will enable the Ministry of Health to formulate policies and guidelines that could better improve the management of direct government funding of primary health facilities programs in Kenya. The findings will also contribute to the existing knowledge in the field of Health Systems Management and also provide information that could be used to strengthen and increase the level of involvement of local communities in the management of direct government funding programs in Kenya and particularly in the County of Meru. In addition, the findings will also assist scholars and other research organizations to identify areas that need further research and in so doing lead to increased knowledge on the appropriate funding systems for primary health facilities.

1.8 Assumptions

The study assumed that the respondents for the interview would be available and would volunteer to provide the information sought. That the weather conditions would be conducive for the study to be conducted without hindrance. Funding would be adequate and the respondents would be honest to provide correct information with no bias regarding the study.

1.9 Operational Definition of Terms

Amount of Funds Received

This will refer to the amount of funds received by the primary health care facilities for their operational costs indicating the source of funds.

Modalities of funding:

This refers to the various existing methods being used to disburse funds to the primary health care facilities. This could affect the general operations of the health facilities.

Functionality of Health Facility Management Committees:

This refers to the management practices of the health facility management committees including administration of the bank accounts, bank signatories, withdrawal and expenditure authorization and the existing accounting processes.

Role of County Health Management Team

This refers to the supervisory and support role provided by the County Health Management Team to the primary health facilities to enhance their capacity to deliver quality healthcare services.

Type of Health Facility

This refers to the type or category of the health facility as per the official classification criteria provided by the Ministry of health.

Service Delivery

This will refer to the act of providing healthcare services to the community members accessing the health facilities seeking such services. This will include treatment services and

the related services including availability of drugs and supplies, equipment and infrastructure.

Direct Facility Funding:

The act of supporting health facilities through direct financial remittances to finance their operations. It is practiced by the Ministry of Health and targets some selected health facilities in rural Kenya.

Primary Health Care Facilities:

Public primary health facilities managed by the health facility committees and offering health care services to the local rural communities.

Health Facility Management Committee:

Committee members elected by the local communities for the purposes of administering direct facility funding in the rural health facilities

Implementation Policy:

Government official document outlining the objectives and management guidelines on the implementation of the direct facility funding program.

Establishment of HFMCS:

This will include the process of constituting a health facility management committee to manage the HSSF program at the health facilities as per policy guidelines. The process may be through democratic elections, appointment, nominations or other methods.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

The chapter discusses financing and governance in health care and their influence on performance and quality of service delivery. It also gives an overview of the health sector in Kenya then presents the origin, management frameworks and community roles in the running of the Direct Government Funding of Primary Health Facilities in Kenya.

2.2 Literature Review

The study looked at the literature on the influence of HSSF monies on service delivery. The study aims to confirm what other researchers have found about the amount of funds received, funding modalities, and the functionality of health facility management committees as influencers of service delivery in primary health care institutions. This literature was examined in order to identify the shortcomings in the written record that the current inquiry sought to fill. The survey identified existing gaps in both the setting and the system used by diverse studies. The report also looked at what different countries have done to improve their health-funding systems.

2.3 Empirical Review

2.3.1 Governance in Health Care Delivery

Governance in the healthcare delivery system has come to be regarded as an essential aspect in the quest for relevant and empirical solutions for strengthening global health systems. According to Brinkerhoff and Bossert (2008) ‘governance is about the rules that distribute roles and responsibilities among societal actors and that shape the interactions among them’ Most studies on governance are primarily dominated by international community development that conceptualizes good governance sufficient formal and technical

prescriptions geared towards better performance of public sector (Espinosa-González et al., 2019.).

However, according to Pyonen et al. (2017) in academia the conception of governance essentially focuses on the structured and systematic interactions of non-state actors for good governance. A critical aspect of strengthening health systems lies with improved governance based on the principles of representation inclusiveness and democratic mechanisms of selection and accountability. Sohani et al. (2003) demonstrated that democratically elected governing structures markedly improved the quality and sustainability of health and development initiatives. The empowerment elements include internal resources; enhance competence and ability based on training, authority to participate in decision making and responsibility for action. Kaufman et al. (2012) argues that good governance requires the effective capacity of the government to manage the societal and economic aspects of the country.

However, even though the governance responsibility is primarily vested in governments the chances of its effectiveness are limited without the synergistic relationship between all players in the health system including key stakeholders such as communities, health service providers and development partners. Maureen (2006) argues that good governance in health systems is about institutions and promoting effective delivery of health services. Many challenges are reported particularly in public health systems including procurement, distribution and general management of medical supplies and equipment.

Leakages of essential commodities along the supply chain system result in lack of drugs in health facilities, broken down equipment adversely affecting delivery of health care services. For example, a study in Nigeria (World Bank, 2004) found out that many primary health facilities were short of equipment and drugs essential to provide the basic health care

services despite the government providing finances for the facilities. Having the right governance and accountability structures coupled with managerial capacity are believed to have a stronger impact on health performance and outcomes than the funding does. (Kagwanja et al., 2020)

2.3.1 Community Role in Management of Direct Government Funds

Good governance practices promote the people's voice, social participation and accountability (WHO, 2007). Involving local health consumers in the management of health facilities makes the facility more accountable to the community and also offers the facility the opportunity to understand the community needs better (Kombe et al., 2019). The guidelines on direct government funds outline processes and procedures of utilizing the funds to enhance accountability and transparency. Communities are accorded opportunities to fully participate in the fund management to safeguard their interest. Facilities are also expected to comply with the 10/20 policy as far as possible (MOH, 2010). One of the objectives for devolving the health function in Kenya was to create an intense and robust community participation in healthcare service delivery models to ensure community specific health needs are met (Kimani & Maina, 2015).

In Ghana and Thailand for example where mechanisms for local community participation had been established there was remarkable increase in the level of positive responsiveness by the communities to the local health facilities. This in turn showed a positive impact in community participation resulting in increase of community attendance of the health facilities. This compared negatively with a similar study in Ethiopia where findings showed low community participation and responsiveness in the absence of proper mechanisms in place to engage communities in decision making.

According to the MoH National Health Sector Strategic Plan (2005-2010) the government policy recommended and encouraged an interface between the lower levels of the health system and the communities. Kenya's health sector strategy plans for 2018-2023 is a document that comes as the country prepares to establish universal health care. Leadership and governance, health workforce, service delivery, health information systems, health goods and technologies, health financing, health infrastructure, and health research and development are the eight investment areas identified in the strategic plan. Community participation is also emphasized in the Ministry of Health Strategic Plan (2014-2018) (GoK, 2013)

The KHSSP 2018-2023 lays out the eight investment areas outlined above to help achieve universal health coverage, and this necessitates a sensible approach to the development, mobilization, and use of health resources, which are relatively rare in our setting. To achieve UHC, government health financing must increase to the level specified in the Abuja Declaration of 2001, i.e., 15% of total government spending on health. It is universally acknowledged that good health outcomes are achieved when health spending accounts for at least 5% of GDP (KHSSP, 2013).

The facility staff and the Health Facility Committees are required to undergo training on the direct government funding program. Local communities are to be empowered to monitor what facilities do with funds through their committee members and through the blackboards and notice boards at the health facilities providing a public display of accounts and facility utilization. According to Mutai (2015) once the community is allowed to define its own priorities and once services are provided that supports such priorities then real ownership and commitment can be expected.

2.3.2 DFF Implementation Policy and Process

The policy on direct government funding requires that health facilities benefiting from the program have a Health Facility Committee (HFC) selected from among the community members in the catchment area (MOH, 2010). The committee's role is to oversee the operation and management of the facility and represent the community interests, facilitate feedback to the community, implement community decisions and mobilize community resources.

The Sub County Health Management Teams are responsible for program implementation in the Sub Counties and the County Health Management Teams at Counties. The officer in charge of health services in the Sub County is responsible for the overall supervision including the approval of work plans, which is a requirement for the disbursement of funds. At the facility level HFCs are expected to be involved in the planning for and utilization of the funds and prepares work plans giving quarterly budgets per expenditure item and an explanation of the purpose (Aga Khan Health Services, 2005).

2.3.3 Community Accountability in Health Care Governance

Meessen et al. (2006) defines community accountability as 'an approach towards building accountability that relies on civic engagement in which it is ordinary citizens who participates directly or indirectly in exacting accountability'. For many years the word 'accountability' was used mainly in connection with the relationship between organizations and donors. However, with time the focus on accountability is also beginning to move towards the relationship between the organization and people it serves (Meessen et al., 2006). This means that organizations take account of the needs, concerns and potential of community members and gives the account of their actions and decisions to them.

Public accountability has re-emerged as a top priority for health systems all over the world. Issues and concerns related to community accountability are found in health systems all over the world over. However, there are particular problems in developing countries where governments have often failed to provide adequate public sector services for their citizens. This explains why there has been demand and increased emphasis on direct public engagement in health delivery especially in the developing countries.

According to the (World Bank, 2019) strengthening community accountability is promoted as a right in itself and to enhance quality of care, appropriateness of health service delivery for users and patient satisfaction and utilization. Good governance needs to be transparent so that people are clear how decisions are made and what evidence and justifications are used to inform the decision-making process. Good community governance is a process that is totally bound up with engagement of residents.

Communities need to be provided with opportunities both to be involved with decision-making processes in a range of ways i.e. from being informed of decisions, to being consulted to actually helping to make decisions. Strong community engagement processes are vital in offering local people information and involvement in making decisions for their local areas. Citizens can contribute to strengthening governance and the quality-of-service delivery through voice and client. According to World Bank, (2011) increasing citizens' voice makes institutions more responsible to citizens' needs and demands and thereby more accountable for their actions.

2.3.2 Performance in Health Care Service Delivery

Measuring performance of healthcare service delivery is critical to establishing benchmarks for efficiency, comparing performances across time and assessing effectiveness of health expenditures. According to Maureen (2006) accountability in health expenditure hinges on

having adequate information about performance in health service delivery meaning having reliable indicators that assist policy makers and providers to improve service delivery.

Many health system performance problems like absenteeism, under performance and mediocre quality of service often emanates from weak governance systems that fail to record good performance and discipline among health workers. In their study Demirel et al. (2009) found a positive and significant relationship between customer's perception of service quality and their willingness to recommend the company to other customers. Kombe et al. (2019) found out that providing quality service has a significant impact on customer satisfaction and customer retention respectively.

Workers in Benin emphasized the importance of 'the ability to perform one's work' by having the necessary resources combined with training and supervision (Mathauer & Imhoff, 2006). According to a similar survey conducted in Zimbabwe, the primary reason stated by health workers for leaving the industry was a shortage of equipment and medical supplies, as well as an undesirable working environment. A suitable working environment with medical supplies and pharmaceuticals was also cited by Ethiopian health workers as one of the most important aspects in improving performance (Lindelow et al., 2005).

Hyun et al, (2015) conducted a study on health financing on the performance of health care in Tokyo, Japan. According to the study, the way a country finances its health care system is a key determinant of the health of its citizenry. Selection of an adequate and efficient method(s) of financing in addition to organizational delivery structure for health services is essential if a country is set to achieve its national health objective of providing health for all. Health care in Japan is financed by tax revenue, out-of-pocket payments, donor funding, and health insurance (social and community). However, achieving a successful health care financing system continues to be a challenge in Japan. The study examined the different

financing mechanisms that have been used in Japan, including the National Primary Health Care Development Fund proposed for increasing the resource allocation to primary health care. The study concluded by recommending the need for Japan to explore and strengthen other mechanisms of the health system and shift focus from out-of-pocket payments, address the issues that have undermined public health care financing in Japan, improve on evidence-based planning, and prompt implementation of the National Health Bill when signed into law.

2.3.2 Health Sector Services Fund at Health Facility Level

On the one hand, the HSSF was formed as an innovative direct transfer of funding to dispensaries and health centers through a ministerial policy contained in Legal Notice No. 401. The finances come from the government, grants or donations from development partners, cost-sharing revenue, and any money created by the fund's activities, according to the legal notice.

The fund is now housed in the MOPHS and is intended to fund all public dispensaries and health centers' activities. That is, allocating funds to implement each facility's Annual Operational Plan (AOP), which addresses preventative, promotive, and curative services at various levels.

The 2007 Public Expenditure Tracking Survey (PETS) indicated that only 67% of allocations as per Authorities to Incur Expenditure (AIE) were actually received at district levels, and that the receipt of AIEs was often delayed (MOH, 2010). The survey also indicated that bureaucratic and liquidity problems at the District Treasuries made it difficult for the peripheral facilities to access the funds.

The survey found that the majority of these funds was utilized at the district levels leaving the peripheral facilities with no or little operating funds. The abolition of the cost sharing

had reduced drastically the capacity of health facilities to meet operational costs and purchase of essential resources (Pearson, 2005). In addition, facility-level resource constraints and a lack of clarity around the user fee levels appeared to be undermining relationships with communities (Molyneux et al., 2021).

In order to mitigate the financial constraints in these health facilities the Ministry of Health with assistance from the Danish International Development Agency (DANIDA) decided to fill the gap of reduced facility funds by piloting an innovative system of direct facility funding (DFF) of rural health facilities. All facilities belonging to the MOH were entitled to receive funds as long as the District Medical Officer of Health (DMOH) could ensure adequate supervision by qualified staff (Boga et al., 2011).

HSSF is a revolving fund that provides direct cash transfer to primary healthcare facilities that include tiers two and three. The fund is managed by the local communities represented by the Facility Management Committees and prioritizes its use depending on their health needs. Muoko and Baker, 2014 avers that the fund endeavors to involve and empower the communities to take charge of their own health by ensuring their active participation in identifying their priorities through the facility management committees. Moreover, in order to provide effective healthcare services that are inclusive and right based on reliable funds for maintenance of the health facilities is one of the key imperatives (Mwangi, 2013).

The primary objective of the HSSF is to give funds for operations to dispensaries and health centers directly at the point of usage. Prior to this strategy, only around half of the targeted funds (Level 2 and 3 facilities, respectively) could reach these facilities. This was due to a number of circumstances, including delays in receiving funding from the Ministry of Finance or the Ministry of Health, shortages in quarterly allocations, MOH financial issues, and inability to follow government accounting processes.

Kiplagat (2015) study on determinants of health insurance choice in Kenya conducted in Kenyatta National Hospital targeting the senior managers. Findings show that, based on the principle of individual responsibility and affordability Kenya has developed a unique healthcare model that has produced outstanding health outcomes per dollar spent. Available data shows that healthcare financing in Kenya is nevertheless highly dependent on individual income levels despite the presence of substantial government subsidies. Moreover, the key medical care instruments, NHIF and government subsidies, are heavily biased towards inpatient treatment and there is little cover for expensive outpatient treatments.

2.3.4 Health facility management committee

Community involvement in health facilities is a technique for increasing service quality and utilization: it should improve facility management' responsiveness to local needs and community members' awareness of available care. Community engagement programs in Kenya have included community people serving on Health Facility Management Committees.

Previously, facility committees were responsible for overseeing the operations and management of health facilities as well as user fees; however, their responsibilities were expanded to include managing facility budgets given from the Health Sector Services Fund (HSSF).

The health facilities management committee's roles and responsibilities include supervising and controlling the administration of funds granted to the facilities. Open and operate a bank account at a bank that has been approved. Prepare work plans based on projected costs. Manage the facility's income, expenditures, assets, and liabilities as directed by the official in charge of the Fund. Handle the maintenance of a permanent record of all its discussions by preparing and submitting certified periodic financial and performance reports as required.

After a year of implementation, in 2012, most institutions had a fully constituted committee that met at least once a quarter. Most institutions also reported executive committee meetings on a monthly basis. Strict control of centrally allocated HSSF funds and user fees at the district and national levels was considered to have led to transparency and confidence between management committees and in-charges, who had typically positive and supportive relationships.

2.3 Theoretical Review

The following hypotheses were used in this study to support the researcher's main goal. The system theory and the structural-functional theory will be included in the research.

2.4.1 The System Theory

The study was based on the systems theory which essentially interprets the interacting relations among the different subsystems. The systems theory was first fronted by Von Bertalanffy in 1956 and has since come to be dominant organizational theories in management. According to viable system theory (Christopher, 2007) a competitive firm behavior is linked to its ability to identify and manage its functions and relationships, eventually forming communication channels, information flow and harmonizing its development to its external relationships The theory holds that each part of the system is functional for the stability of the whole system. This implies that if one part of the system is not working or is dysfunctional it affects all other parts and creates system problems leading to the malfunction of the whole.

The study looked at the government funding of the primary health facilities as inputs with the governance of Facility Committees as process and service delivery performance as the output. In this study, the success of the direct government funding program in primary health facilities of Buuri Sub County, Meru County, would depend on the funds disbursed, funding

modalities, functionality of the health facility management committees. All these factors have a unique role to play and the combined or individual contribution affect service delivery and the success of the program at primary health facilities in Buuri Sub County, Meru County.

2.4.2 The Structural-Functional Theory

The idea, also known as functionalism, views society as a system of interconnected pieces designed to suit the biological and social requirements of its members. Spencer 1820–1903, an English philosopher and biologist, saw parallels between society and the human body in his writings, and argued that, just as the various organs of the body work together to keep the body functioning, the various parts of society work together to keep society functioning as well (Von- Bertalanffy, 1968). The social institutions, or patterns of beliefs and actions focused on addressing social needs, that Spencer was referring to were government, education, family, healthcare, religion, and the economy.

One of the series "policy briefs" prepared by the Aga Khan Health Service's Community Health Department in Kenya. It focuses on a number of issues related to health facility management, including the rationale for decentralization of health services, the role of the community in health facility management, membership of local management committees, selection criteria and the involvement of local politicians. This is an excellent illustration of how functionalism theory was applied to ensure proper disbursement and distribution of HSSF money inside primary health care facilities. The health management committee is an important aspect in gaining access to, managing, and using funds within the health facilities to improve delivery of service to community members.

2.4 Conceptual Framework of the Study

The variables in the conceptual framework are classified as independent variables i.e., amount of funds received by the primary health care facilities, modalities of funding at the primary health facilities and functionality of the facility management committees. The dependent variable will be service delivery. The researcher conceptualizes that the service delivery in primary health care facilities in Meru County is influenced by direct government funding.

Figure 2. 1

Conceptual Framework

Independent Variables

Dependent variable

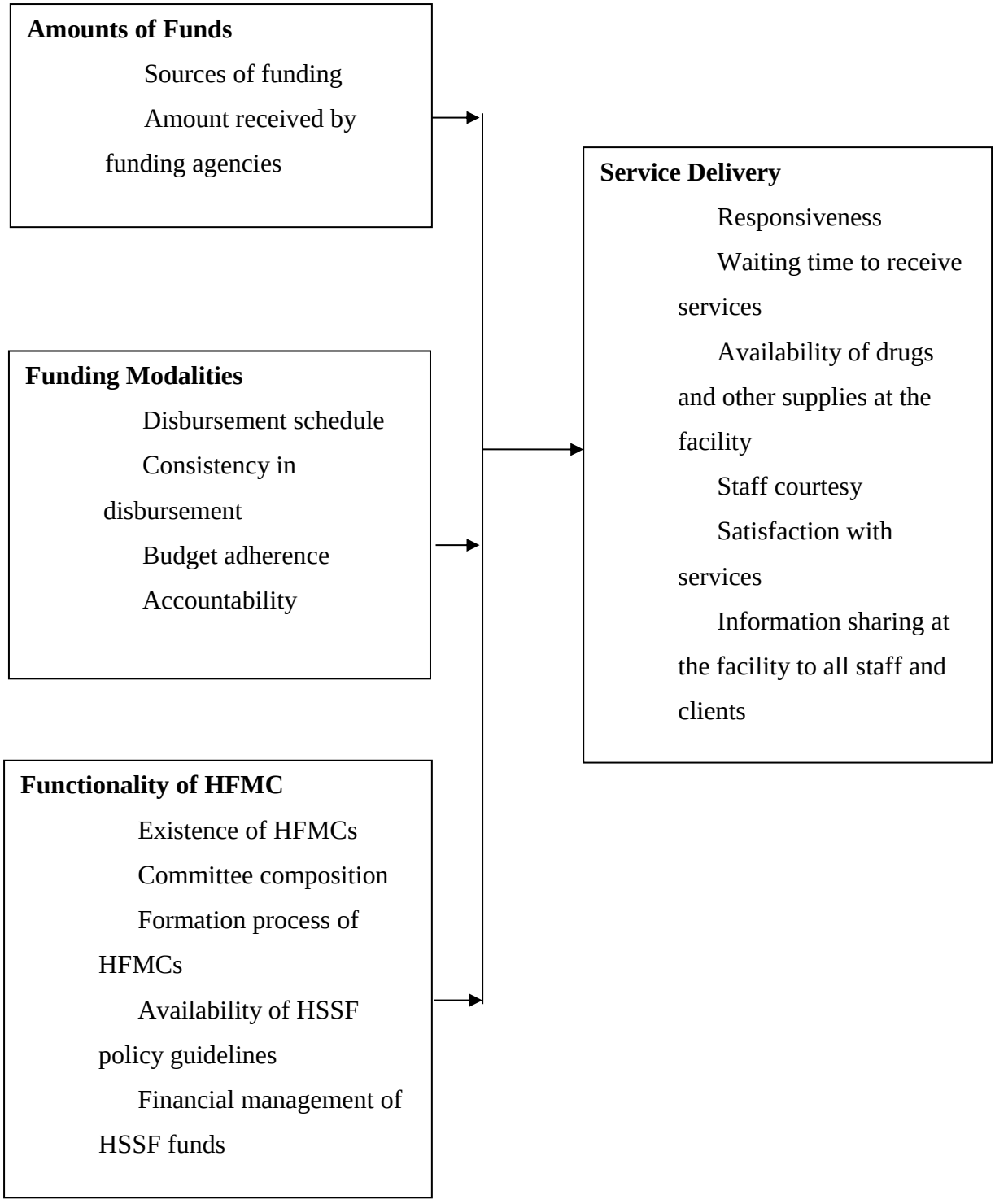


Table 2. 1

Information Methods to be used to answer the specific objectives

Objective	Indicators and Information required	Data collection Methods
To determine the impact of the amount of funds received on service delivery at Meru County's primary health facilities.	Sources of funding Amount of funds received by funding agencies	Open and closed ended questionnaires and FGD guides
To determine the impact of the existing funding modalities on service delivery at Meru County's primary health facilities	Disbursement schedule Consistency in disbursement Budget adherence Accountability	Open and closed ended questionnaires and FGD guides
To determine the impact of health facility committee functionality on service delivery in primary health facilities	Existence of HFMCs Committee composition Formation process of HFMC Availability of HSSF policy guidelines Financial management of HSSF funds (meetings, administration of bank accounts, work plans)	Open and closed ended questionnaires and FGD guides
Service delivery	Responsiveness Waiting time Availability of drugs and other supplies Staff courtesy Satisfaction with services Information sharing at the facility	Open and closed ended questionnaires and FGD guides

2.5 Summary and Research gaps

The chapter presented information on the status of financing health systems with global perspective, governance and service delivery. It also gives historical and current status of the health system in Kenya and also sheds light on the history of the Direct Government Funding Program in Kenya. It also presents information on the implementation policy of the program and the community role in its implementation process. As well as the Health Sector

Service Funds current status within the facilities and the functionality and role of health facility management committees within the facilities.

Health facility management committees were previously responsible for monitoring health facility operations and management, as well as user fees; however, in 2010, their responsibilities were expanded to include managing facility budgets provided by the Health Sector Services Fund (HSSF). The functions and responsibilities of the health facilities management committee include supervising and controlling the administration of funds allocated to the primary health facilities. Open a bank account at a bank that has been approved and use it. Prepare work schedules based on budget estimates. As directed by the Fund's official in charge, manage the facility's revenue, expenditures, assets, and liabilities. Organize the upkeep of the facilities by preparing and submitting financials as well as performance reports.

The HSSF fund provides direct financial transfers to tiers two and three primary healthcare facilities. The funds are handled by Facility Management Committees, who represent local communities and prioritize its use based on the requirements of basic health care facilities. The fund aims to engage and empower communities to take care of their own health by assuring their active involvement in the facility management committees in determining their priorities. Furthermore, one of the most important requirements for providing effective, inclusive, and right-based healthcare services is the availability of sustainable funds for the upkeep of health facilities.

The HSSF's major aim is to provide funds for operations to dispensaries and health centers just where they are needed. Only around half of the targeted funds (Tier 2 and Tier 3 facilities, respectively) could reach these facilities prior to this plan. This was due to a variety of factors, including delays in getting funding from the Ministry of Finance or the Ministry

of Health, deficits in quarterly allocations, financial issues with the Ministry of Health, and an inability to follow official accounting procedures.

The research gets to explore the health facility management committee functionality, performance and impact on delivery of service within the primary health facilities. If the HFMCs are operating and performing as expected in accordance with government rules and their obligations, and what could be done to assist them in improve.

The study aims to discover any gaps in the provision of funds, fund accessibility, fund disbursement, consistency in disbursement, accountability, funds utilization, and whether the funds are sufficient.

However, the impact of direct government funding to primary health care facilities on service delivery, functioning, and performance of HFMCs in Meru County has yet to be investigated, resulting in a knowledge gap that this study aims to fill.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter discusses the research methods that were used to conduct this study. The chapter is structured into research design, study variables, study area, inclusion and exclusion criteria, sampling procedure, sample size determination, reliability of study instruments, data validity, data collection techniques, data analysis and presentation, ethical considerations and data management.

3.2 Research Design

The study used a descriptive cross-sectional study design to collect qualitative and quantitative data on service delivery in order to satisfy the specific objectives and to help solve the three research questions. This design permits data to be collected from respondents in specified health facilities once at a predetermined moment in time, with the predicted measure of effect being percentages and proportions. According to Kothari and Gaurav (2014) the study design is a scheme and blueprint for arriving at a response to the problem statement.

The rationale for the adoption of this approach was based on the ability of the design to capture information based on data collected in a single point in time which can help to prove and/or disprove assumptions on financing factors affecting performance of primary health care facilities in Buuri Sub County. The approach is not costly to perform and does not require a lot of time.

The independent variables included the amount of funds received, funding modalities, functionality of health facility management committees. The dependent variable was service delivery at the primary health facilities which included responsiveness, waiting time,

availability of drugs and supplies, staff courtesy, client satisfaction, and information sharing. The study utilized questionnaires for data collection.

3.3 Study Variables

The dependent variable for this study was service delivery in terms of responsiveness, waiting time to receive services, availability of drugs and other supplies at the facility, staff courtesy, satisfaction with services by clients and information sharing at the facility to all staff and clients. The independent variables were the amount of funds received by health facilities, modalities of funding the health facilities, functionality of health facility management committees, role of county health management committee and type of health facility.

3.4 Location and Description of the Study Area

The study was carried out in Buuri Sub County of Meru County in the Republic of Kenya. Buuri Sub County lies at the extreme end of North West of Meru County. It borders Laikipia County in the North, Isiolo County in the East; Mt. Kenya in the West, and in the Southern part it borders Meru North Sub County. The Sub County has a high number of health facilities that were put up through the community initiative. The facilities were therefore expected to exhibit strong community ownership and active participation in their management. This formed the basis for the selection of Sub County as the study area. The study therefore sought to determine the effect of the government health funds on service delivery at the beneficiary public health facilities in Buuri sub county of Meru County.

3.5 Target Population

The study targeted the two categories of population who have a stake in matters pertaining to service provision, management and receiving of the services in the primary health care facilities. The service providers targeted health care workers that included nurses, clinical

officers and public health officers (three per health facility all totaling to 15 in number) since these are officers expected to always be available and working at that level. The other category of population that was targeted were the dispensary and health Centre management committees (three per health facility management committee all totaling to 15 in number) where the targeted respondents were the chairman, secretary and treasurer and one community health representative as these are the persons expected to be having credible information in regard to the financial and operation of the health facilities. Targeting health workers and health facility management committee members was justified by the fact that they are directly involved in the primary health care service provision. Moreover, they are the principal controllers of the facilities affairs and their duties include ensuring that the facilities have adequate requirements for good performance in provision of quality primary health care. The respondents interviewed were both male and female of above the age of 18 years who live within the catchment area of the health facilities. The respondents should have served within the primary facility for at least 4 years which is the duration the HSSF program became operational. The distribution is as shown in Table below.

Table 3.1

Target Population

Sub-County	**Health Workers**	**HF Management Committee Members**	**Total**
Kirua HC	32	9	41
Mboroga HC	30	9	39
Ontilili Dispensary	7	6	13
Ntirimiti Dispensary	6	6	12
Gundua Dispensary	6	6	12
Total	**72**	**36**	**117**

Source: Meru County Human Resource Records (2020)

3.6 Inclusion and Exclusion Criteria

3.6.1 Inclusion Criteria

All health care workers attached to the selected health facilities and facility management committee members in the health facilities and willing to participate in providing required information. They must have been attached to the facilities for more than six months and willing to participate in the study.

3.6.1 Exclusion Criteria

Persons present at the health facilities who were not health care workers or members of the health management committee were excluded from the study. Health care workers and management committee members who had worked at the facility for six months or more and were not available during the time of administering the questionnaire were excluded. It also excluded health workers and health management committee members who had not worked at the facility for the previous 6 months. The study also excluded non-consenting health care workers or health management committee members.

3.7 Sampling Procedure and Sample Size Determination

3.7.1 Sampling Procedure

To create the sampling frame for the study, the researcher employed a list of all tier two and three primary health care facilities. The researcher then used a simple random sampling method to first select the health facilities to provide respondents for the survey. The researcher then employed a simple random sample procedure to choose the health institutions that would produce survey responses. The researchers then used a purposive sampling technique to select a representative sample of each of the targeted respondents, which included members of the management committee, such as the chairman, secretary,

and community representative, as well as health workers, such as clinical officers, nurses, and public health officers.

3.7.1 Sample size determination

The study sample frame was made up of a list of all health facilities in the study area that received direct government financing. Since the study area, Buuri Sub-County of Meru County has few primary health care facilities, it was convenient to register all the facilities as the sample size (census). Facility management committees for health centers must have nine members, six for dispensaries, according to HSSF policy. As a result, three facility committee members were chosen for interview in each institution: the chairman, secretary, and community representative.

However, to determine the minimum sample size, the study adopted the statistical formula for a single mean as described (Kirkwood, & Jonathan 2017).

$$\mathbf{n = a^2/e}$$

Where:

n denotes sample size

a denotes standard deviation where for this study it was set at 0.5

e denotes required size of standard error where for this study it was set at 0.05 which is the level of significance

$$\mathbf{n = (0.5 \times 0.5)/0.05 = 5}$$

That implies a minimum sample size of 5 per health facility and since 5 facilities were required, a minimum sample size of 25 was arrived at. Practically, the sample size was raised to 30 because there was a need to interview 3 health workers per facility making a total of

15 health workers and 3 health facility committee members per facility making a total of 15 facility health committee members.

3.8 Research Instruments

The study used pre-tested semi-structured questionnaires to collect data from the health workers and health facility management committee members (Appendix B and C). The questionnaire was used because of its economy, as it ensures anonymity, permits use of the standardized questions and has uniform procedures, provides time for subjects to think about responses and it is easy to score. The questionnaires were made up of closed ended and open-ended questions to avoid being too rigid and quantify data especially where structured items were used (Kothari & Gaurav, 2014). This method aided the study to collect enough information, which otherwise would have been impossible by using interviews and observations. Data on the funds received and their sources, services provided and the disease patterns were also captured. The question items of the research instruments were to answer research questions of the study.

3.9 Pre-test Study

The study conducted a field test using respondents that were not included in the pilot study to test whether or not the questions were easily understood. These respondents were demographically and culturally similar to the respondents for refinement and validation. The researcher strived to administer questionnaires to a population equivalent to 10% of the study sample size in the neighboring North Imenti Sub-County which had similar demographic characteristics as Buuri sub-County. The purpose of the pilot study was to measure how relevant the questions were and the return rate. The pilot study also made it possible for the researcher to understand the applicability of the views and opinions of the targeted respondents in answering the main research questions.

3.10 Reliability of the Study Instrument

According to Mugenda and Mugenda (2003), reliability refers to a measure's consistency in producing almost similar result on different but comparable occasions. Cronbach Alfa Measure of reliability was used to determine the degree of the study instrument's reliability. The reliability was able to indicate the accuracy or precision of the measuring instrument. It helped in answering questions such as: does the questionnaire measure consistently what it is expected to measure?

3.11 Data Validity

The validity of the questionnaires was examined by interviewing people after they had completed the questionnaires to find whether or not the responses they had given concurred with their actual opinions. The questions in the interview were worded differently from those in the questionnaires.

3.12 Data Collection Techniques

Both primary and secondary data was collected for this study. Secondary data was collected through the review of existing relevant records at the health facilities including audited books of accounts, patient attendance records, minutes of Health Facility Committees and any other relevant material on the HSSF at the health facilities. The questionnaires were self-administered to the sample participants using drop and pick method. Each participant was given a questionnaire at their respective health facility. The researcher assistant went round the health facilities in the sub county talking to various health workers and facility management committee members. Clear information about the research was given to allow them to make informed decisions regarding their participation in the study. Those who agreed and consented to participate in the study were given the questionnaire to fill and hand

back to the research assistant. This process was repeated until the sample size of each group was obtained.

3.13 Data Analysis and Presentation

The researcher checked for the completeness of the questionnaires immediately after they were returned. The excel software was used to capture and store the raw data from the questionnaires. Data from the two sample groups, health workers and health facility management committee members were stored separately and treated independently throughout the process of analysis.

The raw data was then cleaned and coded for ease of analysis. Thereafter, the cleaned data was exported to the Statistical Package for Social Sciences (SPSS) version 22 for analysis. Data collected was analyzed using both quantitative and qualitative methods. Qualitative data was derived from the open-ended questions in the questionnaire. The responses were assessed thoroughly and organized into various categories, distinct from each other and the relationship among the identified categories established. Once the themes, categories and patterns were identified, narratives were developed, frequencies and percentages used to summarize the data.

Quantitative data was analyzed using both descriptive and inferential statistics. Frequencies, percentages, mean and standard deviation were used to summarize the responses of the Likert-type questions and results were presented using tables. In addition, the multiple regression model, at significance level of 0.05, was used to assess the predictive influence of direct government funding on the performance of service delivery of health facilities in Buuri sub county. The data was analyzed, interpreted and a report compiled from the findings. The findings were presented in the form of text, tables, charts and graphs.

3.14 Ethical considerations and data management.

Ethical approval was sought from the Scientific, Ethics and Research Committee of Kenya Methodist University. A research permit was sought from the National Council for Technology, Science and Innovation (NASCOTI), County health office and health facilities levels. Verbal informed and written consent was obtained from all respondents and the study purpose explained to them, while observing confidentiality of the information collected. Names were not stored with data records and where incriminating information is provided appropriate measures were taken to protect both the incriminated and the respondent. All the data was treated with confidentiality where necessary. The filled questionnaires were scanned and stored in indelible format to retain their integrity and reliability. Clearance was sought from the Ministry of Health. In order to ensure confidentiality, names and addresses were not used in the data collection and analysis and only permitted photographs where necessary to be taken. Names were not stored with data records and where incriminating information was provided appropriate measures were taken to protect both the incriminated and the respondent.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 Introduction

This chapter examines the study findings and analyses for government-funded facilities depending on the research objectives. The information was gathered from five primary health care facilities in Meru County that receive HSSF from the government as well as any other financial sources. Three health workers and three members of the facility management committee were questioned in each facility. The total population was 30 respondents, with 15 comprising health workers, 15 comprising facility management committee members. The analysis will focus on the health workers and management committee for the objectives of this study.

4.2 General Statistics and Interpretation

SPSS statistics software was used to conduct the analysis. In order to conduct this study, descriptive statistics (mode, mean, median, and frequencies were used to describe categorical and continuous variables, respectively) and inferential statistics were used for correlation testing and regression analysis. Tables, pie charts, and bar charts were used to illustrate the proportions.

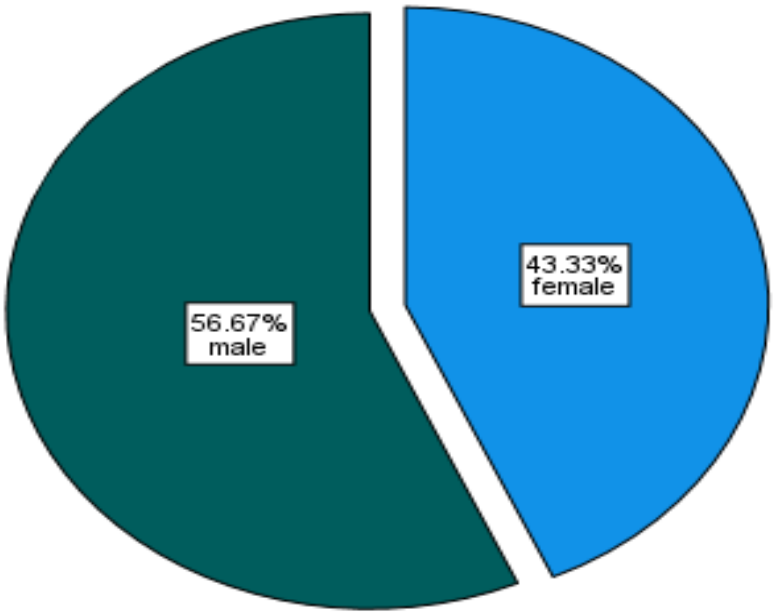
4.3 Demographic Information

4.3.1 Respondents' gender

As shown in the graph below, the gender breakdown of the correspondents was as follows:

Figure 4.1

Respondents' gender distribution



According to the data, males accounted for 57 percent of respondents, while females represented 43 percent of both health workers and committee members. Findings showed, males made up the majority of personnel within the health facilities at the time of the case study. Furthermore, the result shows that the workforce recruitment strategy is geared toward securing a male-dominated workforce.

Table: 4.1

Marital status distribution

Marital Status	Frequency (N)	Percentage (%)
Married	26	87
Single	3	10
Widowed	1	3
Total	30	100.0

According to the table above, 87 percent of respondents were married, 10 percent were single, and 3 percent were widowed. As a result, the vast majority of respondents have families.

4.3.1 Respondents' age

The age distribution of the respondents within the study case region was also relevant because it contributed to the collecting of background information. The table below depicts the age distribution of respondents across all health facilities using frequency and percentages.

Table 4. 2

Respondents age distribution

Age	Frequency (N)	Percentage (%)
21-30 years	1	3
31-40 years	12	40
41-50 years	6	20
51 years and above	11	37
Total	30	100.0

As illustrated from the table above, the majority of the correspondents are between the ages of 31-40 years at 40%, followed by ages between 51 years and above at 37%, the rest were 41-50 years at 20% and finally 21-30 years at only 3%. This shows that the largest age group of respondents were adults ranging from the ages between 31 years and above only a small number were below 30 years that is 3%.

4.3.2 Respondents' position in the committee

The table below indicates the positions held by the facility management committee within the facilities;

Table 4. 3

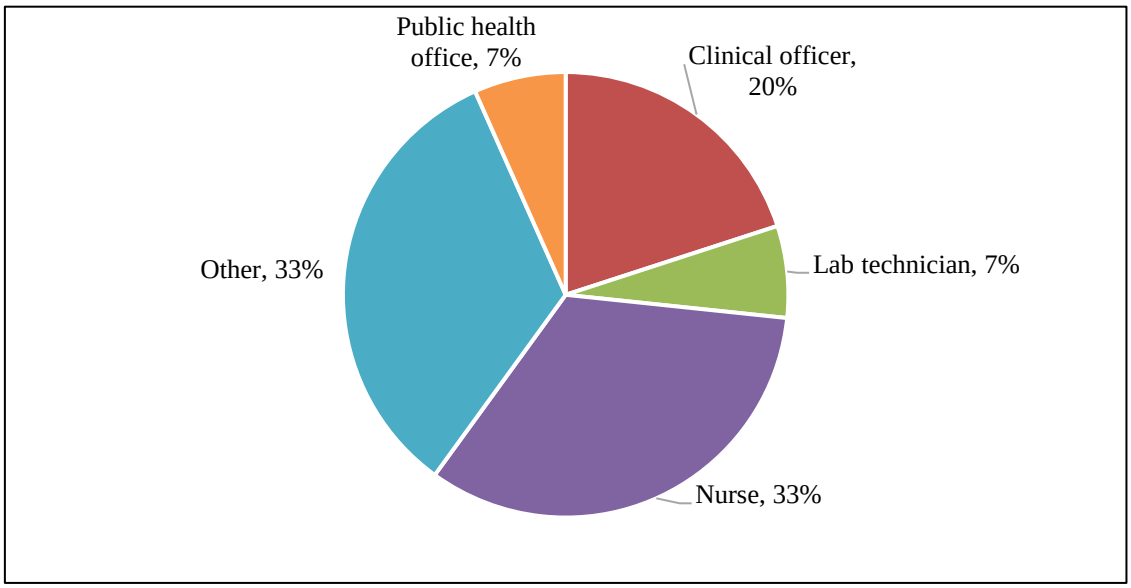
Health Facility Management Committee Position

Position	Frequency (N)	Percentage (%)
Chairman	4	27
Secretary	5	33
Community Representative	6	40
Total	15	100.0

As illustrated from the table above, the largest composition of the management committee was held by the community representatives at 40%, secretary position came in at 33% and chairman was 27%. This further shows that the community was involved in the composition of the committee and they have direct input in the management of the health as well as facility funds.

Figure 4. 2

Professional qualifications



The figure above shows the different professional composition of the facility management committees. Nurses made up 33% of the health workers and the health facility management committee, while other professional credentials made up 33%. (i.e. businessman, farmer, retired teacher, teacher). Clinical officer at 20%, lab technician at 7%, and public health officer at 7% were the other professional qualifications. According to the findings, the majority of the respondents had completed their schooling and possessed the necessary professional qualifications for their employment, indicating that they were qualified to respond to the surveys.

4.3.1 Health Facilities

The primary health facilities where the case study took place are listed in the table below. There was a total of five facilities, three of which were health centers and two of which were dispensaries. As stated, they are entirely owned by the Kenyan government.

Table 4. 4

Health facility levels and ownership

Health Facility Name	Facility Level	Ownership
Kiirua	Health centre	GoK
Mboroga	Health centre	GoK
Ontilili	Dispensary	Gok
Ntirimiti	Dispensary	GoK
Gundua	Health centre	GoK

4.3.2 Respondents' duration of service

For the case study, people who have lived and worked at the facility for more than six months were chosen. This was an important part of the researcher's section because it implied that the respondents knew a lot more about how the facilities were run.

4.4 Amount of funds

The purpose of the study was to determine the extent to which the quantity of funding has an impact on the delivery of services within health institutions in order to meet the objectives. The study examined the amount of funds received, the various sources of financing available, the impact of funds received by facilities, and the adequacy of funds for service delivery.

4.4.1 Sources of funding

The researcher sort to find out if the main source of funding was HSSF and if the facilities had other sources of funding available for proper functioning of facilities and adequate delivery of services. The study indicated that 100% of the respondents, their main source of funding from all the facilities came from HSSF which helped sufficient majority of the

expenditure within the facilities, although they had other sources of funding i.e service charge from the services they offered within the facilities.

4.4.1 Funds received

The study required to establish the extent of funds received by the facilities from HSSF and other sources of funding. A descriptive analysis was conducted to the different sources of funding using mean, median, standard deviation. The results indicated the amount received in the last two years as shown in the table below;

Table 4.5

Descriptive statistics for amount of funds

Source of Funds	Frequency (N)	Minimum	Maximum	Mean	Std. Deviation
HSSF	30	300,000	2,893,711	1,075,373.30	939,746.333
Alternative Funds A (service charge)	30	114,000	486911	284,458.73	125,745.897
Alternative Funds B (sponsors, harambees)	6	1,260,100	1,260,100	1,260,100	0

The results indicated that the minimum amount of funds received from the HSSF funds was Kshs. 300,000 with a maximum of Kshs. 2,893,711. The mean total amount received in from HSSF funds in the last two years within the facilities stood at Kshs. 1,075,373.30 with a standard deviation of Kshs. 939,746.333. The service charge amount received ranged with a minimum (Kshs. 114,000), maximun (Kshs. 486,911), mean (Kshs. 284,458.73) and standard deviation (Kshs. 125,745). Not every facility received an alternative funds from sponsors and harambees, the study showed only (N = 6) received the extra funds with minimum, maximum, mean of Kshs. 1,260,100. The study shows all the facilities were receiving regular HSSF funds for the last two years and also accumulating funds from the service charge and other sources.

4.4.1 Effects of funds on service delivery.

The study sought to know whether the funds were received regularly as scheduled but it seemed there were delays as the majority of the respondents (97%) showed that the funds are not received as regularly as expected with 3% responding that they are received a s expected. The frequency results are represented in the table below.

Table 4.6

HSSF funds received regularly frequency table

	Frequency (N)	**Percentage (%)**
YES	1	3
NO	29	97
Total	30	100.0

According to the study, the HSSF funds should be disbursed on a regular basis, but this does not appear to be the case; the majority of respondents reported that the funds are not received as regularly as they should, and only a small percentage reported that the funds are disbursed on time. This is in violation of the government's disbursement standards and policies.

Table 4. 7

Effects of delay of funds on service delivery

	Frequency (N)	**Percentage (%)**
YES	30	100
NO	0	0
Total	30	100.0

The findings revealed that delays in receiving funding had an impact on service delivery, with the vast majority of respondents (100%) agreeing that it did. This has an impact on responsiveness, wait times for services, medicine and other supply availability within the facilities, and satisfaction times. As shown in the above table.

Table 4.8

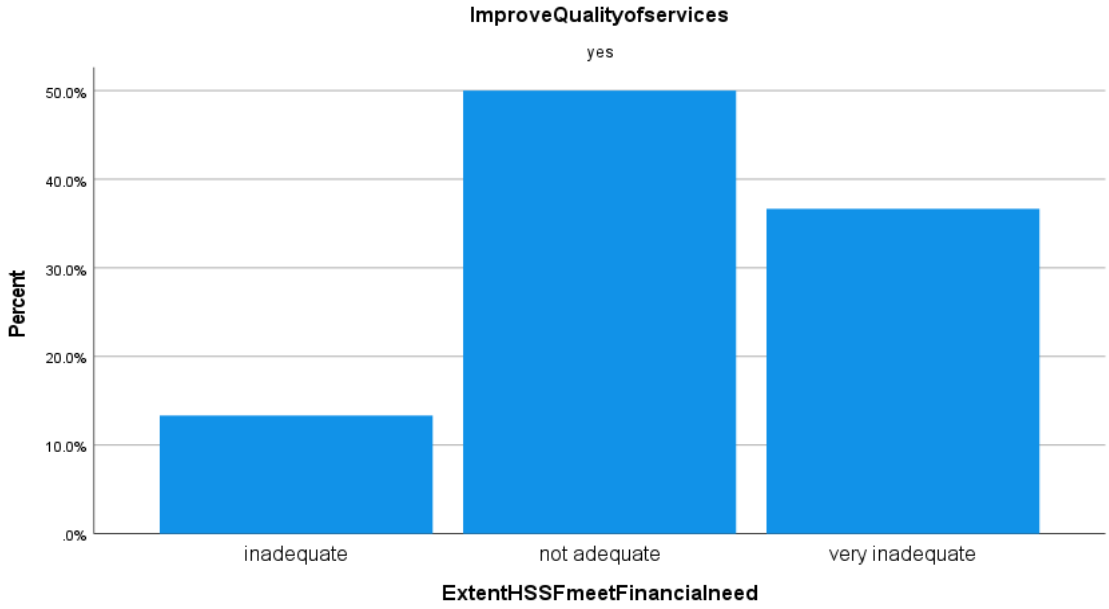
Satisfaction with HSSF funds

Satisfaction Levels	Frequency (N)	Percentage (%)
	1	3
Satisfactory	14	47
Unsatisfactory	13	43
Very Satisfactory	2	7
Total	30	100.0

According to the findings, 47 percent of respondents are satisfied with the present HSSF funds received, while 43 percent are dissatisfied and 7% are extremely dissatisfied. Despite a few expressing otherwise, the majority reported that the general rate of service delivery was good, and the majority were satisfied with the HSSF funding received, showing that the funds have helped improve the delivery of service within the facilities.

Figure 4.4

Effect of HSSF funds on quality of service



All of the facility responders (100%) agreed that the HSSF had contributed to improving the quality of service at their respective facilities. Further research revealed that the health workers and committee management believed the HSSF funds were insufficient to meet the facility's budgetary demands.

4.5 Funding Modalities

The purpose of the study was to determine the extent to which current funding methods influence the delivery of services within primary health facilities in relation to the objectives. The findings examined present funding methods, disbursement schedules, disbursement consistency, budget adherence, and accountability.

4.5.1 Existing funding modalities

At the facility level, the data shows the type of facility, the source of funding methods, such as whether it is government sponsored or funded by other sources, as well as ownership. Except for Gundua, which reported that they also receive funds from sponsors, all five GoK

facilities indicated that their main source of funding was HSSF and their second source of revenue was from service charges.

Table 4.9

The Selected Health Facilities for sampling in Meru County

Health Facility	Facility Level	Ownership	Source funds1	ofSource of funds2
Kiirua	Health centre	GoK	HSSF	Service charge
Mboroga	Health centre	GoK	HSSF	Service charge
Ontilili	Dispensary	Gok	HSSF	Service charge
Ntirimiti	Dispensary	GoK	HSSF	Service charge
Gundua	Health centre	GoK	HSSF	Service charge, Sponsor

According to the findings, all of the facilities receive funds and have alternative financial options to enable them to provide services within the primary health facilities.

4.5.1 Influence funding modality on service delivery

According to the findings, every primary health facility is required to have a bank account that is used to manage funds received from the HSSF, service charges, and sponsors. As seen in the table below, 97 percent of respondents agreed to having a bank account, while only 3% disagreed. The findings suggest that because of the central location for funds

administration and distribution, the data show that the facilities have a level of accountability when it comes to disbursing funds.

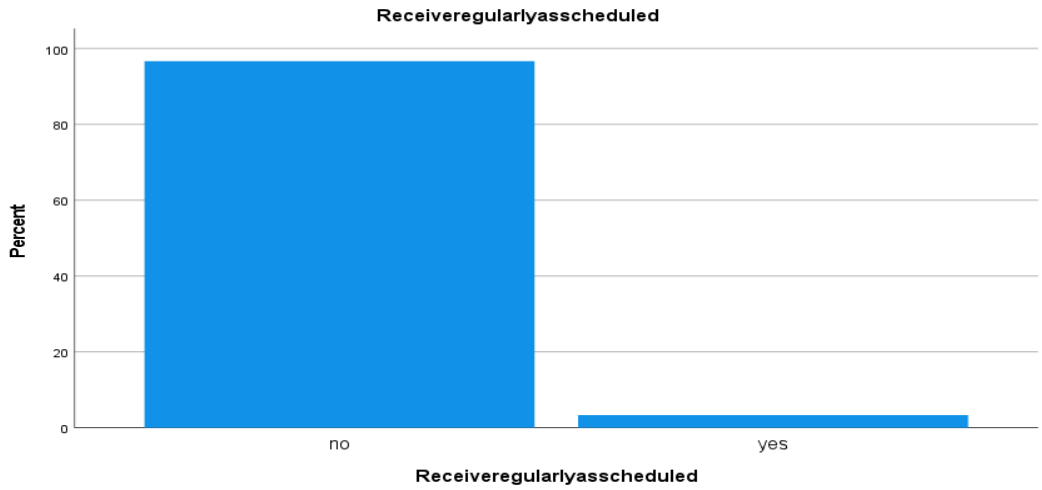
Table 4.10

Bank account

	Frequency (N)	Percentage (%)
NO	1	3
YES	29	97
Total	30	100.0

Figure 4.5

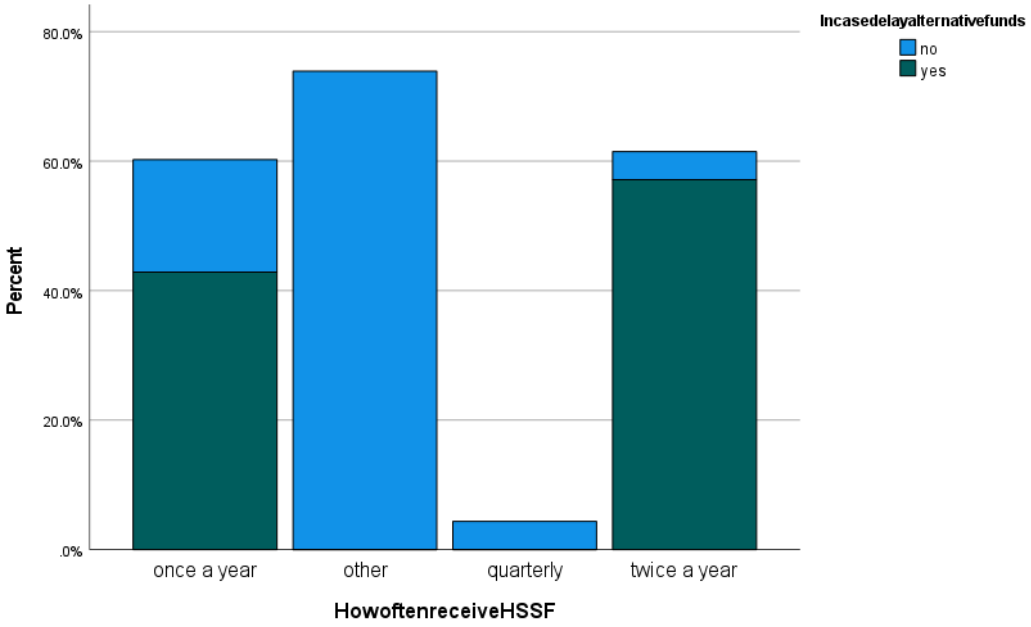
HSSF received regularly as scheduled



The study showed that the HSSF funds are not received as per the scheduled time. 99 percent of the members said no when asked if the funds are received as regularly as required. Only 1% of the respondents responded yes that the funds get received regularly as scheduled. The results indicated that there was inconsistency in funds being disbursed where majority felt that the funds are not disbursed as regularly as they should hence affecting the service delivery within the respective facilities.

Figure 4.6

Alternative funds to the frequency of HSSF funds



The majority of respondents indicated funds were supposed to be received quarterly but most of the time funds faced delays and they would receive them late. The rest responded the funds were received twice a year, responded quarterly and responded once a year.

Table 4. 11

Alternative funds accessibility

	Frequency (N)	**Percentage (%)**
NO	23	77
YES	7	23
Total	30	100.0

Even though health facilities occasionally experienced funding delays, the results revealed that the majority of health facilities (77%) have no alternative funds in the event of HSSF delays, while 23% have alternative funding sources such as service charges, sponsors, and

harambees. As indicated in the diagram above, this has an impact on how services are delivered at the facilities.

Table 4.12

Descriptive percentiles and frequency of infrastructure development

	Frequency (N)	**Percentage (%)**
NO	6	20
YES	24	80
Total	30	100.0

The findings revealed that certain HSSF funds were allocated to infrastructure by the health facility management committees, which improved service delivery by enhancing the workers working conditions. Within the last five years, the funds have aided in the development of infrastructure, according to 80% of respondents, enhancing the quality-of-service delivery. The majority of the funding were used to develop;

- fencing the facility hence increasing the safety and security of patients and workers within the facility,
- Building staff toilets and latrines
- Building staff houses
- Building staff houses
- Buying medical equipment e.g., oxygen cylinders
- Building bedside lockers.

When asked what should be done to improve the management of HSSF, the majority of the correspondents responded that funds should be added to improve the delivery of service within the respective facilities. This implies that additional government funds would help

the facilities improve on delivery of service. Others responded that the money should be disbursed on time to avoid delay of service. As shown from the data the delay of service from the correspondents affects how the service is delivered by the facilities. Data indicates that all the government funded facilities respondents responded agreeing that the funds have a direct impact on service delivery.

4.6 Health Facility Management Committee

The study sought to establish the extent at which the health facility management committee influenced the delivery of service within the health facilities from the objectives. The results will focus on analyzing the existence of HFMCs, committee composition, formation process of HFMCs, availability of HSSF policy guidelines, financial management of HSSF funds.

4.6.1 Functionality of HFMC

The study revealed that all of the primary health facilities had a health facility management committee, indicating that each facility has a management committee with a frequency of 100 percent. As shown in the table below:

Table 4. 13

Availability of HFMC

	Frequency (N)	**Percentage (%)**
NO	0	0
YES	30	100
Total	30	100.0

The study showed that the majority at 60% of the health facility management committee comprised 9 members within each health facility. While 20% of the facilities had 4 members, others had 6 members at a percentile of 17%. This implies that most of the facilities had the required number of members within the committee (median=9) and on average a facility

should have at least 7 members within the committee (mean=7.45). As shown in the table below;

Table 4. 14

HFMC composition

Number of members	Frequency (N)	Percentage (%)
4	6	20
6	5	17
9	18	60
Total	29	97
Missing	1	3
	30	100.0
	7.45	
Total	9.00	
Mean	9	

Majority of the health facility committee members, in the subsequent health facilities were elected by the community members. While the others were elected through church leadership and others through the chief's baraza.

Table 4.15

HFMC composition in compliance with GoK guidelines

	Frequency (N)	Percentage (%)
NO	16	53
YES	14	47
Total	30	100.0

The results indicated that 47% of health facility committees are in compliance with the laid-out government guidelines. While the majority of the respondents (53%) felt that there were

inadequate women in the team where there was a ratio of 1:4. The study showed the need to add more women within the health facility management committee.

Table 4. 16

Access to management policy guidelines

	Frequency (N)	**Percentage (%)**
NO	28	93
YES	2	7
Total	30	100.0

The study indicated that the majority **(93%)** of the respondents from the facility have no access to the policy guidelines on management of HSSF and only a few members **(7%)** responded to have access to the policy guidelines. Thus, concluding that there is a need to ensure the availability of HSSF policy guidelines within the facilities.

4.6.1 Influence of HFMC on service delivery

The study showed that the majority (87%) of respondents responded that the meetings occur on a quarterly basis. The majority 37% of respondents from the primary health facilities disagree that the health facility committee helps the needy to be able to access drugs easily, 33% strongly disagree, **20%** agree and 10% were not sure. According to government funded facilities, the majority 47% of the respondents strongly disagree with the fact that facility committee involvement of budget/activity planning by the health facility committee, while the rest 10% agreed that the committee involves the local community in budget planning, 27% disagree and 17% not sure.

Table 4.17:

Committee involvement of community in facility management

	Agree	Disagree	Not Sure	Strongly Disagree
Committee Facility assist the needy to access drugs	20%	37%	10%	33%
Committee involve community in budget/ Activity Planning	10%	27%	17%	47%

The government funded facilities respondents (33 % strongly disagree, 33% disagree) strongly disagree with the committee having a meeting to give feedback to the community while the rest (17%) agree that there has been a meeting conducted to give feedback to the community and the rest 17% were not sure. 23% from the government funded facilities strongly disagree and disagree respectively on the committee having put a robust system for sharing information on service delivery, while the 13% agree that the committee has put in place a robust system while the remaining 40% are not sure.

Table 4.18

HFMC Responsibility

	Agree	Disagree	Not Sure	Strongly Disagree
HFMC convenes regular meetings to give community feedback on operations	17%	33%	17%	33%
HFMC has put in place robust system of information sharing on service delivery	13%	23%	40%	23%

Less than half of the respondents from government funded facilities responded that the budget approval requests get acted upon promptly by the CHMT thus improving the quality of service within the facilities. While the remaining responded that the CHMT are not approving the budget requests promptly as required.

4.7 Inferential statistics

The study used inferential statistics to properly predict the impact of independent variables to service delivery within the facilities. The study adopted the use of general linear model to perform the analysis using Statistical package for social sciences (SPSS) and decoding the results which comprised of linear model, ANOVA of regression and coefficient of determination.

The R^2 value is the coefficient of determination which represents the extent of change in a dependent variable as a result of change in the independent variable. The coefficient of determination represents the percentage of variation in the dependent variable (Service Delivery) with independent variables Amount of funds, Funding modalities and functionality of Health Facility Management Committee.

Table 4. 19

Model Summary

Model	R	R Squared	Adjusted R Squared	Std. Error of Estimate
1	.748[a]	.56	.475	.40595

a. Predictors: (constant) Amount of funds, Funding modalities and functionality of Health Facility Management Committee.

b. Dependent variable: Service Delivery

The case study indicates that the independent variables have influenced service delivery within the facilities at a percentage of 56%. This implies that the amount funds, funding modalities and Health Facility Management Committee does impact the delivery of service within the facilities. The remaining 44% percentage shows that there are other factors involved apart from the case study research independent variables that influence the service of delivery.

Table 4. 20

ANOVA of regression

Model	**Sum of Squares**	**df**	**Mean Square**	**F**	**Sig.**
Regression	**1.745**	3	**.582**	**3.53**	**.029**[b]
Residual	**4.120**	**25**	**.165**		
Total	**5.865**	**28**			

a. Dependent variable: Service Delivery

b. Predictors: (constant) Amount of funds, Funding modalities and functionality of Health Facility Management Committee.

The model is statistically significant in finding that the amount of funds, funding mechanisms, and functionality of the Health Facility Management Committee influence the delivery of services at health facilities, with a significance value of 0.029, which is less than 0.05.

4.7.1 Coefficient of Determination

Multiple regression analysis was used in the study to determine the influence of independent variables on the dependent variable, which was service delivery at primary health facilities in Buuri County, Meru.

Table 4.21

Coefficient of determination HSSF Satisfaction

	Unstandardized Coefficients		**Standardized coefficients**		
Model	**B**	**Std. Error**	**Beta**	**t**	**Sig.**
(Constant)	2.538	.447		5.675	.001
Amount of Funds	.729	.130	.062	.350	.001
Funding Modalities	.815	.087	.042	.237	.002
Functionality of HFMC	.340	.108	.533	3.152	.004

a. Dependent variable: Service Delivery

The regression equation is: ($Y = \beta_0 + \beta_1X_1 + \beta_2X_2 + \beta_3X_3 + \beta_4X_4 + \varepsilon$);

$Y = 2.538 + .729X_1 + .815X_2 + .34X_3 + \varepsilon$

The study indicates a unit increase in amount of funds results in a .729 increase in service delivery, while a unit increase in funding modalities results in a .815 increase in service delivery, and a unit increase in functionality of HFMC results in a .340 increase in service delivery, according to the regression equation with all independent variables (amount of funds, funding modalities, and functionality of HFMC) set to zero.

With a significance level of 95%, the positive slope for independent variables as predictors for the dependent variable suggested that the amount of funds and funding modalities have the largest influence on service delivery, with significance levels of .001 and.002, respectively. Further the significance value of HFMC's functionality was .004, this means that while HFMC's functionality had a significant impact on service delivery, it had the least impact when compared to the other predicators.

This indicated that change in the predictors (funding amounts, funding modalities, and HFMC functionality) had a considerable impact on service delivery.

4.8 Bivariate Logistic Analysis

The bivariate logistic analysis was conducted using Pearson correlation to examine the magnitude of the link that exists between the independent variables, and the results were drawn using a two-tailed significance test. The results are as follows;

Table 4. 22

Bivariate Logical analysis

		Amount of funds	**Funding modalities**	**Functionality of HFMC**
Amount of funds	Pearson Correlation	1	.319**	.119
	Sig. (2-tailed)		.001	.539
	N	30	30	30
Funding modalities	Pearson Correlation	.319**	1	-.0265
	Sig. (2-tailed)	.001		.893
	N	30	30	30
Functionality of HFMC	Pearson Correlation	.119	-.265	1
	Sig. (2-tailed)	.539	.893	
	N	30	30	30

The bivariate test indicated a positive and negative relationship exists between the variables. The finding showed moderate positive relationship between Funding modalities and amount of funds at Pearson r value of .319 as stipulated by Pearson association of strength. The study further shows negative low relationship between funding modalities and functionality of Health Facility Management Committee at Pearson r value of -.026. The study showed a

positive low relationship between functionality of HFMC and amount of funds at Pearson r value of .119.

The significance value (2-tailed) is 0.001 between amount of funds and funding modalities, which is less than 0.05, hence we can conclude that there is a statistically significant correlation between the amount of funds and funding modalities.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

5.0 Introduction

The chapter discusses the findings on the influence of funding amounts, funding methods, and HFMC functionality on service delivery at primary health facilities in Buuri Sub County in Meru County

5.1 Effects of Funds on Service Delivery

The study set out to establish the sources of health financing in public health facilities in Buuri sub county. The study findings revealed that the government health funds were the main source of funding for primary health facilities and the funds cater for most of the facilities expenditures, with a mean total amount received in from HSSF sources like service charge only served to supplement the government funds. Although the funds were expected to be disbursed on funds amounting to Kshs. 1,075,373.30 and mean service charge amount of (Kshs. 284,458.73). The other a regular basis, the study revealed delays in disbursement as was reported by the majority of the respondents.

The findings revealed that delays in receiving the funds had a negative impact on service delivery. Majority of the respondents reported that the general rate of service delivery was good, and were satisfied with the HSSF funds, showing that the funds have contributed to the improvement of service delivery at the primary health facilities. These findings on delay are confirmed by a study that was conducted on public Expenditure Tracking Survey (PETS) which indicated that only 67% of allocations as per Authorities to Incur Expenditure (AIE) were actually received at district levels, and that the receipt of AIEs was often delayed (MOH, 2007). A delay in receiving funding had an impact on service delivery, with the vast majority of respondents (100%) agreeing that it did. This had an impact on responsiveness,

waiting time for services, medicine and other supply availability within the facilities, and satisfaction times thus in agreement with the findings of study which found out that in order to provide effective healthcare services that are inclusive and right based reliable funds for maintenance of the health facilities is one of the key imperatives (Mwangi, 2013).

The study found that the amount of funds from HSSF contributed to improving the quality of service at the primary health facilities. The HSSF funding, according to the health workers and the health management committee, did not fully meet all of the facility's financial requirements, with all of the facility respondents (100%) being in agreement that the HSSF had contributed in improving the quality of service at their respective facilities. Further to this, the health workers and committee management believed that the HSSF funds were insufficient to meet the facility's budgetary demands. These results again are not different from other studies which revealed that the abolition of the cost sharing had reduced drastically the capacity of health facilities to meet operational costs and purchase of essential resources Pearson (2005) as well as facility-level resource constraints and a lack of clarity around the user fee levels appeared to be undermining relationships with communities (Molyneux et al., 2007).

Regression analysis model results indicated that financing challenges had significantly negative influence on performance of public primary health care facilities in Buuri sub-County. This implies that when financing challenges increase, the performance of primary health care facilities in Buuri sub-County decreases. These findings are supported by those of Kiplagat (2015), who indicated that healthcare financing in Kenya is highly dependent on individual income levels despite the presence of substantial government subsidies.

5.2 Influence Funding Modality on Service Delivery

All the facilities reported receiving finances from a variety of sources, with the majority of their funds coming from HSSF funds, service charges, and sponsorships. They all operated bank accounts that they used to manage the cash received from the HSSF, service charges, and sponsors, indicating that funds are managed centrally.

The findings revealed inconsistency in fund disbursement, with the majority stating that funds are not disbursed as regularly as they should be, impacting service delivery within the facilities. The majority of facilities seemed to have no alternative source of funds in the event of HSSF delays, while a few of the facilities had alternative sources of funds such as service charges, sponsors, and harambee. The study revealed the need for additional government funds to assist facilities in improving service delivery. Further, the funds should be disbursed on time to avoid service delays. As indicated by the data, the delay of disbursement of funds and inconsistency in disbursement has an impact on facilities delivery of service.

Regression analysis indicated that sources of health financing had significantly positive influence on performance of health care facilities in Buuri sub-County. The results of this study translate that by enhancing the effectiveness of sources of health financing, there would be a corresponding improvement in service provision performance of the health facilities. These results are in agreement with the findings from a similar study conducted elsewhere Hyun et al. (2015), which marshalled the arguments that the way a country finances its health care system is a key determinant of the health of its citizenry. These results are further supported by another study conducted elsewhere where it was found that selection of adequate and efficient method(s) of financing in addition to organizational

delivery structure for health services is essential if a country is set to achieve its national health objective of providing health for all (Hyun et al., 2015).

5.3 Functionality and influence of Health Facility Committees

The study revealed that all the facilities have health facility management committees and majority of the health facility committee members were elected by the community, while others were chosen during the chief's baraza. The study established that there are guidelines to be followed while forming a health facility management committee and respondents had clear guidelines on the committee's composition though some felt like there was an under-representation of women with a ratio of women to men remaining at 1:4. In the study findings, the majority of the facility's respondents do not have access to the HSSF management policy guidelines, and only a few members do. As a result, it is necessary to ensure that HSSF policy guidelines are available within the facilities.

The results further disclosed that majority convened their meetings on a quarterly basis, with a majority of respondents from primary health facilities indicating that they don't assist the needy in gaining easy access to pharmaceuticals, with a few agreeing that they assist the needy. According to primary health facilities, the majority of respondents strongly disagree with the fact that the health facility committee is involved in budget/activity planning, while the remaining agreed. Findings from regression analysis displayed a negative low relationship between funding modalities and functionality of Health Facility Management Committee an observation of findings that contradict those of between the amount of funds and funding modalities. (Muoko & Baker (2014). The significance between amount of funds and funding modalities, which is less than 0.05, indicates a statistically significant correlation between the amount of funds and funding modalities thus in support of findings from another study (Mwangi, 2013).

5.4 Effects of Funds on Service Delivery

The study found out that the government health funds were the main source of funding for primary health facilities and the funds cater for most of the facilities expenditures. The other sources like service charge only serves to supplement the government funds.

Although the funds were expected to be disbursed on a regular basis, the study revealed delays in disbursement as was reported by the majority of the respondents.

The findings revealed that delays in receiving the funds had a negative impact on service delivery. Majority of the respondents reported that the general rate of service delivery was good, and were satisfied with the HSSF funds, showing that the funds have contributed to the improvement of service delivery at the primary health facilities.

The study found that the amount of funds from HSSF contributed to improving the quality of service at the primary health facilities. The HSSF funding, according to the health workers and the health management committee, did not fully meet all of the facility's financial requirements.

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All the facilities reported receiving finances from a variety of sources, with the majority of their funds coming from HSSF funds, service charges, and sponsorships. They all operated bank accounts that they used to manage the cash received from the HSSF, service charges, and sponsors, indicating that funds are managed centrally.

The findings revealed inconsistency in fund disbursement, with the majority stating that funds are not disbursed as regularly as they should be, impacting service delivery within the facilities. The majority of facilities seemed to have no alternative source of funds in the

event of HSSF delays, while a few of the facilities had alternative sources of funds such as service charges, sponsors, and harambee.

The study revealed the need for additional government funds to assist facilities in improving service delivery. Further, the funds should be disbursed on time to avoid service delays. As indicated by the data, the delay of disbursement of funds and inconsistency in disbursement has an impact on facilities delivery of service.

5.6 Functionality and influence of Health Facility Committees

The study revealed that all the facilities have health facility management committees and majority of the health facility committee members were elected by the community. Others were chosen by church leadership and foundations, while others were chosen during the chief's baraza. The study established that there are guidelines to be followed while forming a health facility management committee and respondents had clear guidelines on the committee's composition though some felt like there was an under-representation of women with a ratio of women to men remaining at 1:4.

According to the study, the majority of the facility's respondents do not have access to the HSSF management policy guidelines, and only a few members do. As a result, it is necessary to ensure that HSSF policy guidelines are available within the facilities.

The study showed that majority convened their meetings on a quarterly basis. The majority of respondents from primary health facilities indicated that they don't assist the needy in gaining easy access to pharmaceuticals, with a few agreeing that they assist the needy. According to primary health facilities, the majority of respondents strongly disagree with the fact that the health facility committee is involved in budget/activity planning, while the remaining agreed.

The CHMT acts quickly on budget approval requests, according to a minority of respondents from primary health care facilities, which increases the quality of service within the facilities. While the majority of respondents stated that the CHMT does not approve budget requests as quickly as required, causing delays in service delivery.

In general, the committee had an impact on service delivery because they were obligated to approve budgets and share information.

5.7 Conclusion

The government health funds have benefited research facilities in their efforts to stay afloat. All of the respondents agreed that the funds were beneficial in getting the facilities up and running and delivering services. Despite the fact that government-funded facilities have a limited budget capacity, many health facilities have been able to provide a comprehensive range of health care services and serve a big catchment area. However, in some situations, the facilities did not have strategies in place for how they would use the funds that were available. Majority indicated that the funds were insufficient and couldn't fulfill all of their financial needs. Also, the majority of primary health facilities had no financial plans for the fund, which is against the fund's criteria, which require expenditure plans before spending authority is issued.

The study showed that the funds received have improved the delivery of service within the primary health facilities where majority of the funds were spent on recurring expenses such as buying drugs, paying casual workers, building infrastructure and purchasing oxygen cylinders. Health facilities are required to be managed by community-elected committees of which the study confirmed is the case in the research area.

The health facility management committee performs visits to primary facilities, which has shown to increase service delivery, courtesy, and waiting time satisfaction. Despite the fact

that service delivery in the facilities has improved, the survey claimed the committees should hold seminars for the community or health personnel on a regular basis.

In this study, there was significant evidence that government funding had benefited health facilities in Buuri in becoming more effective and providing services to a wide population. This was in line with similar studies conducted in Nigeria and Benin, which revealed improved service delivery outcomes as a result of increased funding. Nonetheless, the fund's beneficiaries believe that there is still more that can be done to improve the fund's performance. Increasing funds and assisting health facilities in developing financial strategies are two approaches that could help the fund improve.

The study concluded that the health facility management committee had the least significance and influence on service delivery with a significance value of.004, while the amount of funds and funding modalities had the highest significance values of.001 and.002, respectively, based on the bivariate logical analysis.

5.8 Recommendations

i. There is a need for the government to consider increasing the amount of health funds allocated to the primary health facilities as the current amounts were reportedly inadequate for the facilities operations.

ii. The current disbursement method of government funds to primary health facilities is inefficient and delays the funds from reaching the facilities in real time. It is recommended that the current modality in use for funds disbursement should be phased out and replaced with a more reliable and efficient system.

iii. The Ministry of Health should supply the policy guidelines on management of government health funds to primary health facilities to be used by the facility management committees and the health workers.

iv. The facility management committees should be encouraged to put mechanisms in place to prioritize service delivery especially supply of drugs to the vulnerable patients.

v. More research to be undertaken on the performance of government health funds and its effect on service delivery at the primary health facilities.

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APPENDICES

Appendix A Informed Consent

Kenya Methodist University P. 0 Box 267-60200

MERU, Kenya

SUBJECT: INFORMED CONSENT

Dear Respondent,

My names are I am a MSc. student from Kenya Methodist University. I am conducting a study titled: ……

The findings will be utilized to strengthen the health systems in Kenya and other Low-income 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 departments to address the six pillars of the health system. I will record the information from you in a questionnaire checklist. 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, Department of Health Systems Management, 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 B: Research Instruments

QUESTIONNAIRE 1: FOR THE HEALTH FACILITY MANAGEMENT COMMITTEES

Sheet Code No: ……...

Name of interviewer …… Date……

Name of Health Facility ……..

Facility code: (1) Health Center (GoK)

1. Health Center (NGO)
2. Dispensary (GoK)
3. Dispensary (NGO)

Fill in one questionnaire for each member interviewed.

1. Sex code

(1) Male

(2) Female

2. Age in number of completed years (Please tick)

(1) 18-20 years

(2) 21-30 years

(3) 31-40 years

(4) 41-50 years

(5) 51 years and above

3. Marital status

(1) Married (2) Single (3) Widowed (4) Divorced

4. What is your position in the Facility Management Committee?

(1) Chairman

(2) Secretary

(3) Community Representative

5. What is your professional qualification?

(1) Medical Doctor

(2) Clinical officer

(3) Kenya registered community nurse

(4) Community nurse

(5) Enrolled nurse

(6) Others, Specify……..

6. Does your facility receive direct government health (HSSF) funds?

(1) Yes

(2) No

7. If yes above (6) please indicate below the amount your health facility received in the last two years (K.Sh)……

8. Please choose below the alternative sources and amounts of funds received by your facility in the last two years.

(Amount K.Sh.)

(1) Service charge …….

(2) Sponsor (s) …….

(3) Harambees …….

(4) Other (please specify) ……..

9. If your facility receives HSSF/operational funds, do you receive the funds regularly as scheduled?

(1) Yes

10. NoIf (No) above does the delay affect your service delivery at the health facility?

(1) Yes

(2) No

11. How often does your health facility receive (HSSF)/operational funds?

(1) Quarterly

(2) Once a year

(3) Twice a year

(4) Other (specify)

……

12. In case of delays in disbursement of HSSF funds to your health facility do you have an alternative method of funding your operations?

(1) Yes

(2) No

13. Please indicate the extent to which HSSF/operational funds meet the financial needs of running your health facility?

(1) Very Adequate

(2) Adequate

(3) Not Adequate

(4) Inadequate

(5) Very Inadequate

14. Do you think that HSSF has helped to improve quality of services in your facility?

(1) Yes

(2) No

15. What is your level of satisfaction on the current method of government funding health facilities (HSSF)?

(1) Very satisfactory

(2) Satisfactory

(3) Unsatisfactory

(4) Very unsatisfactory

16. Is there a Health Facility Management Committee at your health facility?

(1) Yes

(2) No

17. If (yes) above what is the total number of members in the Facility Committee?

(1) Less than 7

(2) 7

(3) 8

(4) 9

(5) More than 9

18. How was the Facility Committee formed?

(1) Elected by the community

(2) Selected by the area chief

(3) Self-Appointed

(4) Any other(please indicate)……...

If elected, how? …….....

If self-appointed–why?

…….

Does the composition of your Committee in compliance with the Government guidelines?

(4) Yes

(5) No

19. If (not) above please indicate who is missing in the composition

……..

20. Is your health facility gazetted?

(1) Yes

(2) No

21. Do the Facility Committee members have access to policy guidelines on the management of HSSF?

(1) Yes

(2) No

22. How often does the Facility Committee meet?

(1) Monthly

(2) Quarterly

(3) Twice a year

(4) Yearly

(5) Any other indicate

23. Does your health facility operate a Bank Account?

(1) Yes

(2) No

24. If(Yes) above who are the Account signatories .....…

25. Does your Facility have an annual work plan?

(1) Yes

(2) No

26. If (Yes) 20 above are you able to meet your annual performance target with the current level of funding?

(1) Yes

(2) No

27. If (Yes) above please indicate the percentage of meeting annual performance targets

(1) Below 25%

(2) Between 25 to 50%

(3) Between 50 to 75%

(4) Between 75 to 100%

28. Which priority areas does the Facility Committee spend more money? Please specify

(1) Paying casual workers

(2) Buying drugs

(3) Infrastructure/equipment

(4) Others please specify …….

29. Has there been any infrastructure developed / constructed in the last five years

(1) Yes

(2) No

30. If (Yes) above please specify the type of infrastructure including equipment, buildings and transport …….

31. Do you usually get visits from the County Health Management Team?

(1) Yes

(2) No

32. If (Yes) above, how often are the visits?

(1) Quarterly

(2) Twice a year

(3) Yearly

(4) Other, please indicate ……

33. Has there been any management seminars/training courses organized for the Committee members or health workers by the CHMT?

(1) Yes

(2) No

34. If (Yes No.19 above) please give the last date the seminar/training was conducted and the training body

Date of training …….. Trainer ……..

35. Do you feel that visits by the CHMT help in any way to improve service delivery?

(1) Yes

(2) No

36. Do you feel the budget approval requests from health facilities are acted upon promptly by the CHMT?

(1) Yes

(2) No

If (yes) please specify ……..

37. Are HSSF expenditures at your health facility regularly audited as per the policy guidelines?

(1) Yes

(2) No

38. Does the facility experience shortage of drugs?

(1) Yes

(2) No

39. If yes, does the facility committee assist the needy patients to access drugs?

1. Strongly Disagree 2. Disagree 3. Not sure 4. Agree 5. Strongly agree

	1	2	3	4	5
The facility committee and assist needy patients to access medicines					

40. Does the Facility Committee involve the local community in the budget/activity planning?

1. Strongly Disagree 2. Disagree 3. Not sure 4. Agree 5. Strongly agree

	1	2	3	4	5
The local community is involved in budget/activity planning					

41. The health facility committee convenes regular meetings to give community feedback on its operations/expenditures?

1. Strongly Disagree 2. Disagree 3. Not sure 4. Agree 5. Strongly agree

	1	2	3	4	5
The Health Facility Committee convenes regular meetings with community					

42. The health facility committee has put in place a robust system for information sharing on service delivery?

1. Strongly Disagree 2. Disagree 3. Not sure 4. Agree 5. Strongly agree

	1	2	3	4	5
There is a system of sharing information on service delivery at the health facilities					

43. How satisfied are you with current waiting time for service delivery?

1. Very Satisfied 2. Satisfied 3. Not Satisfied 4. Dissatisfied 5. Very Dissatisfied

	1	2	3	4	5
The Community is aware of government policy guiding operations					

44. How do you rate the general courtesy of staff at your health facility?

1. Very good 2. Good 3. Fair 4. Poor 5. Very poor

	1	2	3	4	5
The overall rating of the committee members and health workers					

45. How do you rate the overall service delivery at your health facility?

1. Very good 2. Good 3. Fair 4. Poor 5. Very poor

	1	2	3	4	5
The overall rating of the committee members and health workers					

46. What do you think should be done to improve management of HSSF for better service delivery at your facility? Please explain

……..

...…… ……..…..

END

Thank you very much for your time and valuable responses. You are most welcome to ask any question or clarification

Appendix C: Questionnaire 2 for Health Workers

Sheet Code No: ……...

Name of interviewer ……Date ……

Name of Health Facility ……..

Facility code:

(1) Health Centre (GoK)

(2) Health Centre (NGO)

(3) Dispensary (GoK)

(4) Dispensary (NGO)

Fill in one questionnaire for each staff interviewed.

1. Sex code

(1) Male

(2) Female

2. Age in number of completed years (Please tick)

(1) 18-20 years

(2) 21-30 years

(3) 31-40 years

(4) 41-50 years

(5) 51 years and above

3. Marital status

(1) Married (2) Single (3) Widowed (4) Divorced

4. What is your professional qualification?

(1) Clinical officer

(2) Kenya registered community nurse

(3) Community nurse

(4) Enrolled nurse

(5) Public Health Officer

(6) Others, Specify……..

5. Does your facility receive direct government health (HSSF) funds?

(1) Yes

(2) No

6. If yes above (5) please indicate below the amount your health facility received in the last two years (K.Sh)……

7. Please choose below the alternative sources and amounts of funds received by your facility in the last two years.

(Amount K.Sh.)

(1) Service charge …….

(2) Sponsor (s) …….

(3) Harambees …….

(4) Other (please specify) ……..

8. If your facility receives HSSF/operational funds, do you receive the funds regularly as scheduled?

(1) Yes

(2) No

9. If (No) above does the delay affect your service delivery at the health facility?

(1) Yes

(2) No

10. How often does your health facility receive (HSSF)/operational funds?

(1) Quarterly

(2) Once a year

(3) Twice a year

(4) Other (specify)…….

11. In case of delays in disbursement of HSSF funds to your health facility do you have an alternative method of funding your operations?

(1) Yes

(2) No

12. Please indicate the extent to which HSSF/operational funds meet the financial needs of running your health facility?

(1) Very Adequate

(2) Adequate

(3) Not Adequate

(4) Inadequate

(5) Very Inadequate

13. Do you think that HSSF has helped to improve quality of services in your facility?

(1) Yes

(2) No

14. What is your level of satisfaction on the current method of government funding health facilities (HSSF)?

(1) Very satisfactory

(2) Satisfactory

(3) Unsatisfactory

(4) Very unsatisfactory

15. Is there a Health Facility Management Committee at your health facility?

(1) Yes

(2) No

16. If (yes) above what is the total number of members in the Facility Committee?

(1) Less than 7

(2) 7

(3) 8

(4) 9

(5) More than 9

17. How was the Facility Committee formed?

(1) Elected by the community

(2) Selected by the area chief

(3) Self-Appointed

(4) Any other (please indicate) ……

If elected, how? …….....

If self-appointed why? ..…….

18. Does the composition of your Committee comply with the Government guidelines?

(1) Yes

(2) No

19. If (not) above please indicate who is missing in the composition

……..

20. Is your health facility gazetted?

(1) Yes

(2) No

21. Does the Facility Committee members have access to policy guidelines on the management of HSSF?

(1) Yes

(2) No

22. How often does the Facility Committee meet?

(1) Monthly

(2) Quarterly

(3) Twice a year

(4) Yearly

(5) Any other indicate

23. Does your health facility operate a Bank Account?

(1) Yes

(2) No

24. If (Yes) above who are the Account signatories?

……

25. Does your Facility have an annual work plan?

(1) Yes

(2) No

26. If (Yes) 20 above are you able to meet your annual performance target with the current level of funding?

(1) Yes

(2) No

27. If (Yes) above please indicate the percentage of meeting annual performance targets

(1) Below 25%

(2) Between 25 to 50%

(3) Between 50 to 75%

(4) Between 75 to 100%

28. Which priority areas does the Facility Committee spend more money? Please specify

(1) Paying casual workers

(2) Buying drugs

(3) Infrastructure/equipment

(4)Others please specify …….

29. Has there been any infrastructure developed / constructed in the last five years

(1) Yes

(2) No

30. If (Yes) above please specify the type of infrastructure including equipment, buildings and transport ……

31. Do you usually get visits from the County Health Management Team?

(1) Yes

(2) No

32. If (Yes) above, how often are the visits?

(1) Quarterly

(2) Twice a year

(3) Yearly

(4) Other, please indicate ……

33. Has there been any management seminars/training courses organized for the Committee members or health workers by the CHMT?

(1) Yes

(2) No

34. If (Yes No.19 above) please give the last date the seminar/training was conducted and the training body

Date of training …….. Trainer ……..

35. Do you feel that visits by the CHMT help in any way to improve service delivery?

(1) Yes

(2) No

36. Do you feel the budget approval requests from health facilities are acted upon promptly by the CHMT?

(1) Yes

(2) No

If (yes) please specify ……

37. Are HSSF expenditures at your health facility regularly audited as per the policy guidelines?

(1) Yes

(2) No

38. Does the facility experience shortage of drugs?

(1) Yes

(2) No

39. If yes, does the facility committee assist the needy patients to access drugs?

1. Strongly Disagree 2. Disagree 3. Not sure 4. Agree 5. Strongly agree

	1	**2**	**3**	**4**	**5**
The facility committee and assist needy patients to access medicines					

40. Does the Facility Committee involve the local communityin the budget/ activity planning?

1. Strongly Disagree 2. Disagree 3. Not sure 4. Agree 5. Strongly agree

	1	**2**	**3**	**4**	**5**
The local community is involved in budget/activity planning					

41. The health facility committee convenes regular meetings to give community feedback on its operations/expenditures?

1. Strongly Disagree 2. Disagree 3. Not sure 4. Agree 5. Strongly agree

	1	**2**	**3**	**4**	**5**
The Health Facility Committee convenes regular meetings with community					

42. The health facility committee has put in place a robust system for information sharing on service delivery?

1. Strongly Disagree 2. Disagree 3. Not sure 4. Agree 5. Strongly agree

	1	**2**	**3**	**4**	**5**
There is a system of sharing information on service delivery at the health facilities					

43. How satisfied are you with current waiting time for service delivery?

1. Very Satisfied 2. Satisfied 3. Not Satisfied 4. Dissatisfied 5. Very Dissatisfied

	1	**2**	**3**	**4**	**5**
The Community is aware of government policy guiding operations					

44. How do you rate the general courtesy of staff at your health facility?

1. Very good 2. Good 3. Fair 4. Poor 5. Very poor

	1	2	3	4	5
The overall rating of the committee members and health workers					

45. How do you rate the overall service delivery at your health facility?

1. Very good 2. Good 3. Fair 4. Poor 5. Very poor

	1	2	3	4	5
The overall rating of the committee members and health workers					

46. What do you think should be done to improve management of HSSF for better service delivery at your facility?

Please explain……..……

……

END

Thank you very much for your time and valuable responses. You are most welcome to ask any question or clarification.

Appendix D: Questionnaire 3: Community Members

Sheet Code No: ……...

Name of interviewer …… Date ……

Name of Health Facility ……..

Facility code:

(1) Health Center

(2) Dispensary

Fill in one questionnaire for each person interviewed.

1. Sex code

(1) Male (2)Female

2. Age in number of completed years

(1) Less than 20 years

(2) 21-30 years

(3) 31-40 years

(4) 41-50 years

(5) 51 years and above

3. Marital status

(1) Married (2) Single (3) Widowed (4) Divorced

4. What is your academic qualification?

(1) Primary level

(2) Secondary level

(3) Diploma level

(4) Graduate

(5) Any other, Specify ……

5. What is your current occupation?

(1) Student

(2) Formally employed

(3) Farmer

(4) Business

(5) Casual Laborer)

(6) Any other, please specify

6. Are you aware whether there is a management committee for this health facility?

(1) Yes

(2) No

7. If (Yes) above do you know how the Committee was formed?

(1) Yes

(2) No

8. If yes choose any of the methods below that was followed to form the Committee

(1) Through election by the community

(2) Selected by the area chief

(3) Appointed by the local MP

(4) Self Appointed

9. Are you aware if your Facility receives direct Government funding (HSSF)?

(1) Yes

(2) No

10. If (Yes) 9 above do you get regular information from the Facility Committee on how the money is spent in your facility?

(1) Yes

(2) No

11. If yes above how do you get information on the use of the HSSF by the Facility Committee?

(1) Through notice board

(2) Through the public baraza

(3) Quarterly reports

(4) Any other (please specify)……

12. If yes how satisfied are you with its management?

(1) Very Satisfied

(2) Dissatisfied

(3) Neutral

(4) Satisfied

(5) Very Dissatisfied

13. Do you always get services you need at every visit in this Facility?

(1) Yes

(2) No

14. Please tick in the boxes provided your level of satisfaction with the services listed 1-7 below:

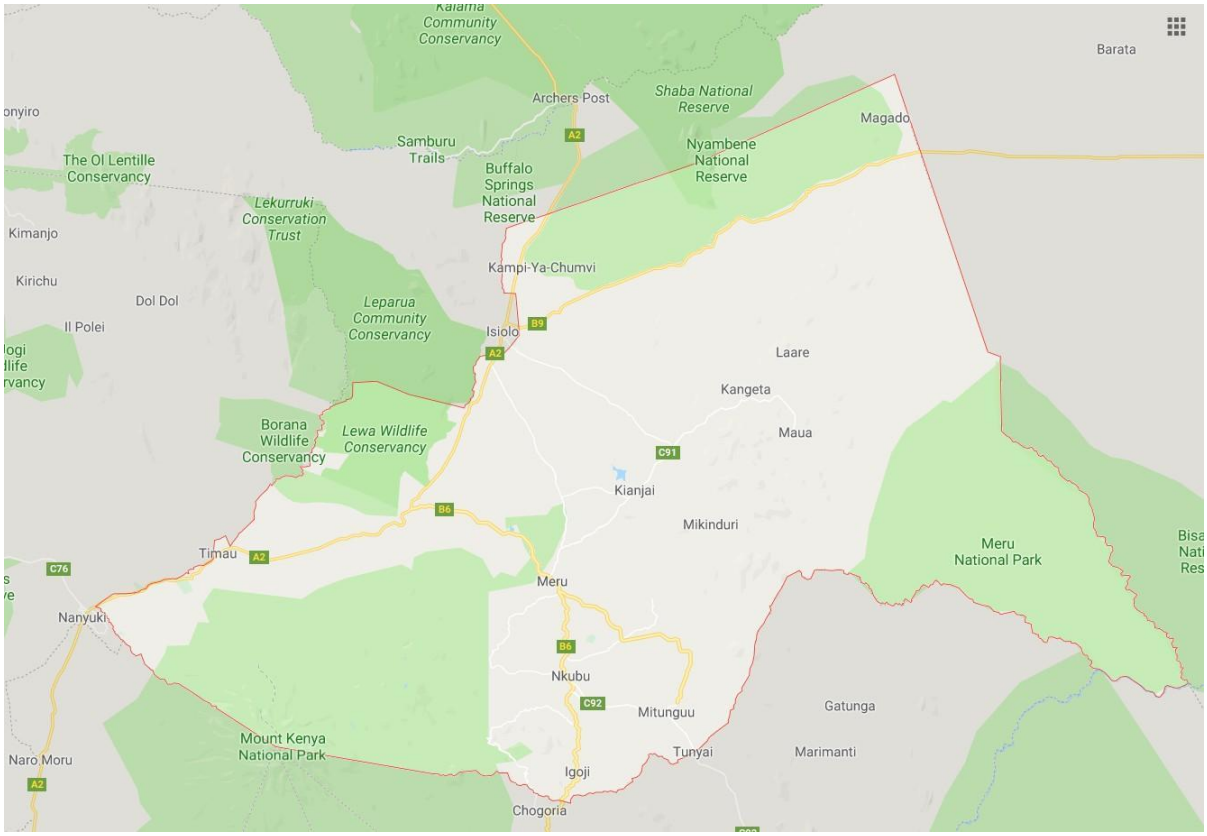
No.		**Strongly Satisfied**	**Satisfied**	**Not Satisfied**	**Dissatisfied**	**Strongly Dissatisfied**
1.	Waiting time for services					
2.	Availability of drugs					
3.	General courtesy by Facility staff					
4.	Charges of services					

5.	Information sharing by the Facility Committee					
6.	Overall Performance of the Facility Committee					
7.	Overall quality of services at the Facility					

END

Thank you very much for your time and valuable responses. You are most welcome to ask any question or clarification

Appendix E: Meru County Map



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

5TH SEPTEMBER 2018

Joel Mubichi Gitonga
HSM-3-2144-1/2009

Dear Joel,

RE: ETHICAL CLEARANCE OF A MASTERS' RESEARCH THESIS

Your request for ethical clearance for your Masters' Research Thesis titled **"The Influence of Direct Government Health Funds on Service Delivery in Primary Healthcare Facilities in Meru County, Kenya"** has been provisionally granted to you in accordance with the content of your project proposal subject to tabling it in the full Board of Scientific and Ethics Review Committee (SERC) for ratification.

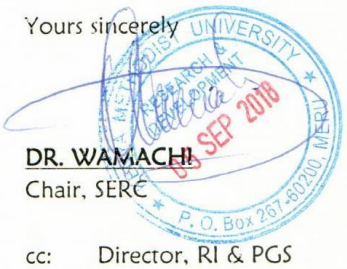
As Principal Investigator, you are responsible for fulfilling the following requirements of approval:

1. All co-investigators must be kept informed of the status of the project.
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 project 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.

Yours sincerely



DR. WAMACHI
Chair, SERC

cc: Director, RI & PGS