INFLUENCE OF INSTITUTIONAL REORGANIZATION ON THE ACCESS TO PRIMARY CARE HEALTH SERVICES IN A TRANSITION PERIOD: A CASE OF IFO CAMP, DADAAB REFUGEE COMPLEX, KENYA

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DECLARATION

Student

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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Supervisors' Approval

We confirm that the work reported in this thesis was carried out by the candidate under our supervision.

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DEDICATION

This thesis is dedicated to my daughter Joy, all members of my family, refugee operations and colleagues at work who inspired and encouraged me, above all Almighty God the provider of life, knowledge and the power to think and put up these ideas. Thank you.

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May God bless you All.

ABSTRACT

The refugee population verification exercise in 2016 indicated Dadaab Refugee Camp population to be on a declining trend. The declining trend was due to relocations, and voluntary repatriation of the refugees. With the call for repatriation, it was expected that health service delivery would be affected. Therefore the study sought to assess the influence of institutional reorganization on the access to primary health services during the transition period in IFO Camp of Dadaab Refugee Complex, Garissa County. Specific objectives included: to establish the influence of structural re-organization on the access to primary care services; determine the influence of resource re-adjustments on the access to primary care services; investigate stakeholders influence on the access to primary care service; and assess the influence of management processes on the access to primary care services during the transition period. The study adopted cross-section descriptive study design that combined both qualitative and quantitative methods of data collection. 384 sample size was estimated through Krejcie and Morgan formulae. Random, exhaustive and purposive sampling were applied in the selection of the sample. The study used both questionnaires and interviews in collecting primary data and statistical package for social sciences (SPSS) version 23.0 for data analysis of quantitative data. Study findings revealed that four institutional re-organizations had taken place in the primary healthcare sector of Ifo Camp in the last 12 months (transition period), namely; management process (51.3%), resource re-adjustment (11.7%), structure re-organization (9.9%), and stakeholders' role (5.5%). Structural reorganization and Resource re-adjustments factor had a positive correlation and influence in accessing primary care services at Ifo Camp (X^2 (1) = 204.0, p < .001) and (X^2 (1) = 67.9, p < .001) respectively. The two variables had positive and significant correlation to healthcare access. Stakeholder's involvement in the institution reorganization ((X^2(2) > = 2.597, p = 0.25) and management processes ((X^2 (2)> = 2.236, p = 0.157) were found not to have significant correlation with access to primary care services. It was recommended that there should be an effective and proper structural reorganization during the transition period to enhance access to primary service; collaboration with other stakeholders is recommended; and instituting effective and proper management during the reorganization period. Further research needs to be carried out to establish other institutional factors/reorganizations that affect access to primary care services at Ifo Camp in Dadaab Refugee Complex in Garissa and other refugee camps.

ABBREVIATIONS AND ACRONYMS

ANC	Ante – Natal Care
CoD	Congo, Democratic Republic
CPHC	Community Health Primary Care
CHC	Community Health Committee
CHS	Community Health Strategy
DAR	Developing Assistance for Refugee
DRA	Department of Refugee Affairs
FGD	Focus Group Discussion
CHU	Community Health Unit
GDP	Gross Domestic Product
CHW'S	Community Health Workers
HIS	Health Information System
ICC	Interagency Coordinating Committee
IFRCS	International Federation of Red Cross Society
IOM	International Organization of Migration
KEMU	Kenya Methodist University
KCPR	Kenya Comprehensive Programme for Refugee
KNBS	Kenya National Bureau of Statistics
KEPH	Kenya Essential Package for Health
KHSSP	Kenya Health Sector Strategic Investments Plan
KII	Key Informant Interview
M&E	Monitoring and Evaluation
MOH	Ministry of Health
NACOSTI	National Commission for Science, Technology and Innovation
MSF	Medicines San Frontiers
NGOs	Non - governmental Organizations
PHC	Primary Health Care
SPSS	Statistical Package For Social Sciences
UNHCR	United Nation High Commission for Refugee
USD	United States Dollar
WHA	World Health Assembly
WHO	World Health Organization

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OPERATION DEFINITION OF TERMS

Comprehensiveness - provision of health care services that has promotive, curative, preventive, and rehabilitative services.

Institutional - primary care service delivery institutions and its organized systems of operation.

Primary Care Services – refers to health promotion services, disease prevention, and basic outpatient diagnostic delivery services, and medical surgical/rehabilitative services, clients for observation, referral of patients from Communities and referral to facilities.

Refugee - Refugees refer to foreigners who have come to Kenya from Somali, Burundi, Democratic Republic of Congo (DRC) or Rwanda due to war or generalized conflict in those countries, and who now live in the IFO Dadaab Kenya. The refugees must possess a refugee certificate from Department of Refugee Affairs (DRA) as stipulated in the Kenyan Refugees' Act 2006 or a refugee mandate letter from United Nations High Commission for Refugees.

Residual Caseload – Remaining population after repatriation.

Reorganization – Rearrangement, readjustment, realignment, restructuring or change.

Transition – Changing from a stable population to a reducing population.

Voluntary Repatriation – Voluntary return of refugee to country of origin

Health Service Delivery Structures – arrangement, organization and framework on implementation approach of health service

CHAPTER ONE:

INTRODUCTION

1.1 Background of the Study

Health Service delivery is a health system strengthening pillar, which focus "on delivering of quality and safe, health interventions" (World Health Organization [WHO], 2018). There should be a deliberate focus on quality of health services, which involves providing effective, safe, people-centered care that is timely, equitable, integrated and efficient; and not only coexistence of infrastructure, medical supplies and health care providers. Primary care is the backbone of any effective health system that aims for better population health and that act as people's first contact and that are comprehensive, coordinated, people-centred, continuous and accessible (WHO, 2018). The characteristics ascribed to high-quality primary care systems are mutually beneficial and associated.

Across the world, countries have identified primary care as an important element of healthcare system. In addition, many parts of the world, including the United States (US) have identified the imbalance between specialist care and primary health services. For instance, in 2008, US had a total of 954,224 medical doctors, with about 784,199 engaged in active practice where about 32% of them (305,264) were mostly offering primary care specialties (Agrawal & Venkatesh, 2016). Based on the WHO report (2017), the continent of Africa has not attained unbiased as well as sustainable access to properly working health systems. Geographical disparities in access to health have continued increasing, with most people in rural areas having to walk for long distances to access primary care. It has been noted that many people forego treatment due to high cost (unaffordability), wanting quality of service, and others willing to pay find it costly. Many countries have identified major constraints to efficient and improved healthcare, including poor implementation of health programs, poor management of the scarce resources, inadequate resources, disconnects in policy continuation, and rapid turnover of

specialists in key position Aron et al., (2015). For instance, Ethiopia is still below the anticipated US$ 35 per-capita needed to achieve full health coverage. Despite the low standards of healthcare, the government has increased her expenditure from 4% (in 1995-96) to 5% (2004-05), and further to 11.6% in the financial year 2006-07 (Government. of Ethiopia, 2012). In Kenya, primary care service delivery is disapprovingly constrained by several elements including finance, medical product supplies and human resources. As per the (Kenya National Bureau of statistics [KNBS], 2015) report, the country experiences disparities and inequalities in areas like availability, distribution as well as utilization of healthcare services. Many of the healthcare indicators like maternal health and child health have scored poorly due to the inequalities. The maternal outreach and referral services are inadequate to the extent that they do not prevent women from delivering at home. Maternal and child health is further compromised by low numbers of skilled professional for women delivering at home (Mohamed et. al., 2020).

Refugee camps have more challenges in accessing primary care when compared to other settings across the developing countries. A common feature of the refugee camps is that they are likely to be remotely situated, with unreliable transport network, especially roads (Siegel, 2020). The growing populations in camps versus the inadequate resources further make it hard to have access to quality primary care services. The dynamic nature of refugees in the camp makes the government and other concerned authorities to prioritize specialized healthcare over some time (Millington, 2019). An example of refugee crises is in Iraq, where the cost of refugee healthcare services is high and uncertain even when there are robust fund-raising efforts by the country. The cost for the Iraqis refugees' emergency, specialty, primary and even secondary healthcare needs are proving hard to meet (United Nations High Commission for Refugees [UNHCR], 2015).

Refugees have difficulties in accessing quality healthcare as expressed by (Matlin et al., 2018). Migrants' and refugees' health is depended on support and policies from the host countries. Refugees and migrants experience challenges when accessing health services due to their compromised economic, social and environmental situations. The findings in the study were based on refugee's experiences from Europe (German, Italy), Iran, South Africa and Turkey. From the world stage, the refugees experience successes and challenges relating to access to health services. The domains identified from the study included education and training on health issues, service delivery and design, as well as health policy coverage. Since most of the refugees are held in developing nations, there is high likelihood of having challenges in accessing health. There are many host countries that limit the privileges of undocumented refugees, including restricted access to health services to discourage more refugees from fleeing into the countries. Internationally, only Spain, Portugal, France and Netherlands in Europe offered entitlement to health services. While the study identified some good practices in some countries in reference of access to health, there was need for structural changes to promote good practices in health practice and policy. To react to the concerns of refugees accessing health, World Health Organization in 2017 resolved to support and promote health of refugees and migrants at the 70th World Health Assembly (WHA). Refugees also experience a change in the nature and severity of diseases at the entry into host countries, as supported by (Matlin et al., 2018).

Other studies have also highlighted the plight of refugees worldwide on their quest to access health. Harild et al., (2015) noted that refugees in Afghanistan were challenged on their access to healthcare after their displacements. The authors also presented the Bosnia-Herzegovina refugees' case where they faced challenges of reintegration with the host communities, often witnessing prejudice in accessing healthcare. In Africa, the Burundi and Rwanda case studies

showed that refugees experienced greater challenges in accessing health services among other social and economic services.

The Kenya and generally East Africa, most refugees are mostly from countries experiencing civil wars. In the last three decades, Eastern Africa region has seen several civil wars that have been fought with no clear end. South Sudan achieved her independence from the larger Khartoum-based Sudan government in 2011, but the fighting did not cease, sending emigrants to the neighboring countries, mostly in Kenya and Uganda. The civil wars in Somalia after the fall of Siad Barre government in 1991 led to influx of refugees in Kenya, mostly settling at the Dadaab Refugee Camp. Other wars fought in Burundi and Rwanda during the 1994 genocide left thousands as refugees in Kenya and other peaceful countries in East Africa. The instability in the DR Congo has also led to many refugees and IDPs (internally displaced persons) in the region. Kenya thus houses many refugees, mostly from Somalia, South Sudan, DR Congo, Ethiopia, Burundi, and Rwanda. The situation of refugees has led to need for humanitarian services, including offering of health services and other basic services. Therefore, the nature of refugees in Kenyan camps is based on the recent instability in the region.

The developed tripartite agreement between the United Nations High Commission for Refugees (UNHCR), Federal Republic of Somalia and Government of Kenya, proposed a return formula for the refugees. In article 2, the aim of this treaty was to share a legal framework to enable dignified and safe voluntary repatriation of Somali refugees from Kenya, and to subsequently reintegrate with the people in Somalia. The verification exercise of the refugees in 2016 across all programs provided an understanding of the population trends, and thus the subsequent adjustment of beneficiary figures (UNHCR, 2016). The report further noted that the Somali refugee population was expected to decline in Kenya due to the voluntary

repatriation. The reduction of the Somali refugees started in 2016 when about 2,000 refugees agreed to return to Somalia. The repatriation causes disruptions to the delivery of primary healthcare services. In the refugee operations, health services delivery is amongst the routine services provided including pre-departure primary services.

In the refugee context, health service delivery emerged as emergency services, then post-emergencies services; initially, with two basic approaches for providing health services to a large displaced population that includes, community and facility-based approach. The facility-based services are established to augment the local health service delivery facilities, establishing distinct health facilities or establishing a mobile or outpost clinics. The host country policies on health system are adopted for ensuring healthcare are in line with the national health system (International Federation of Red Cross and Red Society [IFRCS], 2014). In a protracted crisis, sub-county and county health facilities assume greater responsibility in offering healthcare services refugees but in the case of Dadaab, establishing a distinct health care system was necessary due to inaccessibility of same. This forces service providers to get authorization from the state health authorities in the beginning Ventevogel et al., (2019). According to the United Nations High Commissioner Refugee Global Public Health Strategy, 2014-2018, the main objective of health programme is to minimize mortality and morbidity and improve the quality of life of refugees. Currently, the set, separate health facilities in Dadaab still provide primary care services with the support of Pre-departure health screening during repatriation exercise.

1.2 Statement of the Problem

As per the Kenya Health Sector Strategic Plan 2014-2018, primary care services comprise of level two (majorly dispensaries) and level three facilities (Health Centers), in addition to the

health facilities manned by non-state players. Averagely, a community health facility should serve five thousand (5,000) people. Primary care services (tier II and III) cover 10,000 persons. Dadaab operation had transmuted from difficult situations to deliver quality services. For example, the issue of overcrowding in a health facility in one of the camp noted to serve 39,000 people instead of 10,000 persons (Chkam, 2016). Currently, with the wave of repatriation, the population is seen to be reducing with one camp reducing from 90,025 and currently standing at 83,884 persons (UNHCR, 2016) an indication that a health facility is serving approximately 9,000 persons which is against the Kenya Health Sector Strategic Investments Plan benchmark.

The declining population trends as evidenced in population fixing exercise by Government of Kenya and UNHCR postulate a situation of suboptimal utilization and waste of scarce resources; and this calls for institutional reorganization. The study sought to establish the influence of reorganization on the access to primary healthcare during transition period.

1.3 Research Objective

1.3.1 Broad objectives

The study was guided by the broader objective of assessing the influence of institutional reorganization on the access to primary care health services during the transition period in IFO Camp, Dadaab Refugee Complex in Kenya.

1.3.2 Specific Objectives

i. To establish the influence of structural re-organization on the access to primary care health services during the transition period in Ifo Camp, of Dadaab Refugee Complex.
ii. To determine the influence of resource re-adjustments on the access to primary care health services during the transition period in Ifo Camp, of Dadaab Refugee Complex.

iii. To investigate the influence of stakeholders re-organization on the access to primary care health service during a transition period in Ifo Camp, of Dadaab Refugee Complex.

iv. To evaluate the influence of management processes on the access to primary care health services during the transition period in Ifo Camp of Dadaab Refugee Complex.

1.4 Research Questions

The research was guided by the following questions;

i. What was the influence of structural re-organization on the access to primary care health services, during the transition period in IFO Camp, of Dadaab Refugee Complex?

ii. What was the influence of resource re-organization on the continuity of primary care health services delivery during the transition period in IFO Camp, of Dadaab Refugee Complex?

iii. How does stakeholder's re-organization influence access to primary care health service delivery during the transition period in IFO camp, of Dadaab Refugee Complex?

iv. What was the influence of management processes on the access to primary care health services during the transition period in IFO Camp of Dadaab Refugee Complex?

1.5 Study Justification

This is timely study following the recent call by the government of Kenya on the need to repatriate refugees to their country of origin. The researcher found it most appropriate to undertake this study in the refugee camp so as to fill the knowledge gap existing on access to primary health care service in a transition period as a result of reducing population due to

repatriation in a refugee environment. The study focused on the Northern Camp in Dadaab Complex since it has three camps and a higher population when compared to Southern Camp which currently has one camp. The northern camp has a larger population from where a sample of the population was taken. The findings are also useful to inform policy and planning that promote sustainability in health service delivery, from the emergency context to a protracted refugee situation. Through the study, the findings contribute to the health systems pillar of "delivering of quality and safe, health interventions." Further, the current study was more specifically interested in the influence of institutional reorganization on access to primary care service in a transition period in Dadaab refugee camp. Evidently, there are no known studies that have been conducted on continuity or parameters of access to primary care service in a reducing population. The research was driven by limited information on how health service institutions can reorganize the access to primary care services in a transition period without affecting the quality nor contravening the laid down policies of the hosting country.

1.6 Study Limitation and Delimitations

1.6.1 Study Limitation

Time constraints and bureaucracy within the government structures was one of the study's limitations. The study was done in the Northern Camp of Dadaab Complex, thus the omission of Southern Camp was a limitation to the study. Though it could be interesting to conduct the same study in the Southern Camp, financial and time constraints were a limitation thus it was not possible to carry out the study in both Northern and Southern Camp. Moreover, this did not affect the findings given that there are many similarities and few differences in the Southern and Northern Camp in terms of operation. There were challenges associated with language barriers where the refugees were not able to answer questions in English. The language barrier

was mostly associated with refugees where most of them were Somalis and knew little English and broken Kiswahili.

1.6.2 Study Delimitation

Time constraints and bureaucracy within the government structures was solved by having an introduction letter from the university, NACOSTI, County government authority and the camp administration. The letter eased the bureaucracy and reduced the time spend moving from office to office explaining the aim and scope of the project. In focusing on the Northern Camp of Dadaab Complex, and omitting the Southern Camp, it was assumed that the sample selected was representative of the general population of the refugees, and that the information could be generalized across all the refugees undergoing transition. The limitation of financial and time constraints was partly solved by having a representative sample, and narrowing to the Northern Camp of Dadaab Complex. The limitation of language barrier was solved by having interpreters where a respondent could not explain themselves using Kiswahili. In general, the tool was translated into Kiswahili to enable easy answering from the refugees who had challenges in using English. The limitations were thus moderated to reduce the effect they could have on the final findings from the data collected.

1.7 Significance of the Study

This is a timely study following the recent call by the government of Kenya, United Nations High Commissioner for Refugees and other local and international non-state actors on the need to repatriate refugees to their country of origin. The research fills the knowledge gap on the effect, continuity and sustainability of primary care service delivery in a reducing population hence strengthens the performance of health systems organizations that might be in the similar situation in future.

CHAPTER TWO:

LITERATURE REVIEW

2.1 Introduction

The section covers primary care service delivery health systems, institutional structures, resources reorganization, stakeholders' role and management processes during the transition period.

2.2 Health Systems

The framework for Health System was laid down by World Health Organization as a guidance for the system strengthening; this entails six pillars (Manyazewal, 2017). The removal of one pillar interferes with the entire system since there is interdependency. The pillars include; leadership and governance; health financing, health information systems; health services delivery; medical workforce; and medical product vaccine and technology. Health workforce relates to a well-functioning human resource for health that is responsive, fair, efficient, well-motivated and competent.

Components of health information system include processing of health information, analysis, production as well as utilization of timely and reliable information. Health system ensures that there is equitable and efficient access/distribution of medical products, vaccines, technologies, and other medical products that are safe, of good quality, cost-effective, scientifically sound and efficient. Cost-effective health financing should be able to raise adequate funds to ensure people are protected from the financial burden and also provides incentives for the providers of services. Leadership and governance (the sixth pillar) ensure a strategic policy framework exists with effective oversite and attention to system designs and accountability (WHO, 2014).

The current adapted health service delivery structures or institutional arrangement should enable the access to quality services. Moreover, service delivery pillar among other pillars is governed by the country policies and effective governance to ensure that standards of care and targets for coverage are set, monitored and maintained. It also does implement, and monitor the basic legal framework required for effective operation of both public and private health services (Management Science for Health, 2015).

Service delivery among refugees presents a challenge especially where disruptions are rampant on key resources and delivery system. Wilson, et al., (2015) observed that being marginalized and a special population presented challenges in access to primary care health services. Reorganizations are associated with limitation of resources and shift of focus on delivering the basic health services. Successful service delivery is associated with components like availability of resources, committed leadership and conducive environment. Refugees therefore experience unique challenge compared to the general population in accessing health services.

2.3 Institutional - Service Delivery Structures

Service delivery structures or institutional arrangement is governed by specific country health policies, regulations, performance monitoring and standards **(**WHO, 2014). The current vision for service access to Essential Package for Health Services (KEPHS) was laid down through the Kenya Health Policy 2014-2030. The policy indicates clearly that healthcare and associated services should be accessible to every citizen within the identified cohorts through the four-tier healthcare system, starting from the community, to the primary care, then county and national services.

Some of the related figures to the four tiers are well indicated in KHSSP (2014-2018). For instance, a community of five thousand (5,000) people needs to have a community health

facility. Primary healthcare services at tier II and III are offered mostly in dispensaries (mobile or static clinics), and healthcare centers even those offered by private actors. The primary healthcare services facilities should cover 10,000 people with an average of thirty (30) visits per day seeking health services (curative, preventive, or heath promotive) and maternity services that at least conduct three deliveries per day in tier III. The priority target to improvements of access including social - cultural access to service, of which all 100% of required KEPHS should be available for populations in congregate settings, prisons, IDP, refugee camps and army barracks (KHSSP 2014-2018). In hospitals, management of referral care is divided into three types as per KHSSP i.e. primary, secondary and tertiary referral unit to serve a population of 100,000, 1million and 5million respectively.

Presently, the health facility in this category possess different competences, for instance, KHSSP states that the medium-term goals for the primary referral facilities to include offering emergency services like light surgeries. According to Kenya Community Health Policy 2020-2030, while the community unity creates demand for health services; the policy defines that the primary health care system focusses on responding to this demand.

Health services has been coordinated to provide a full continuum of care and access to services that prevent or treat the most common causes of illness is ensured (Management for Science , 2015). Services delivery is important to the health status of the people and other social predictors. The network of services delivery key features of good performing healthcare system includes aspects like comprehensiveness where a scope of services is offered tailored to the targeted population. The comprehensiveness should cover palliative, rehabilitative services, preventive, curative and health promotion services. Another key feature is accessibility where health services need to be permanently and directly accessible without undue barriers of culture, cost, geography or language among others, and that the services are close as possible

to people at entry level for primary care level. According to National Academies of Sciences (2018), access required gaining entry into the health-care system, getting access to sites of care where patients can receive needed services, and finding of providers who meet the needs of patients; timely access to health care is important to prevent illness, control acute episodes, or manage chronic conditions, any of which could avoid exacerbation or complicate health condition.

Study done by Kringos et al., (2015) suggested that accessibility to primary care services is determined by several factors and the volume and types of services should be in good proportion relative to the needs of the population. The remoteness of services in terms of travel distance for patients determines the geographic accessibility of primary care. *Coverage* is the other important aspect for health service delivery where a defined target population is able to access services with ease. *Continuity* enables health services to be delivered without shortages across a network of services, at all levels of service provision, and over the entire healthcare lifecycle. Person-centered and high quality health services ought to ensure full participation of the target population. Primary care services were meant to encourage an integrated approach to healthcare, it puts more emphasis on strengthening health care system at all levels, particularly at the primary care level, promoting both integrated fashion and integrated approaches in health care delivery.

UNHCR's public health programs are implemented within a public health and community development framework, with an emphasis on primary care services and support for secondary and occasionally tertiary hospital care. The main aim of UNHCR's health programme is to reduce incidences of morbidity and mortality while improving the quality of life of refugees. In the refugee context, health service delivery emerged as emergency services, then post-emergencies; primarily there are two basic strategies that included, community and facility-based health care. Facility-based health care was established to augment the local health care

system through mobile, satellite clinics or setting up a separate health care system. In ideal situation, the hosting country health policies and systems ought to be applied for coordination of healthcare for the disadvantaged communities, as cited by (International Federation of Red Cross Society [IFRCS], 2014).

When local healthcare services are inaccessible to the refugees or other common people, a need arises to set up a separate healthcare system to address the challenge of short-staffing, overloading and poor health services from other far placed public facilities. It begins with getting approved by the National Health Authorities; adapting policies that includes: therapeutic protocols; clinical diagnosis; essential drugs and drug supply, use of essential list and pull system for procurement; Referral system and patient flow; equipping health workers serving displaced persons; minimum employment levels and expatriates per facility; health information system; association with the countrywide health care scheme as well as coordinating health care (IFRCS, 2014).

Primary care service delivery with the basic strategies for providing both community and facility-based health care, in line with health system policies of the hosting country's national health program (IFRCS, 2014). According to UNHCR (2018), supporting, integration of health system to strengthening local - and where necessary central - health services to extend the same to the refugee population, is to be considered. However, health programme must be planned to bring it rapidly in line with national health principles and guidelines and to promote sustainability.

2.4 Resource Re-adjustment

As highlighted in the report, Kenya Comprehensive Programme for refugee [KCPR] (2016 a total of $1.5billion was used for the Kenya refugee operations in the last five years. However,

the report predicted a reduction in the overall humanitarian funding in future owing to the increasing funding requirements globally, as it has been witnessed in the prior three years; the international refugee body witnessed a 24% reduction in health budget to $4.6 million in 2015 from the initial $6.05 million in 2014. The decrease continued where a 19% reduction was witnessed for the year 2016. Due to the reduced health budgets, consolidation of health in the refugee camps occurred, expanding geographical catchments, and increasing population covered. (KCRP, 2016).

Resource mobilization involves sourcing and subjecting funding or resources into action to implement a project. According to Joint Partnerships and Resource Mobilization Strategy 2012 – 2015 (UN Zimbabwe), "At the global level, resource division among the Low-Income Countries (LICs) is projected to reduce with the same rate, with 21 LICs out of the 61 having to receive less development aid. Assistance to the continental Africa expected to increase by 1% annually in real terms, a decrease from an average of 13% in the three years preceding to 2010. The report further projected that with the reduced growth of aid, the population growth was likely to subject the resources to constraints. According to Wilson et al., (2015) primary care service practice level, resources should be organized in such a way as to accommodate access.

Dadaab operation is funded by UNHCR and other donors from the Non-governmental organizations. According to (UNHCR, 2014), the funds are from volunteer donations – majority of it from non-governmental organizations, donor nations as well as private sector players like foundations, trusts and distinct persons. The health sector is among the traditional basic service sector, with high priority that is allocated the highest amount of funding above (22%) of the available funding, including reproductive health (UNHCR, 2015). The Kenyan

government has not met the WHO Abuja Declaration since the total government expenditure on health was 6% of the total expenditure of US$27 in 2008/9, below the set limits.

Since Dadaab Refugee Complex emerged from the three different scenarios, that is; emergency, stable and currently breakthrough where voluntary repatriation has been agreed upon. Changes in resource mobilization strategies from routine method is devised including fund raising strategy (Wilson, et al., 2015). This involves creating inventories of possible avenues of resources as well as fining means to access them. Involving key donors and partners while having fully integrated the programme into national planning and budgeting frameworks; the article advises that the programme should be an integral part of the country operation plan As cited in UNHCR (2014), countries are expected to use existing resources while pursuing other sources of funding. Partnerships can also be used to fund UNHCR programs waiting for more fund allocations. Bilateral funding has also been cited as possible source of running such programs. Collaborations and funding agreements like cost sharing, trust funding, parallel funding has been discussed and recommended as possible effective means of mobilizing resources (UNHCR, 2014). Financial protection for preventing overboard expenditures in existing economically susceptible groups, for example by giving sustaining health insurance in the host and home country, and while on transit ought to be considered. (WHO,2017).

In human resources, availing health care services, world organization health (WHO) provides basic lowest threshold of 2.3 medical physicians, midwives as well as nurses per group of 1000 persons requirement for the access to essential maternal and child care services WHO Global Health Workforce Statistics database, 2010). Kenya's most recent ratio stands at 13 per 10 000 (1.3 per 1000 persons). In the recent study by Transparency International indicated this shortage being worse in remote rural areas where challenges like under-staffing levels exist

ranging from 50 to 80 per cent in both rural and provincial health care facilities (KPMG, 2015). The report further showed that there was 0.1 pharmacist for every 1000 persons, or one pharmaceutical technologist/pharmacist per 10,153 people. According Jordan, (2019) some of the changes required in primary health care changes would include the redistribution of existing resources (financial, material, and human) in order to enable health system to respond to challenges of implementing primary health care services.

2.5 Stakeholder Roles

Stakeholders are those entities that are integrally involved in the healthcare system, in Dadaab Refugee Complex. The key shareholders in healthcare system are clients who are community members, service providers/ health care workers, NGOs implementing health services, the government and the donor i.e. UNHCR. The important role of involving stakeholders cuts across in both implementation of repatriation/relocation and provision of quality health services delivery during the transition period. Stakeholder involvement helps ensure accountability, transparency and efficiency (Samuels et al., 2017).Their involvement is critical in determining and designing desired service levels and development of strategies geared towards the enhancement of primary care service delivery. Involvement of stakeholder is one way of ensuring buy-in and acceptance of reorganizing service and making it possible for people to participate in decisions affecting their health and health system (Wilson et. al., 2015)

The role of NGOs extends beyond advocacy; they support in providing information on demystification of health policies, regulations, and responsibilities to enable citizens become knowledgeable consumers of health services. It is expected during repatriation/relocation the clients should have adequate information related to continuity of services; either to the remaining population and the population that is going.

Reorganization of primary care service heavily depends on community participation. The community leaders must, therefore, be fully informed about the different stages of the reorganization of service during the transition. The community leaders should be able to address questions on service reorganization and properly disseminate information to the population in the camp.

A study conducted by Tammy et al., (2016) confirms that different forms of change in health care system are strongly motivated by stakeholder participation. In this study, participants described two needs that motivated them to participate; increased access to primary care services and improved human resource capacity ad that System change initiatives typically rely on the voluntary commitment of stakeholders.

Gregory et al., (2010) also noted that many benefits can be brought by "Involving stakeholders. This includes; increasing transparency; securing buy-in or increasing support from key decision-makers; Ensuring quality implementation; empowering community members to be involved in either activity; increasing public awareness; improving coordination of implementation efforts and advancing policy changes.

2.6 Management Process

The management process is composed of connected activities and functions happening in a formal institution or organization to achieve predetermine objective. Management has been described as an act of getting people together to accomplish desired goals and objectives using available resources efficiently and effectively. Management comprises organizing, planning, staffing, leading and controlling an organization to achieve the goals (Echeverri et al., 2018). In this research study, the independent variable is also determined by the management process of the institutions, which has to ensure primary care service delivery is comprehensiveness, the services are still accessible during the transition period and there is continuity of care with

efficiency. The other objectives related to reorganization, in the actual implementations, will also depend on the organization management process. A study conducted by Gerrish (2016) on the impact of performance management indicated that there is a relationship between performance management and organization effectiveness and that the organization outcome depends on performance management. The outcome of institutional reorganization on the access to primary care services will be geared towards the management process in the actual sense and that is why the study seeks to assess its influence.

2.7 Theoretical Framework

2.7.1 Contingency Theory

In the theoretical framework of the research, contingency theory was selected to be relevant; this theory asserts that there is no single best way to design organization structures, it recognizes the need for managers to consider the relationship between a changing environment, managerial decision-making, performance and that situational awareness. The four points out have been linked to effectively aligning company resources in a changing environment. During the 1950s, researchers at Ohio State University administered extensive questionnaires measuring a range of possible leader behaviors in various organizational contexts. Although multiple sets of leadership behaviors were originally identified based on these questionnaires, two types of behaviors proved to be especially typical of effective leaders, this included starting building leader behaviors that provided structure (e.g., planning, scheduling role) to make sure the task completion and goal attainment.

In Dadaab Refugee Complex, access to health services has gone through different phases based on the operation context; from emergency, stable protracted situation and currently on-going repatriations. Health services providing organization, with all the stakeholders, had to focus on

the changing environment, thus contingency theory recognizes that as effectiveness is concerned there is a need for management to consider the relationship between managerial decision making, changing environment, situation awareness and performance as a key to effectively aligning the company resources in changing competitive environment. In the study, the researcher expects to establish and determine the key service delivery structural adjustment, resources adjustment that has taken place, given that the access to primary care services, will be taking place in a new environment that has both external and internal forces.

2.7.2 Theory of Change – William Bridges Transition Model

Gill (2018) quoting Bridge's (1991) transition model states that transition occurs in 3 phase process; the end loosing, neutral zone and a new beginning. In the end and losing stage, people enter into this stage when first introduced with the new changes and due to change in perceptions and behaviour, there is need to involve and communicate to the stakeholders and explain how their needs will be met for instance resources, to work effectively in a new environment. In the neutral zone, the products tend to be low coupled with high staff turnover hence mandatory to review the policies, roles, structures, resources, histories and leadership to successfully and effectively manage the transition.

As much as Bridges transition model highlights the feelings that people go through during change; it helps managers to guide people through the transition process thus unfreezing the undesired state and freezing the desired state (Bridges & Bridges, 2019). The model is relevant to the research study since it is a theory related to change. In the research study, there will be establishment of service delivery structural changes including key services adjustments and synchronization of pre-existing structures; also, the research will involve determination of key resources adjustment, stakeholder's roles upon access to primary care services, given that the

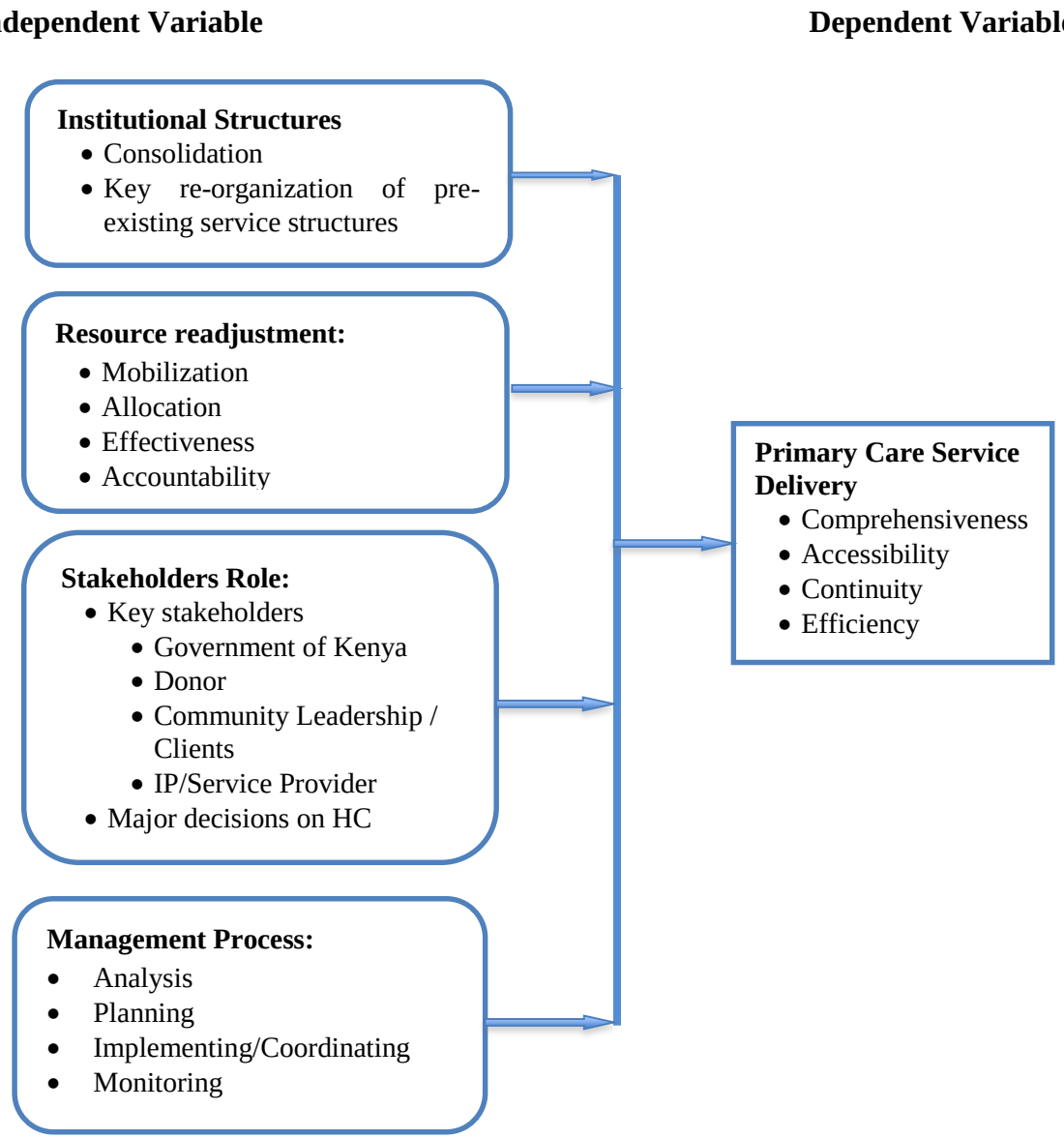
researcher has to measure the influence that comes along with changes during the transition process.

2.8 Conceptual Framework

Figure 2.1 illustrates the relationship between the independent variable (institutional reorganization) and the dependent variable (access to primary care services) to the refugees during the transition period. The study assessed how various re-adjustments on (institutional service delivery structures, resources) and the role of stakeholders influences the access to primary care during the transition period.

Figure 2. 1

Conceptual Framework



In the institutional structures, the study focused on the consolidation of services and other key structural readjust that was done during the transition period and had an influence on the primary health care service delivery. In regards to resource readjustment; the study considered changes related to mobilization, allocation, effectiveness, accountability and its influence on the access to primary care services. The involvement of stakeholders was also a major issue that was measured whereby different stakeholders like donors, the Government of Kenya, and the community members could have had different roles and level of involvement for decision making related to the access to primary health care services, hence the need to use them as indicators of the stakeholders' role on institutional reorganization.

Last but not least on the independent variables was management processes that took place during the reorganization period. It plays a major role in the entire process of institutional re-organization, thus this research measured how effective the process was, just to ensure primary care service delivery was comprehensive, accessible, efficient, and continuity even after the transition period. Eventually, the study had to confirm the influence of the four mentioned independent variables (structural reorganization, resource re-adjustment, stakeholders' role, and management processes) on the dependent variables (access to primary care services) during the transition period. The indicators of access to primary care services were comprehensiveness, accessibility, continuity, and efficiency.

2.8.1 Operationalizing Institutional Reorganization

Institutional reorganization was represented by four key independent sub-variables for this study. Reorganization represented readjustments that were most likely to happen at a health institution serving refuges. For this study, institutional reorganization was influenced by structural changes, resource re-adjustments, management process changes and stakeholders' roles in the changes effected. In many cases, the changes are likely to affect the four, initiated

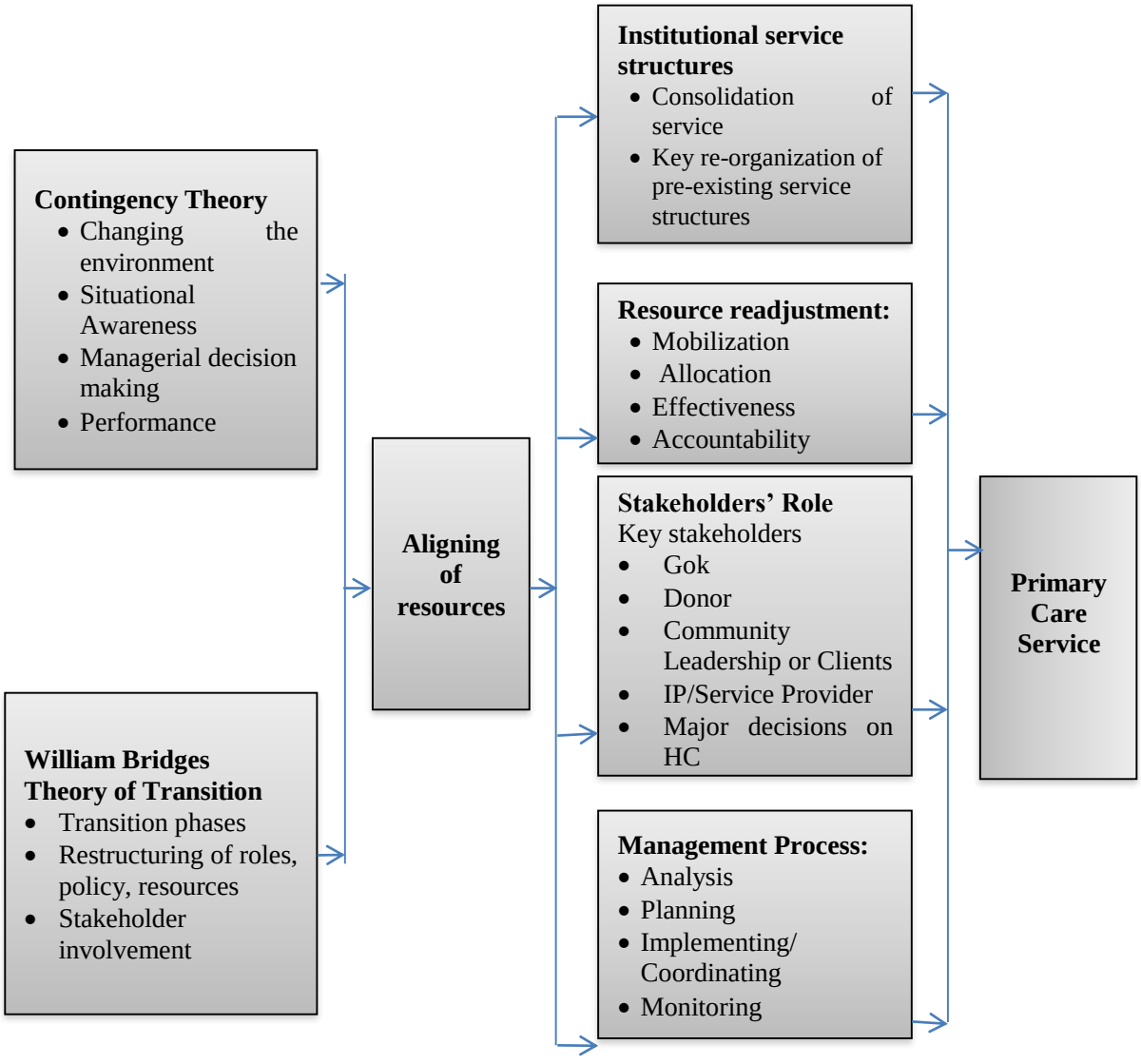
by the management, and having participation of stakeholders to influence the structure and resources directed towards giving health services to the refugees and other needy persons. The four variables work together to constitute institutional reorganization of delivery and access to health services (HS) at the Ifo refugee camp in Dadaab.

2.9 Link between the conceptual framework and theoretical framework

The study developed a framework showing the link between the theoretical and conceptual framework as depicted in Figure 2.2.

Figure 2. 1

The Link between Theoretical and Conceptual Framework



CHAPTER THREE:

RESEARCH METHODOLOGY

3.1 Introduction

This chapter talks about the research design and research methodology used under the study. It outlines the location or region where the study took place, target population, sample technique, sample size, data collection and analysis.

3.2 Research Design

A descriptive cross-sectional design was used for the study. Cross-sectional analyzes data from a sample of the population at a specific point in time. According to Varkevisser et al., (2003) a descriptive study involves describing the characteristics of a particular situation, events or cross-sectional descriptive survey aimed at quantifying the distribution of the certain variable in a study population at one point in time. The design was most appropriate for this study because it involved the measurement of perceptions to derive conclusions. The paradigm shift for this study was more of qualitative and less of quantitative approaches hence the choice of the research design.

3.3 Study Site

The Dadaab refugee camp is located in North Eastern Kenya in Garissa County, 500 kilometres from Nairobi and 90 kilometres from the Kenya-Somalia border, it is the largest refugee settlement in the world and spreads over an area of more than 50 square kilometres. According to UNHCR Dadaab population statistics (January 2017), the population in Dadaab is 270,100 individuals. The Northern Camp comprises of Dagahaley, IFO with a total population of

176,162. The study site will be in IFO with a total population of 103,147 as shown in Table 3.1.

Table 3. 1
Population of Dadaab (IFO) Camp Population Statistics

Country Of Origin	FEMALE		MALE		Grand Total	Percentage
	IFO 1	IFO 2	IFO 1	IFO 2		
Burundian	31	15	39	23	108	0.1
CoB	2	0	0	0	2	0
COD	34	7	56	21	118	0.1
Eritrea	0	0	1	0	1	0
Ethiopia	2692	121	2789	126	5728	8
Rwanda	6	0	10	1	17	0
Somalia	32,113	16, 245	30862	16850	96070	91.4
South Sudan	91	382	118	384	975	0.3
Sudan	7	18	12	18	55	0
Uganda	30	0	36	1	67	1
Yemen	1	0	5	0	6	0
Grand Total	35007	16788	33928	17424	103, 147	
Percentage	50.80%	49.00%	49.2	51.00%		100%

Source: UNHCR (2017)

3.3 Target Population

Study population covered the refugees and camp leaders staying in the camp, Sub-County Government representative from the host country, facilities in charges, technical team leaders and field manager. The camp leaders were targeted because they are the gatekeepers of the community; refugees were targeted because they are the main users of primary health care services and institutions; Sub-County government representative is the custodian of the government policy and they also provide governance and direction primary care; facility in charges are qualified medical personnel (clinical/nursing officers), while technical team leaders refer to health managers are in charge of the facilities under the study.

3.4 Sample Size Determination for Respondents

The sample is representative of the study population. A sample frame is a list of an element from which the sample is drawn. According to Kothari (2004), if the sampling frame is not available, then the researcher has to prepare it.

The study will utilize Krejcie and Morgan formula to determine the sample size as shown below.

$$S = \frac{X^2 NP(1-P)}{d^2(N-1) + X^2 P(1-P)}$$

Where:
S = Required Sample Size
X = Z value (e.g. 1.96 for 95% confidence level)
N = total Population Size
P = Population proportion (expressed as decimal) (assumed to be 0.5(50%)
D = Degree of accuracy (5%), expressed as a proportion (0.5): it is margin error

$$S = \frac{1.96^2 103{,}147 * 0.5(1-0.5)}{0.05^2(103{,}147-1) + 1.96^2 0.5(1-0.05)}$$

S=?

X=1.96

N=103,147

P=0.5

d=0.05

By substituting we have;

S= 1.96 X1.96 X 103147 X 0.5(1-0.5)

0.05X0.05 (103107-1) + 1.96 X 1.96 X 0.5 (1-0.5)

= 99373.5484 /258.8254

S = 383.9

S=384

The sample size of 384 arrived was the minimum number of respondents and thus the researcher could have increased based on certain circumstances. For instance, in cross-

sectional studies where some respondents could decide to drop out by choosing not to continue in answering the prompts in the questionnaire.

3.5 Sampling Procedure

To arrive at the study population, the researcher used probability and non-probability sampling techniques.

Sampling of refugees: Systemic sampling technique was employed to get participants from the refugees. This was done per block and there were a total of 126 blocks IFO1 where the respondents were sampled. A total of 3 respondents were randomly selected per block in IFO while, two local leaders, one facility in-charge, one SMOH and two UNHCR technical lead respondents where interview in their respective offices, making the total sample 384 persons.

Sampling of camp leaders and facility in-charges: Exhaustive sampling technique was adopted for this category of respondents. This sampling technique allowed for the inclusion of all the targeted categories of participants.

Sampling of Sub-county and UNHCR Technical leaders: Purposive sampling technique was used to get Sub-County and UNHCR officials. This sampling technique was of great use for this category of persons because it was done on purpose based on the nature of their job in the context of this study.

Table 3. 2
Study Sample Selection and Distribution

Description	Total Population	Technique	Sample Selected
Refugees	103,147	Random	384
Camp Leaders	8	Exhaustively	8

Facility In-Charges	7	Exhaustively	7
Sub-County Official	1	Purposive	1
UNHCR Technical Team	2	Purposive	2
Total			**402**

3.6 Research Instruments

The study used a semi-structured and undisguised questionnaire to gather primary data. The questionnaire comprised of both open and closed-ended questions. The open-ended questions were used to enable the respondent to give detailed information while the closed-ended questions were used to test the rating of various attributes. Ordinal and nominal scales were used to rate the different variables.

The questionnaire was divided into two sections, i.e. section I and II. Section I was used to collect general information on the respondents while section II was used for collecting information on the specific objectives. The respondents filled the questionnaires with the help of the researcher assistants using semi-formal interviews while some questionnaires were emailed to the respondents and a timeline given for feedback. The researcher used the following methods for data collection:-

a. **In-depth interview guide for Key Informant**: This targeted UNHCR technical leader, Sub County government representative, health coordinator or health manager
b. **Questionnaires**: This involved in-depth interview using structured questionnaires with the health in charges and refugees.

Secondary data was collected through a desk review of the existing data from trusted and accredited sources to allow and enable the researcher to do triangulation before making inferences.

3.6.1 Pre-Testing of Study Instruments

A pilot test was done using the structured questionnaire in one of the health facility and household to check on the relevance and clarity of the questionnaire. This was done one week before the initial commencement of data collection. The pretest of the research instruments was done using 40 questionnaires and 3 key informants (approximately 10% of the sample size). According to Bullock et al., (2017), the respondents on which the research instruments are pretested should not form part of the sample size selected from the target population of the study. However, the selected population for pretesting should have similar characteristics as the actual target population of the study. The researcher, therefore, conducted the pretesting exercise and administered questionnaires with 40 refugees and in-depth interviews with three key informants drawn from Southern Camp of Dadaab Refugee Complex. This is because this study targeted respondents from the Northern Camp of Dadaab Refugee Complex. The information obtained during the pre-testing of the research instrument was used to revise and improve on the questionnaire for accurate results. The results from the pretesting exercise helped the researcher to find out the validity and reliability of the research instruments especially the questionnaires. This ensured that the questions in the research instruments were stated clearly and had the same interpretation to all the respondents.

3.7. Validity and Reliability of the Research Instruments

3.7.1 Validity

According to Bullock et al. (2017) validity is the degree to which results obtained from the analysis of the data correspond to the objectives of the study. The study made use of both construct and content validity. Construct validity was achieved by dividing the research instruments into sections based on the objectives of this study. On the other hand, the researcher ensured content validity of the research instruments through the use of research experts in the field of study, supervisors and peers (colleagues at work and in the college during the study). Research experts closely examined the research instruments to check the relevance of the questions in terms of their objectivity in the area of study, their meaning and clarity. The supervisors and peers also checked the research instruments and ensured that the questions were valid enough to achieve the objectives of the study. The concerns arose by the research experts, supervisors and peers were taken into account to enable changes that were made in the content or the arrangement of the items in the research instruments. The accuracy was also tested during the pretesting exercise among the respondents sampled randomly from Southern Camp of Dadaab Refugee Complex. This ensured that there was no ambiguity in the questions. Based on the responses, questions were restructured, rewritten based on the way the respondents understood them, to get accurate responses during the actual study.

3.7.2 Reliability

According to Toke et al. (2012), reliability analysis aims to find the extent to which a measurement procedure produces the same result if the process is repeated over and over again under the same conditions. This was also noted by Bullock et al. (2017) who noted that reliability refers to a measure of the degree to which research instruments yield consistent results. Reliability of the research instruments in this study was ensured through the use of pretesting. The research instruments were pretested in a population with similar characteristics as the research area, that is, Southern Camp of Dadaab Refugee Complex. The results were

then subjected to reliability tests through the use of Cronbach Alpha test analysis which ensures that the same questions in the research instruments produce similar results in repeated trials.

Cronbach's alpha coefficients (α) analysis determines the average internal consistent (reliability) of items that are on multiple Likert scales. The higher the (α) coefficient the more reliable is the construct. As a rule of the thumb, the acceptable range of Cronbach alpha coefficients is between 0.70 and 0.90 or higher depending on the type of research. A Cronbach alpha coefficient of 0.70 or more is acceptable for exploratory or descriptive research while 0.80 and 0.90 are acceptable for basic research and applied sciences respectively. This study being descriptive, Cronbach alpha coefficient of 0.70 or more as the acceptable one applied

3.8 Data Collection Method

The study used interview guides and questionnaires to gather raw data from the respondents. The research instruments to the refugee community were administered by research assistants. These research assistants underwent training to ascertain familiarity and common understanding of the items in the research instrument. Key informant guides and interviews with the technical team were personally administered by the researcher. Secondary data was collected through a thorough desk review of the existing data from trusted and accredited sources to allow and enable the researcher to do triangulation before making inferences.

3.9 Ethical Considerations

Professionalism, the behaviour of the researcher was applied; confidentiality was upheld throughout and after the study. The Kenya Methodist University (KeMU) research and ethics board's approval was sought before commencing of the study. The researcher sought permission from NACOSTI (National Commission for Science, Technology and Innovation) to conduct the study among the special populations in Dadaab. The participants were given

freedom to withdraw from answering the questions at their will. The researcher also ensured there was a given a verbal or written consent to proceed with the information collection from the respondent. Further, the researcher also was willing to share the research findings with the respondents or their representatives for further actions that could benefit them in policy making or project adjustments. Permission was also sought from relevant key leaders in the Camp, including Camp Managers.

3.10 Study Variables

The independent variables in the study were; institutional service delivery structures readjustments, resource readjustment, the role of stakeholders on access to primary care services while the dependent variable was the primary care service delivery.

3.9. Data Analysis

Data analysis was done immediately after data collection. The first step by the researcher was to clean up the raw data to ensure that data collected from the field met the threshold set by the researcher. Data analysis, therefore, was done using the Statistical Package for Social Sciences (SPSS) version 23.0 by putting the items in the research instruments into SPSS Code Book.

The researcher analyzed the survey data and interpreted the results using nationally/internationally recognized standards. SPSS version 23.0 was used to perform correlation (chi-square analysis) and regression analysis on the primary data to establish the relationship between the variables to determine the existence of a relationship, the strength of the relationship, make forecast and decision to either accept.

Chi-square analysis was done to establish association between each independent variable and the dependent variable. The regression analysis done was simple linear regression and this was more on the contribution of the four independent variables to the dependent variables. Linear

regression was also done to establish the overall contribution and variance of the independent variables on access to primary care. This predicted the relationship of the independent variables to the dependent variable. The data obtained was presented using pie charts, bar graphs and tables.

CHAPTER FOUR:

RESULTS AND DISCUSSIONS

4.1 Introduction

Study findings that were obtained during data collection are analyzed, presented, interpreted and discussed in this chapter as per the research objectives and relevant literature review. The sampled population included refugees at IFO Camp, IFO Camp leaders, Facility In-Charges, Sub-County Officials, and UNHCR Technical Team. The data were obtained using structured questionnaires for refugees and in-depth interviews for key informants. SPSS version 23.0 was used to analyze quantitative data obtained from the questionnaires, while qualitative data obtained from interviews with key informants were analyzed using a thematic approach. Study findings are presented using graphs, pie-charts, and tables. For qualitative data, findings reported using direct quotes.

4.2 Response Rate

The sampled population or this study comprised of 384 refugees at IFO Camp, eight (8) camp leaders, seven (7) Facility In-Charge, one (1) Sub-County official, and two (2) UNHCR Technical Team. As per the sampled population, the researcher sought to administer 384 questionnaires with refugees and conduct 18 in-depth interviews with the selected key informants. For questionnaires, all the 384 that were administered were returned while duly filled. This implies that the response rate for questionnaires was 100%. For in-depth interviews with key informants, all (100%) Camp leaders participated (100%), 5 (71.4%) of the Facility-in-Charges participated, one (100%) Sub-County Official participated, and one (50%) UNHCR Technical Team participated.

Table 4. 1

Response rate

Classification of respondents	Targeted sample	Sample Responded (n)	Response rate (%)
Refugees	384	384	100%
Camp Leaders	8	8	100%
Facility In-Charges	7	5	71.4%
Sub-County Official	1	1	100%
UNHCR Technical Team	2	1	50%

In descriptive research, a response rate of 50% of the sample size in a descriptive study is acceptable to enhance data analysis and make inferences, 60% is good, while 70% or more is superb (Bullock, et al, 2017). This implies that this study's response rate of 99.3% is superb, thus the researcher could validly make relevant inferences and conclusions. The high response rate was achieved because questionnaires were administered through the face-to-face method; thus, ensuring that all respondents effectively participated as required of them. The researcher conducted the Cronbach alpha test analysis using questionnaires that were obtained from the pretesting exercise. The findings of the Cronbach alpha test analysis on that one variable were as presented in Table 4.2.

Table 4. 2

Cronbach's Alpha Coefficients for Multiple Likert Scale Items

Category of multiple likert scale items	Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	No. of Items
Structural reorganization factor	.889	.888	7
Resource re-adjustment factor	.771	.775	6
Stakeholders' role factor	.851	.853	8
Management processes	.808	.885	11

Table 4.2 shows that Cronbach's alpha coefficient for all the four variables with items in a multiple Likert scale was more than 0.7, implying that the level of internal consistency for all the items in a Likert scale in each variable was acceptable. Therefore, the statements that were used to measure the influence on institutional reorganization (structural reorganization, resource re-adjustment, stakeholders, role, and management processes) on access to primary care services were reliable**.** This means that the questionnaire that was used in this study was reliable thus the findings were accurate, valid and relevant to this study according to the purpose of this study.

4.3. Demographic Information of Respondnts at IFO

Demographic data is usually an important aspect of any research since it helps the researcher to compare sub-groups to evaluate how responses vary between these subgroups and the how respondents' background can influence the answers, views, interests and perceptions. The demographic variables used in this study in establishing social-demographic characteristics of the respondents at IFO included gender, age, education level and period stayed at IFO Camp. The summary of the findings of the demographic information of the respondents is shown in Table 4.3.

Table 4.3

Demographic Information of Respondents

Demographic data	No. Responses (n)	Percentage (%)
Gender of respondents		
Male	179	46.6
Female	205	53.4
Age of respondents		
Below 50 years	200	52.1
51-55 years	115	29.9
56-60 years	18	4.7
61-65 years	51	13.3
Education level		
None	186	48.4
Primary	77	20.1
Secondary	76	19.8
Certificate	15	3.9
Diploma	23	6.0
Undergraduate	7	1.8
Period Stayed at the Camp		
1-5 year	21	5.5
6-10 years	119	31.0
11-15 years	65	16.9
16-20 years	179	46.6

4.3.1 Gender

Study findings on gender distribution among respondents at IFO Camp in Dadaab Refugee Complex are presented in table 4.3. As per the findings, female respondents who participated in this study were 179 (53.4%) while the male was 205 (46.6%). From this finding, there was gender balance when the respondents were selected leading to approximately 1:1 ratio in terms

of male to female respondents. Therefore, this study was not gender-biased thus the conclusions and recommendations are not informed by one gender respondents.

4.3.2 Age of respondents

Age of the respondents at IFO Camp was the second demographic information that the researcher sought to know. The findings were as shown in table 4.3. From the study findings on the age distribution of the respondents, 200 (52.1%) of the respondents were below 50 years old, 115 (29.9%) were 51-55 years old, 18 (4.7%) were 56-60 years old, while 51 (13.3%) were 61-65 years old. Putting the respondents into two categories, 200 (52.1%) of them were below 50 years while 184 (47.9%) were above 50 years old. These findings imply that the refugees at IFO Camp fall under various age bracket with some being as old as 60 years and above while others being a bit young, that is, below 50 years. The findings are similar to the conclusions made by Ammar et al. (2016) who implied that refugees had no specific age limits, despite the fact that children and women were viewed as the more at risk than other age groups. The findings also relate to the study by Jiwrakja et al., (2017) who opined that majority of the refugees are the young people, aged below fifty years.

4.3.3 Education Level

The education level of refugees at IFO Camp was another demographic variable that this study sought to measure. Findings were as shown in table 4.3. Findings in Figure 4.3 above show that only 7 (1.8%) of the respondents had managed to obtain education up to undergraduate level. A few 23 (6%) had managed to obtain education up to Diploma level, 15 (3.9%) had education up to certificate level, 76 (19.8%) had obtained education up to secondary level,

while 77 (20.1%) had education up to primary level. Some 186 (48.4%) of the respondents indicated that they had not obtained any education.

4.3.4 Period Refugees Had Stayed at IFO Camp

The researcher wanted to know the number of years the refugees had stayed at IFO Camp. This was necessary because the study's focus was on an institutional reorganization that had taken place for the past 12 months. From the findings are presented in table 4.3, 179 (46.6%) of the respondents had stayed at IFO Camp for 16-20 years, 119 (31.0%) had stayed at IFO Camp for 6-10 years, 65 (16.9%) had stayed for 11-15 years, while a few at 21 (5.5%) had stayed for 1-5 years. The findings show that all respondents had stayed at IFO Camp for more than 12 months (1 year), thus they had experienced institutional re-organization and its influence on services offered at the primary healthcare sector. Therefore, study results are based on facts that were provided by refugees with experience; thus, the findings are valid and reliable.

4.4 Access to primary care services among the Refugees

Access to primary healthcare was the dependent variable where six prompts were answered by the respondents. The summary of the dependent variable is as shown on Table 4.5. Majority of respondents at 322 (83.9%) agreed that reorganization of IFO Camp led to changes in resource mobilization that in turn led to effective access to primary care services. About 62 (16.1%) of the respondents disagreed that the reorganization of the IFO camp was associated with increased resources which in turn led to effective access to primary care services. The information was summarized in table 4.5;

Table 4.5

Access to primary care services in percentage (n=384)

Statement	N	Disagree (%)	Agree (%)
The reorganization of IFO Camp led to changes in resource mobilization which have been effective in the access to primary care services	384	16.1	83.9
Due to the reorganization of primary care services in IFO Camp, the current resources allocated are sufficient for effective service access to primary care services	384	24.2	75.8
Reorganization of IFO Camp led to resource readjustment (staff reduction, reduction in supplies) which improved access to primary care services is effective	384	33.1	66.9
The reorganization of primary care services required policy support from the government to ensure effective access to primary care services	384	33.1	66.9
Implementation of the access to primary care services during the transition period is inclusive of all stakeholders	384	68.3	31.8
Major decisions by stakeholders on health care influenced access to primary care services during the transition period in IFO Camp.	384	70.6	29.4

Key: N= Total respondents who answered a particular prompt

It was also noted that 291 (75.8%) of the respondents agreed that reorganization of primary care services in IFO Camp led to resources allocation sufficient for effective service access to primary care services, while 93 (24.2%) disagreed that the reorganization was associated with effective resource allocation and thus consequent access to primary care services.

When asked about whether reorganization of IFO Camp led to resource readjustment (staff reduction, reduction in supplies) which improved access to primary care services is effective, most respondents at 257 (66.9%) agreed while 127 (33.1%) disagreed to the statement. On

whether the reorganization of primary care services required policy support from the government to ensure effective access to primary care services, 257 (66.9%) agreed while 127 (33.1%) strongly disagreed. About 262 (68.3%) and 122 (31.8%) disagreed and agreed respectively that implementation of the access to primary care services during the transition period is inclusive of all stakeholders. Furthermore, 271 (70.6%) and 113 (29.4%) disagreed and agreed respectively that major decisions by stakeholders on health care influenced access to primary care services during the transition period in IFO camp.

4.4.1 Efficiency in access to primary healthcare

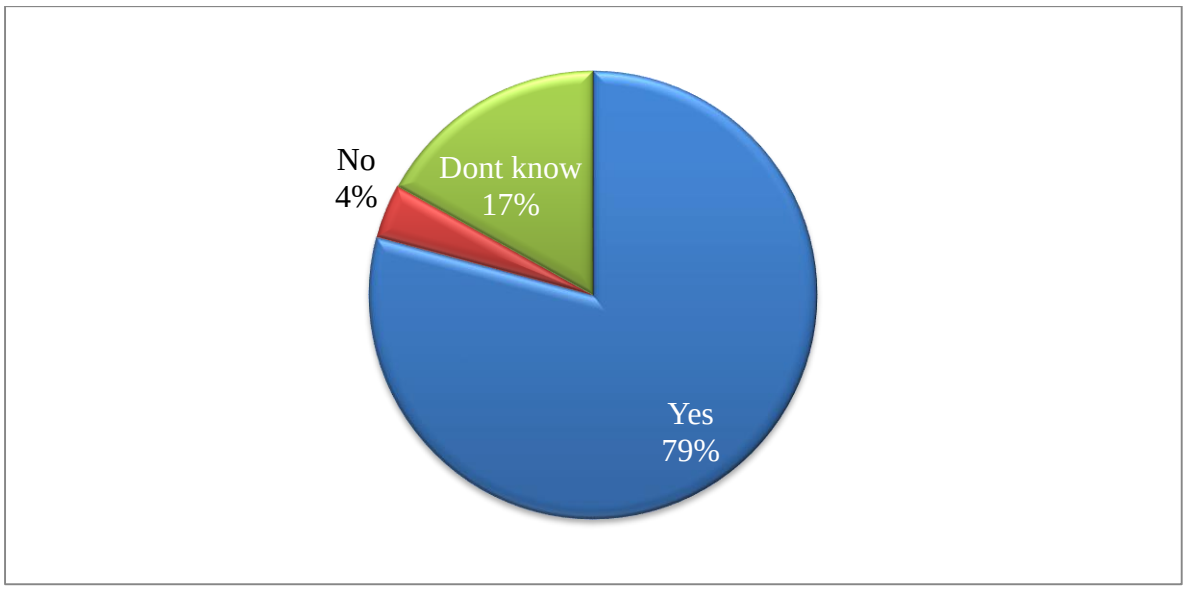
Efficiency of healthcare services was measured using four prompts that sought to link reorganization with access to primary health services. One of the components measuring efficiency in delivery and access to healthcare was whether reorganization at the camp had led to changes in resource mobilization, where 16.1% and 83.9% disagreed and disagreed respectively. It was noted that the respondents agreed there was efficiency associated with reorganization, and resource mobilization. The other component associated with efficiency was whether reorganization led to resource readjustment and improved access to primary care services, where 33.0% and 66.9% disagreed and agreed respectively. Reorganization of primary care services required policy support from government to ensure effective access to primary care services, where 33.1% and 66.9% disagreed and agreed respectively to the statement. The other component measuring efficiency in access to primary care access was on whether involvement of government of Kenya in the reorganization of primary care services influenced access of services, where 62.0% and 38.0% of the respondents agreed and disagreed respectively.

4.5 Institutional Re-organization at IFO Camp and Access to Primary Care Services

The respondents were asked whether the institutional re-organization indeed took place at IFO Camp in the last 12 months. Their responses are presented in Figure 4.1.

Figure 4. 1

Occurrence of institutional re-organization at IFO camp for the last 12 months



The majority 304 (79%) of the refugees in IFO Camp accepted that institutional re-organization took place at IFO Camp for the last 12 months from the time this study was conducted. Another 15 (4%) indicated that they were not aware that that institutional re-organization took place at IFO Camp for the last 12 months while 65 (17%) denied that institutional re-organization took place at IFO Camp for the last 12 months from the time this study was conducted. With most of the refugees 303 (79%) agreeing and some not being aware that that institutional re-organization took place at IFO camp, it implies that indeed institutional re-organization had taken place in the last 12 months from the time this study was undertaken. Further, respondents

were asked to highlight some of the institutional re-organizations that had taken place at IFO Camp. Table 4.6 summaries the results.

Table 4. 6

Type of Re-organization that took place in IFO Camp (n=218*)

Institutional re-organization that had taken place at IFO Camp	No. of responses	Percentage
Primary health care services	52	23.9
Secondary health services	99	45.4
Education services	34	15.6
Health infrastructural services	30	13.8
Management and administration	3	1.4

*Out of the 384 participants, only 218 filled the responses, with the others not knowing if any form of reorganization had occurred at the IFO camp.

The findings in table 4.6 above show that there were five main institutional re-organizations that had taken place at IFO Camp, Dadaab Complex in the last 12 months, namely; primary healthcare services 52 (23.9%), secondary health services 99 (45.4%), educational services 34 (15.6%), health infrastructural services 30 (13.8%), and management and administration services 3 (1.4%). Based on these findings, it is obvious that the health sector at IFO Camp had highly undergone institutional re-organization as compared to other sectors. It ranges from primary healthcare, secondary healthcare, and health infrastructure. These findings present a good case study on the influence of institutional re-organization on access to primary healthcare since the health sector is the most affected.

The type of re-organization was associated with an extent to which beneficiaries experienced an improvement in their primary health access. In addition, it is recommended by CGI White

Paper 2014 that having periodical re-organizations in healthcare facility can improve primary healthcare services, educational services, secondary healthcare services, and management practices. The findings were similar to those by Jiwrajka et al., (2017) who recommended that there was need to make structural changes and make administrative policies to ensure the vulnerable populations (in this case the Rohingya refugees) has better access to the health services.

To narrow institutional re-organization to primary health care services only, the researcher asked respondents to indicate the re-organizations of primary healthcare services that had taken place at IFO Camp during the transition period. In response to the question, the respondents highlighted four major institutional re-organizations of primary healthcare services that had taken place at IFO Camp during the transition period as shown in Table 4.7.

Table 4. 7

Re-organization of Primary Healthcare Services that had taken place at IFO Camp

Re-organization of primary care services	Frequency	Percentage (%)
Structure re-organization	199	51.8
Resource re-adjustment	84	21.9
Management process	80	20.8
Stakeholders' role	21	5.5
Total	**384**	**100.0**

Table 4.6 shows that the following four institutional re-organization of primary care health services that had taken place at IFO Camp in Dadaab Complex, Kenya in the past12 months (transition period): structure re-organization 99 (51.8%), resource re-adjustment 84 (21.9%), management process 80 (20.8%), and stakeholders' role 21 (5.5%). These four institutional re-organizations in the primary healthcare sector could influence access to primary healthcare

services to refugees; thus the reason for this study's focus on the effect of why institutional re-organizations on access to primary healthcare sector at IFO Camp. A study by Ventevogel et al., (2019) also found that the four components of management processes restructuring, stakeholder involvement, resource adjustments and institutional structures were influential in accelerating primary care delivery in special populations.

4.5.1 Structural reorganization of Primary Care Health Services in IFO Camp

The study sought the respondents' views on the structural re-organization of primary care health services during the institutional reorganization of IFO camp. The researcher designed seven statements to measure the views based on a five-point likert scale (SA=Strongly Agree, A=Agree, NS=Not sure, D=Disagree, SD=Strongly Disagree). The findings have been categorized into two options, agree and disagree. Those who were not sure, it was classified under disagree. Table 4.8 shows the findings.

Table 4. 8

Structural Re-organization of Primary Care Health Services in IFO Camp

Statement	N	Disagree %	Agree %
Primary care services in IFO Camp have been consolidated in the last 12 months	384	3.2	96.9
The consolidation of primary care services in IFO Camp has had positive effect on access to primary care services	384	14.1	85.9
The consolidation of services has contributed to reduction of scope in primary care service since repatriation begun	384	16.7	83.3
The structural changes introduced have improved access to primary care services for residents of the camps	384	8.4	91.6
The reorganized structures have an effect on the access to primary care services	384	7.8	92.2
The structural reorganization ensures continuity of primary care services	384	7.3	92.7
Structural reorganization of primary care services has ensured provision of comprehensive services.	384	7.2	92.8

Key: N= Total respondents who answered a particular prompt

As per the findings, 372 (96.9%) refugees generally agreed that primary care health services in IFO Camp have been consolidated in the last 12 months. This concurs with the earlier findings shown in Table 4.3 whereby 344 (89.6%) of the respondents identified primary healthcare as one of the institutional re-organization that took place at IFO Camp among other re-organizations such as educational services, secondary healthcare services, health infrastructure services, and management and administration.

Table 4.8 further show that most respondents, at 330 (85.9%) agreed that the consolidation of primary healthcare services in IFO Camp had a positive effect on access to primary care services, however 320 (83.3%) respondents agreed that the consolidation of primary healthcare services in IFO Camp had contributed to reduction of scope in primary care service since repatriation began. These findings imply that consolidation of primary healthcare services at IFO has contributed to factors that influence primary care services delivery through changes in the institutional structures. About 356 (92.7%) of the respondents agreed that structural reorganization ensured continuity of primary care services and ensured provision of comprehensive services. This is witnessed by the fact that primary care services are separate from secondary care services and healthcare infrastructure (see Table 4.5).

The findings above were similar to those Worku et al., (2019) who indicated that there were priorities that the governments needed to make in respect to structural readjustments for the provision of health to refugees. Similar findings were expressed by Krämer and Fischer (2019); Gandham et al., (2013); and Maneze et al., (2015) who opined that resource allocation, stakeholder involvement, and community leadership was necessary for improved access to primary care in the settings of refugees and other compromised populations.

In-depth with the Ifo Camp Leaders also revealed that there was consolidation of primary care health services in IFO camp during the transition period. For instance, one Camp Leader had the following to say:

> *"...Here, there is a continuous offering of services despite the consolidation of the refugee camp. Service delivery has to continue because the refugees need services for their survival..."*
>
> *(KII, 001, Male)*

Another Camp Leader added;

> *"... More people are waiting for services. Therefore, service delivery continues as normal despite the consolidation and reorganization process..."*
>
> *(KII, 002, Male)*

From Table 4.7, about 199 (51.8%) refugees disagreed that structural changes that were introduced during the institutional re-organization had improved access to primary care services for residents of IFO Camp. However, 330 (85.9%) respondents agreed that, structural reorganization affected the access to primary care services, and this is consistence with Table 4.6 showing 199 (51.8%) of the respondents identified structural changes as a major institutional re-organizations of primary healthcare services that had taken place at IFO Camp. In support of these findings, an in-depth interview with Facility-In-Charge revealed that access to primary care services was affected by structural re-organization of health facilities. For example, one Facility-In-Charge said;

> *"...During the reorganization of IFO Camp, two health facilities were closed. As a result, most refugees have difficulty in accessing the remaining one health facility due to its geographical location within the Dadaab Refugee Complex. Some refugees walk up to more than 5 kilometres to access services in the remaining functional facilities. Furthermore, there is overcrowding due to consolidation which has translated to poor quality issues ..."*

Moreover, in Table 4.6 also shows that the structural changes that were introduced during the institutional re-organization ensured continuity of primary care services (supported by 356 refugees- 92.7%) and it ensured the provision of comprehensive services. In other findings from in-depth interviews, the key informants had mixed responses with regards to the influence of structural reorganization on the continuity of primary care services. One Camp Leader had the following to say;

> *"…The minority of the refugees and other stakeholders in IFO Camp were not considered during the structural reorganization of the Dadaab Refugee Complex. They were left out thus showing some biases towards some groups of people…"*

Another Camp Leader added,

> *"…Although the Camp continued to offer primary health care services during the transition period, patients were forced to travel long distance for the services since some health facilities were closed…"*

An in-depth interview with the Sub- County ministry of health representative revealed that the structural reorganization ensures continuity of primary care services. The Sub-County official said,

> *"…During the reorganization of the Dadaab Refugee Complex, refugees were being directed to the nearest health facility because of the closure of some health facilities within the Camp. The closure of some health facilities led to over-crowding in the remaining health post thus the need to refer some people seeking primary care services to nearest health facilities…"*

Findings from the Facility In-Charge revealed that consolidation of services in IFO Camp influence access to primary care services during the transition period. For example, one Facility-In-Charge said;

> *"…Due to the closure of some health facilities as a result of the restructuring of the health sector, most of the patient refugees are now forced to walk a long distance to the only available health facilities to get health services. The number of health posts at Ifo Camp was reduced from seven (7) to five (5) thus leading to a high number of patients in one facility. This interfered the quality of primary care services that are being offered…"*

In this research, despite the respondent agreeing that there is the consolidation of service, findings show that structural re-organization at IFO Camp especially in the primary healthcare sector ensured comprehensive access to the primary care services, continuity and access. This is in line with the KHSSP 2014-2018 plan, of which all 100% of required KEPHS should be available for populations in congregate settings, including IDP, refugee camps. Moreover, Medecins San Frontieres (2014) advocates for comprehensiveness as a key characteristic of a well-functioning health system. A study by Santoro et al., (2016) found that refugees had challenges in accessing healthcare and thus readjustments in the allocation of resources, policy-making and stakeholder contributions were associated with improved access to primary care services. The restructuring also had its disadvantages as some patients were made to walk long distances to seek the primary care health services and the number of hospitals was reduced leading to overcrowding; this implies geographical access was interfered with. Accessibility is another characteristic for a well-established system in a health facility, thus services accessibility of primary healthcare services should be enhanced in a manner that challenges such as cost, topography, culture, language barrier among others are minimized (Taylor-Robinson & Oleribe, 2016).

4.5.2 Resource Re-adjustments and Access to Primary Care Service

4.5.2.1 Influence of resource re-adjustments on access to primary care services

In-order to access primary care services, human resources; consumable like medical supplies; finances are key input resources of primary care services. Unsurprisingly, many people don't seek treatment because they cannot afford them. Limited resources and lack of optimal utilization of the available is being experienced among many developing countries, thus improving healthcare systems to acceptable standards has been a challenge to WHO (2014).

Further, an examination of the effect of resource re-adjustments access to primary healthcare service at IFO Camp during institution reorganization was conducted. Results were as presented in Table 4.9.

Table 4.9

Influence of resource re-adjustments on access to primary care services

Statement	N	Disagree %	Agree %
There has been a readjustment in the mobilization of resources (Funds, human resource, materials) for the access to primary care services	384	33.9	66.2
The reorganization of IFO Camp led to changes in resource mobilization which have been effective in the access to primary care services	384	16.1	83.9
Due to the reorganization of primary care services in IFO Camp, the current resources allocated are sufficient for effective service access to primary care services	384	24.2	75.8
Due to the reorganization of IFO Camp, the current resource allocated resulted in optimal utilization	384	53.1	46.9
Reorganization of IFO Camp led to resource readjustment (staff reduction, reduction in supplies) which improved the access to primary care services is effective	384	33	66.9
Reorganization of primary care services in IFO Camp led to the improvement in accountability of resources allocated	384	51.3	48.7

Key: N= Total respondents who answered a particular prompt

From the findings in Table 4.8, there was a general agreement (322 refugees, 83.9%) by the respondents that there has been readjustment in the mobilization of resources (funds, human resource, materials) for access of primary healthcare service. They were 62 (16.1%) on whether the reorganization of IFO Camp led to changes in resource mobilization which have been effective for the access of primary care services. Further, 291 (75.8%) respondents agreed to the fact that reorganization of primary healthcare services in IFO Camp led to the sufficient allocation of resources for effective access to primary healthcare service. About 197 (51.3%) also disagreed that re-organization of primary care services in IFO Camp led to the improvement in accountability of resources allocated. The respondents agreed (257 refugees,

66.9%) that reorganization of IFO Camp led to resource readjustment (staff reduction, reduction in supplies) which improved access to primary care services. They disagreed (204 refugees representing 53.1%) that due to the reorganization of IFO Camp, the current resource allocated resulted in optimal utilization.

From these findings, the majority of the refugees at IFO Camp were not aware of resource re-adjustment activities that had taken place at IFO Camp during the transition period. This is because most of their responses were neutral towards the statements with regards to the influence of resource on access to primary care services. This, therefore, implies that resource readjustments that happened during the transition period did not adequately involve refugees; thus their little know-how on resource adjustments that happened during the transition period and the influence on access to primary care services. The findings in this study were similar to those by Senkubuge et al., (2014) and Muhammed, et al., (2013) who indicated that governments needed to understand and solve the barriers related to utilization of primary healthcare among the low-income settings.

4.5.3 Stakeholders' Role in Reorganization and Access to Primary Healthcare

4.5.3.1 Stakeholders' influence on the reorganization on access to primary healthcare

The study investigated the influence of the stakeholders on the reorganization and its effect on access to primary care service during a transition period in IFO Camp. Various statements which outline the stakeholders' influence on the reorganization and its effect on the access to primary care service were set. Participants were asked to rate them. Table 4.10 shows the results.

Table 4.10

Influence of stakeholders, involvement in the reorganization on access to primary care service

Statement	N	Disagree %	Agree %
The reorganization of primary care services required policy support from the government to ensure effective access to primary care services	384	33.1	66.9
The instituted management process ensured that the reorganization of primary care services is in line with the Kenya Health Policy	384	5.4	94.5
The government of Kenya's involvement in the re-organization of primary care services influenced effective service delivery during the transition period	384	38	62
The Donor's involvement in the re-organization of primary care services influenced effective service delivery during the transition period	384	37.5	62.4
Community leadership was involved during the reorganization of IFO Camp enhancing access to primary care services during the transition period	384	37.2	62.8
IP/Service providers facilitated the reorganization of primary care services ensuring better access to primary care services during the transition period	384	65.1	34.9
Implementation of access to primary care services during the transition period is inclusive of all stakeholders	384	68.3	31.8
Major decisions by stakeholders on health care influenced access to primary care services during the transition period in IFO Camp.	384	70.6	29.4

As per the findings, there was a third (257 refugees 66.9%) the respondents that the reorganization of primary care services required policy support from the government to ensure effective access to primary care services. They were also neutral that the instituted management process at Ifo Camp ensured that the reorganization of the primary health sector was in line with the Kenya Health Policy. According to WHO, (2012), institutional structures are governed by specific country health policies, regulations, performance monitoring and standards. This implies that the structural reorganization of health services at Dadaab Refugee Complex was guided by Kenya's Health Policy as the findings have shown regardless the fact that many

respondents were uncertain that the reorganization of the primary health sector was in line with the Kenya Health Policy.

Further, 238 (62.0%) of the respondents agreed that the government of Kenya's involvement in the re-organization of primary care services influenced effective access to primary healthcare service during the transition period. Likewise, 241 (62.4%) of the respondents were not sure that the donor's involvement in the re-organization of primary care services influenced effective access to primary healthcare services during the transition period.

On community involvement, the majority of the respondents at 242 (62.8%) agreed that community leadership was involved during the reorganization of Ifo Camp in enhancing access to primary care services during the transition period. There were 250 (65.1%) of respondents who also disagreed that IP/Service providers facilitated the reorganization of primary care services ensuring better access to primary care service during the institutional reorganization.

The respondents disagreed (262 refugees, about 68.3%) that implementation of the primary healthcare services during the institutional reorganization of IFO Camp was inclusive of all stakeholders. They also disagreed (about 271, representing 70.6%) that major decisions by stakeholders on health care influenced access to primary healthcare services during the institutional reorganization of Ifo Camp. These findings imply that stakeholders' influence in the re-organization of Ifo did not have much influence on access to primary healthcare services during the institutional reorganization.

Findings from in-depth interviews with the Camp Leaders revealed that government involvement in the reorganization of Ifo Camp influenced access to services. One Camp Leader said;

> *"…The government has been chasing refugees from Ifo Camp and this minimizes their commitment in services offered to us…"*

Another Camp Leader noted that community leadership's involvement in the reorganization of primary care services in IFO Camp influenced access to services during the transition period. He said;

> *"…They informed the researcher that community leadership tried their best especially through the community leaders engagement and helping in meeting their communities members…"*

Other Camp Leaders noted that donors were not involved in the reorganization of primary care services in IFO Camp thus influencing to primary care services during the transition period. They indicated that the directive by the government to reorganize the Dadaab Refugee Complex made some donors pull out in enhancing access to primary care services at the camp.

One Camp Leader was also quoted saying;

> *"…IP/ services providers facilitated in the reorganization of primary care services, with limited involvement of the community during the planning stage in IFO Camp since all service delivery responsibility were given by them…"*

These findings have shown that the stakeholders' role in Refugee Camp Reorganization was immense though most of the refugees were not aware of their role. As a result, the refugees did not perceive the stakeholders' role during the transition period as an important factor that could influence access to primary care services. However, the key informants' responses revealed that indeed stakeholders' role during the reorganization of IFO Camp influenced access to primary care services to some extent.

4.5.4 Management Processes and Access to Primary Care Services

4.5.4.1 Influence of management processes on access to primary care services

Findings on the influence of management processes on access to primary healthcare services during the institutional reorganization of IFO Camp were as presented in Table 4.11.

Table 4. 11

Influence of management processes on access to primary care services

Statement	N	Disagree %	Agree %
A joint analysis by the management before and during the reorganization ensure effective access to primary care service during the transition period	384	68	32
The re-organization analysis that was carried out incorporated measures that provide useful information about the effective access to primary care services	384	67.5	32.6
Periodic detailed re-organization analysis helped in identifying inefficiencies that arise in the access to primary care services during the transition period and developing strategies for resolving them.	384	73.7	26.1
Proper joint planning for the reorganization of IFO Camp ensure effective access to primary care services during the transition period	384	73.2	26.9
Effective re-organizational planning of IFO Camp helped the management to appropriately allocate the available resources for the access to primary care services during the transition period	384	70.1	29.9
Through effective re-organizational planning, primary caregivers have managed to envision possible risks in access hence developing contingency plans to deal with them	384	70.9	29.1
Effective joint coordination of activities during the reorganization ensured effective access to primary care services during the transition period	384	71.3	28.6
Re-organization has ensured good coordination between employees in IFO Camp leading to improved access to primary care services during the transition period	384	16.9	83.1
Re-organization has improved coordination between IFO Camp and its stakeholders leading to improved access to primary care services during the transition period	384	15.9	84.2
Effective joint monitoring of the reorganization process ensure better access to primary care services during the transition period	384	61.4	38.7
Effective monitoring ensured that re-organization of primary care services was implemented as planned leading to improved access to primary care services during the transition period	384	13.3	86.6

As per the findings in Table 4.11, about 261 (68.0%) of the respondents generally disagreed that joint analysis by the management before and during the reorganization of Ifo Camp

ensured effective access to primary care service during the transition period. They also (about 259 refugees, representing 67.5%) disagreed that the re-organization analysis that was carried out at Ifo Camp incorporated measures that provide useful information about effective access to primary care services. Further, the respondents disagreed (about 283 refugees, translating to 73.7%) that periodic detailed re-organization analysis helped in identifying inefficiencies that arose in the access to primary care services during the transition period and developing strategies for resolving them.

The findings also indicate that the respondents disagreed (about 281 refugees, 73.2%) that proper joint planning for the reorganization of Ifo Camp ensured effective primary healthcare service delivery during the institutional reorganization. They also disagreed (about 269 refugees, translating to 70.1%) that effective re-organizational planning of Ifo Camp helped the management to appropriately allocate the available resources for primary healthcare service delivery during the institutional reorganization. Likewise, they disagreed (about 272 refugees, 70.9%) that through effective re-organizational planning, primary caregivers have managed to envision possible risks in service delivery hence developing contingency plans to deal with them.

Further findings show that respondents disagreed (275 respondents, 71.3%) that effective joint coordination of activities during the reorganization ensured effective on primary healthcare service delivery during the institutional reorganization of IFO Camp. Consequently, the respondents disagreed (236 refugees, 61.4%) that effective joint monitoring of the reorganization process ensured better primary healthcare service delivery during institutional reorganization. These findings show joint coordination and monitoring of activities during the re-organization of Ifo Camp did not bear fruits in terms of promoting primary healthcare service delivery during the institutional reorganization.

Further on coordination and monitoring of activities during the reorganization of Ifo Camp, the respondents agreed (about 319 refugees, 83.1%) that the re-organization of Ifo Camp had ensured good coordination between employees in Ifo Camp leading to improved access to primary care services during the transition period. They also agreed (323 refugees, 84.2%) that the re-organization had improved coordination between IFO Camp and its stakeholders leading to improved access to primary care services during the transition period. Last but not least, about 333 (86.6%) of the refugees agreed that effective monitoring ensured that re-organization of primary care services was implemented as planned leading to improved primary healthcare service delivery during the institutional reorganization of IFO Camp. These findings imply that management processes influence on primary healthcare service delivery during institutional reorganization to some extent (Senkubuge et al., 2014).

4.6 Relationship between structural adjustment and access of primary health services

Further, the research examined the relationship between structural reorganization and service delivery in the primary healthcare sector among refugees at Ifo Camp. To achieve this, the researcher resorted to a cross-tabulation using chi-square analysis to establish existence of any association between structural reorganization statements and the statement on the access to primary care services. Findings were as presented in Table 4.12.

Table 4.12

Chi-Square Tests for Structural adjustments * Health access

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	204.000a	1	0.00	0.00	0.00
N of Valid Cases	204				

a 3 cells (75.0%) have expected count less than 5. The minimum expected count is .12.
b Computed only for a 2x2 table

From the chi-square table, the test statistic was 204.0 and the corresponding p-value was p< 0.001 as shown. The decision is based on the following null and alternative hypotheses;

H_0: structural adjustment is not associated with access of primary health services

H_1: structural adjustment is associated with access of primary health services

Discussion: since the resultant p-value is less than the chosen significance level of $\alpha = 0.05$, the null hypothesis is rejected, and it is thus concluded that there is an association between structural adjustments and access to primary health access among the refugees. Based on the results, it can be stated as follows;

$(X^2 (1) = 204.0, p < .001)$.

Findings in Table 4. 12 show that structural reorganization factor influenced positively the access of primary care services at Ifo Camp during the transition period since the coefficients β=0.860 and p=0.000 which is less than the standard 0.05. The beta value implied that for one unit increase in structural reorganization factor, access to primary care services at Ifo camp increased by 86.0% (0.860). Consequently, the findings suggest that structural reorganization factor is significantly related to primary care service delivery at Ifo Camp during the transition period. This is also in line with Sije et al., (2016) findings which indicated that there was the positive and significant relationship in the reorganization of the structures in the SMEs sector in Kenya when Turnaround Strategy was introduced. They asserted that reorganization of the structures during the implementation of the Turnaround Strategy should have been evaluated continuously.

4.6.2 Relationship between resource re-adjustments and access to primary healthcare

This research sought to determine the correlation between resource re-adjustments and access to primary care services. To achieve this, the researcher resorted to a cross-tabulation and a chi-square analysis. From the chi-square results, the null hypothesis was analysed and the decision made based on table 4.13 as follows;

Table 4.13

Chi-Square Tests for resource adjustments * Health access

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	67.947a	1	0	0	0
N of Valid Cases	104				

a 2 cells (50.0%) have expected count less than 5. The minimum expected count is .23.
b Computed only for a 2x2 table

From the chi-square table, the test statistic was 67.9 and the corresponding p-value was p< 0.001 as shown. The decision is based on the following null and alternative hypotheses;

H_0: resource adjustment is not associated with access of primary health services

H_1: resource adjustment is associated with access of primary health services

Discussion: since the resultant p-value is less than the chosen significance level of $\alpha = 0.05$, the null hypothesis is rejected, and it is thus concluded that there is an association between resource adjustments and access to primary health access among the refugees. Based on the results, it can be stated as follows; (X^2 (1) = 67.9, p < .001).

Therefore, the findings suggest that resource re-adjustments factor was significantly related to the access to primary care services at Ifo Camp during the transitional period. These findings are in support of Sommer et al., (2018) who also found that that resources realignment including an incentive for human resource for health affects primary healthcare delivery.

4.6.3 Relationship between stakeholders' involvement and access to health service

The researcher further sought to determine the relationship between stakeholders' involvement in reorganization and primary healthcare service access during the institutional reorganization at Ifo Camp in Dadaab Refugee Complex. To achieve this, the researcher resorted to a chi-square correlation, based on cross-tabulations. Table 4.14 presents the findings.

Table 4.14

Chi-Square Tests for stakeholder involvement * Health access

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	2.597[a]	1	0.107	0.251	0.155
N of Valid Cases	215				

a 2 cells (50.0%) have expected count less than 5. The minimum expected count is 1.38.

b Computed only for a 2x2 table

From the chi-square table, the test statistic was 2.597 and the corresponding p-value was p< 0.251 as shown. The decision is based on the following null and alternative hypotheses;

H_0: stakeholder involvement is not associated with access of primary health services

H_1: stakeholder involvement is associated with access of primary health services

Discussion: since the resultant p-value (0.251) is more than the chosen significance level of α = 0.05, the null hypothesis is not rejected, and it is thus concluded that there is no observed

significant association between stakeholder involvement and access to primary health access among the refugees. Based on the results, it can be stated as follows; ($X^2(2)> = 2.597$, $p = 0.25$).

Therefore, the findings suggest that stakeholders' involvement in the institutional reorganization was not significantly related to the access to primary care services at Ifo Camp in Dadaab Refugee Complex. The current study's findings were contradictory to a study conducted by the Dimitropoulos et al., (2019) also found that stakeholder roles and involvement in the access to health services has contributed to an increase in service quality. Besides, the evidence has shown how the increase in stakeholder involvement in Trusts' decision-making processes has enhanced not only stakeholder representativeness, but also improved organizational strategic awareness and, ultimately, raised board effectiveness.

4.6.4 Relationship between management processes and access to primary healthcare service

In addition to the above respondent perception, the study sought to determine the relationship between management processes during institutional reorganization and access to primary care services at Ifo Camp in Dadaab Refugee Complex. To achieve this, the researcher conducted a simple linear regression of the variables involved. Results are presented in Table 4.15.

Table 4.15

Chi-Square Tests for Management involvement * Health access

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	2.236a	1	0.135	0.157	0.157
N of Valid Cases	320				

a 2 cells (50.0%) have expected count less than 5. The minimum expected count is 1.48.
b Computed only for a 2x2 table

From the chi-square table, the test statistic was 2.236 and the corresponding p-value was p< 0.157 as shown. The decision is based on the following null and alternative hypotheses;

H_0: management involvement is not associated with access of primary health services

H_1: management involvement is associated with access of primary health services

Discussion: since the resultant p-value (0.157) is more than the chosen significance level of α = 0.05, the null hypothesis is not rejected, and it is thus concluded that there was no observed significant association between management involvement and access to primary health access among the refugees. Based on the results, it can be stated as follows; (X^2 (2)> = 2.236, p = 0.157).

Therefore, the findings suggest that management processes during institutional reorganization were not significantly related to the access to primary care services at Ifo Camp in Dadaab Refugee Complex. In contradictory with this study's findings, a study conducted by Gerrish (2016) on the impact of performance management indicated that there exists a correlation between performance management and organization effectiveness and that the organization outcome depends on performance management. Santoro et al., (2016) confirmed that management including the management strategies have an effect or influence on the outcome.

4.6.5 Summary of influence of institutional reorganization on access to primary care services at Ifo Camp

To establish the overall influence of the four independent variables forming institutional reorganization on access to primary care a linear regression analysis was performed. The results were presented as follows;

Model Summary

The results of the model summary of the regression analysis are presented in Table 4.16.

Table 4. 16

Model Summary of the Regression Analysis

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.883a	.780	.778	.38401	.780	336.567	4	379	.000

a. Predictors: (Constant): Structural reorganization, resource re-adjustments, stakeholders' involvement in the institutional reorganization, and management processes during institutional re-organization

Findings in Table 4.16 indicate that the four independent variables (structural reorganization, resource re-adjustments, stakeholders' involvement in the institutional reorganization, and management processes during institutional re-organization) that were studied explained 77.8% (Adjusted R^2=0.778) of the dependent variable (access to primary care services). This, therefore, means that other institutional factors/reorganizations contributing to 22.2%, not considered in this research, influenced the access to primary care services at Ifo Camp during the transition period. Therefore, there is the need for more research to establish these other institutional factors/reorganizations that affect the access to primary care services at Ifo Camp in Dadaab Refugee Complex in Garissa County, Kenya.

ANOVA Results

Further, the researcher tested if the overall model summarized in Table 4.16 is valid. Table 4.17 shows a summary of the ANOVA statistics obtained from the means of the four reorganizations in the primary healthcare sector (structural reorganization, resource re-

adjustments, stakeholders' involvement in the institutional reorganization, and management processes during institutional re-organization) that influenced the access to primary healthcare services at Ifo Camps in Dadaab Refugee Complex. ANOVA results were obtained based on the consideration of average values of respondents' views and opinions on the access to primary care services at Ifo Camp. Estimates were made based on the respondents' perception of structural reorganization, resource re-adjustments, stakeholders' involvement in the institutional reorganization, and management processes during institutional re-organization.

Table 4. 17

ANOVA of the Regression

ANOVAa						
Model		Sum of Squares	Df	Mean Square	F	Sig.
	Regression	198.525	4	49.631	336.567	.000b
	Residual	55.889	379	.147		
	Total	254.414	383			

a. *Dependent variable: Access to Primary care services*
b. Predictors: (Constant): Structural reorganization, resource re-adjustments, stakeholders' involvement in the institutional reorganization, and management processes during institutional re-organization

The significance value (p) for the relationship between institutional (structural reorganization, resource re-adjustments, stakeholders' involvement in the institutional reorganization, and management processes during institutional re-organization) and access to primary care services at Ifo Camp is p=0.000. Since the statistical significance (p) value of 0.000 was less than the accepted standard statistical significance of 0.05 ($p<0.05$), it was concluded that the relationship between institutional reorganizations and access to primary care services at Ifo Camp was statistically significant. This, therefore, meant that institutional reorganization greatly influenced access to primary healthcare at Ifo Camp at Dadaab Refugee Complex.

4.6.6 Summary on institutional Reorganization effects on Access to Primary Care Services at Ifo Camp

The four independent variables studied were structural reorganization, resource re-adjustments, stakeholders' involvement in the institutional reorganization, and management processes during institutional re-organization. This, therefore, means that other institutional factors/reorganizations contributing to 22.2%, not considered in this research, influenced the access to primary care services at Ifo Camp during the transition period. Therefore, there is the need for more research to establish these other institutional factors/reorganizations that affect the access to primary care services at Ifo Camp in Dadaab Refugee Complex in Garissa County, Kenya.

From the four reorganizations (variables) two influenced access to primary healthcare including structural reorganization, and resource re-adjustments. The other two variables, stakeholders' involvement in the institutional reorganization, and management processes during institutional re-organization), had no significant influence on access to primary health care.

CHAPTER FIVE:

SUMMARY, CONCLUSIONS,

RECOMMENDATIONS AND AREAS OF FURTHER RESEARCH

5.1 Introduction

This provides the study's conclusions, recommendations, and areas for further research.

5.2 Summary

The following are the summaries based on the research questions;

On the research question on whether there was an influence of structural re-organization on the access to primary care health services during the transition period in IFO Camp of Dadaab Refugee Complex, there was established a significant and positive association between the two variables.

On the research question on whether there was influence of resources re-organization on the continuity of primary care health service delivery during the transition period in IFO Camp, of Dadaab Refugee Complex, the study established strong and significant relationship between the two variables.

For the research question on whether stakeholder's re-organization influence access to primary care health service delivery during the transition period in IFO camp, of Dadaab Refugee Complex, there was not any significant association between the two variables. The study thus established no influence of stakeholders' reorganization on access to primary care services.

On whether there was influence of management processes on the access to primary care health services during the transition period in IFO Camp of Dadaab Refugee Complex, the study established no significant association between the two variables.

5.3 Conclusions

There are relationships between institutional reorganization that took place in the access to primary health care during the transition period in IFO camp, Dadaab complex. The significance value (p) for the relationship between institutional (Structural reorganization, resource re-adjustments, stakeholders' involvement in the institutional reorganization, and management processes during institutional re-organization) and access to primary care services at Ifo Camp is p=0.000. Since the statistical significance (p) value of 0.000 is less than the accepted standard statistical significance of 0.05 ($p < 0.05$), it can be concluded that the relationship between institutional reorganizations and access to primary care services at Ifo Camp is statistically significant.

For instance, this study established that there was a significant relationship between institutional reorganizations that took place in the primary healthcare sector at Ifo Camp in Dadaab Refugee Complex and access to primary care services during the transition period. The four main institutional re-organizations that took place in the primary healthcare sector of Ifo Camp in the last 12 months (transition period) from the time this study was conducted include structural reorganization, resources re-adjustment, stakeholders role/involvement and management processes, during the reorganization process.

Structural reorganization significantly influences the access to primary care services to some extent during the transitional period. The current study established that structural reorganization at Ifo Camp influenced the access to primary care services by 73.9% during the transition period. This is a clear indication the structural reorganization is very influential in the access to services especially in the health sector during the institutional reorganization period.

Resource re-adjustments is another institutional reorganization activity that significantly influences primary healthcare service delivery during the transition period. For example, this study established that resource re-adjustments at Ifo Camp during institutional reorganization influenced the access to primary care services by 40.7%. Resource re-adjustments comprises both financial and human resources.

Stakeholders' participation was found not to play a major role during the institutional reorganization period. While this study did not establish significant positive association to access to healthcare, stakeholder involvement cuts across in both implementations of the reorganization plan and provision of quality services during the transition period. From the about 50.5% respondents, stakeholder's involvement in the institution reorganization influenced the access to primary care services at Ifo Camp. Respondents believed that stakeholder involvement helps to ensure effective access to primary care services in terms of accountability, transparency and efficiency. Therefore, stakeholders' involvement in the institutional reorganizational might help in determining and designing desired service levels and development of strategies geared to enhance primary care service delivery.

Last but not least, effective service delivery during an institutional reorganization requires proper management. About 25.5% of the respondents agreed that management processes during institution reorganization influenced the access to primary care services at Ifo Camp during the transitional period, although there was no significant association established from chi-square analysis. The management process is composed of connected functions and activities occurring in a formal institution or organization to accomplish a predetermined objective. This is an indication that proper management in all organizational activities enhances effective service delivery. As noted by Echeverri et al., (2018), proper management processes during the transition period help in accomplishing the desired goals and objectives of the institutional reorganization through effective utilization of the available resources

efficiently and effectively. Management processes include the planning, organizing, staffing, leading or directing, and controlling the institutional reorganization for better service delivery. Therefore, in this study, the management process during the reorganization period ensure primary care service delivery is comprehensiveness, the services are still accessible during the transition period and there is continuity of care with efficiency.

5.4 Recommendations

Based on the study's findings, the following are the recommendations of this study:

1. There should be effective and proper structural reorganization during the transition period to enhance primary service delivery.
2. The institution in collaboration with other stakeholders should ensure that there are effective resource re-adjustments during institutional reorganization to enhance better service delivery during the transition period.
3. The institution should ensure that the stakeholders' role and involvement during the reorganization process are adhered to. This is because stakeholders play a major role in ensuring that there is accountability, transparency, and efficiency during the transition period thus ensuring that services are still accessible during that the transition period.
4. The institution should ensure that there is effective and proper management during the reorganization period. This is because proper management helps in planning, organizing, staffing, directing, and controlling the institutional reorganization thus improving service delivery during the transition period and ensures efficiency.

5.5 Areas for Further Research

1. Study findings indicate that the four independent variables (structural reorganization, resource re-adjustments, stakeholders' involvement in the institutional reorganization, and management processes during institutional re-organization) that were studied

explained only 77.8% (Adjusted R^2=0.778) of the dependent variable (access to primary care services). This, therefore, means that other institutional factors/reorganizations contributing to 22.2%, not considered in this research, influenced the access to primary care services at Ifo Camp during the transition period. Therefore, further research needs to be carried out to establish these other institutional factors/reorganizations that affect the access to primary care services at Ifo Camp in Dadaab Refugee Complex in Garissa County, Kenya.

2. This study concentrated on primary healthcare services only. This implies that the study was limited since institutional reorganization affects all sectors including secondary services in the institution. Therefore, further research is recommended to include secondary as sectors in an institution. The findings of such study will be compared to the findings of this study thus giving a clear picture of the influence of institutional reorganization on general health service delivery in a transition period.
3. The current study concentrated on one Refugee Camp, that is, Dadaab Refugee Complex.

4. The Study concentrated on resources re-adjustment as one of the independent variables. Therefore research can be done to evaluate the performance of human resources in the access to primary care services and factors affecting their performance during their transition period.

5. The Study did not asses to what extent services utilization was taking place after institutional re-organization during the transition period; therefore it will be an area of research study.

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APPENDICES

Appendix 1: Informed Consent Form

Consent to participate in this study:

Reggie Ann Jaji
P.O Box 18772 – 00100
Nairobi

Kenya Methodist University
P. 0 Box 267-60200
MERU, Kenya

SUBJECT: INFORMED CONSENT

Dear Respondent,

My name is REGGIE ANN JAJI. I am a student studying Master of Science in Health Systems Management at the Kenya Methodist University. The study focuses on "The Influence of Institutional Reorganization on delivery of primary care services during the transition period." You have been selected to participate in this research because you have particular knowledge and experiences that may be important in improving service delivery in the health sector. This research will be utilized to strengthen the health systems in Kenya and other low-in- come countries in Africa including refugee operations across the continent. As a result, countries, communities and individuals will benefit from improved quality of healthcare services. In addition, this research will generate new knowledge in the field of Health Systems Management hence informing decision makers and policy makers on relevant issues to be considered decision making and development of policies on health care respectively.

Procedure to be followed

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

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

Please remember that participation in the study is voluntary. You may ask questions related to the study at any time. You may refuse to respond to any questions and you may stop an interview at any time. You may also stop being in the study at any time without any consequences to the services you are rendering.

Discomforts and risks.

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

Benefits

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

Rewards

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

Confidentiality

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

Contact Information

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

1. Dr. Wanja Mwaura- Email address - wanjamwaura@gmail.com; +254726678020)
2. Head of Department of Health Systems Management of Kenya Methodist University, Nairobi campus.
3. Lilian Muiruri- Email - address wambuikaburi@gmail.com.

Participant's Statement

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

Name of Participant……. Date……..

Signature…….

Investigator's Statement

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

Name of Interviewer……Date…….

Interviewer Signature……

Appendix 2: Questionnaire for Refugees (Community members)

Instructions

In some questions, choices are provided so please put a **tick**☑ in the appropriate box. Where choices are not provided, answer using your own words in the most appropriate and complete way for open-ended questions. Kindly complete all sections of the questionnaire.

SECTION A: DEMOGRAPHIC DATA

1. Gender: Male [ ] Female [ ]

2. Your age: Below 50 years [ ] 51 – 55 years [ ] 56 – 60 years [ ]
61 – 65 years [ ] 66 – 70 years [ ] above 70 years [ ]

3. Education level:

None	[ ]	Primary	[ ]	Secondary	[ ]	Certificate	[ ]
Diploma	[ ]	Undergraduate	[ ]	Masters	[ ]	PhD	[ ]
Professional	[ ]	Technical	[ ]				

4. Period you have stayed in IFO Camp:

Less than a year	[ ]	1 – 5 years	[ ]	6 – 10 years	[ ]
11 – 15 years	[ ]	16 – 20 years	[ ]	above 20 years	[ ]

SECTION B: INSTITUTIONAL REORGANIZATION OF IFO CAMP

5. Has institutional re-organization taken place in IFO Camp for the last 12 months?
Yes [ ] No [ ] Don't know [ ]

6. If Yes to question 7 above, kindly indicate some of the institutional re-organization that has taken place in IFO Camp (*You can tick more than one*)

Primary Health care services [ ]
Education services [ ]
Secondary Health Services [ ]
Health Infrastructural [ ]
Management and Administration services [ ]

Any other (specify) …….

7. Kindly indicate the re-organization of primary care services that have taken place in IFO Camp during the Transition Period (*You can tick more than one*)

Structural re-organization [ ]
Resource re-adjustments [ ]
Stakeholders' Roles [ ]
Management Processes [ ]

Any other (specify) …….

SECTION C: INFLUENCE INSTITUTIONAL REORGANIZATION OF IFO CAMP ON ACCESS TO PRIMARY CARE SERVICES DURING TRANSITION PERIOD

8. Using the scale of 1 to 5 in the table below, please indicate the extent to which you agree or disagree to the items with regard to the effect of **structural re-organization** on the access to primary care services during the transition period in IFO Camp.

NB: **5**=Strongly Agree, **4**=Agree, **3**=Not sure, **2**=Disagree, **1**=Strongly Disagree

Item	**5**	**4**	**3**	**2**	**1**
Primary care services in IFO Camp have been consolidated in the last 12 months					
The consolidation of primary care services in IFO Camp has had positive effect on access to primary care services					
The consolidation of services has contributed to reduction of scope in primary care service since repatriation begun					
The structural changes introduced have improved access to primary care services for residents of the camps					
The reorganized structures have an effect on the access to primary care services					
The structural reorganization ensures continuity of primary care services					
Structural reorganization of primary care services has ensured provision of comprehensive services.					

9. Using the scale of 1 to 5 in the table below, please indicate the extent to which you agree or disagree to the items with regard to the effect of **resource re-adjustments** on the access to primary care services during the transition period in IFO Camp.

NB: **5**=Strongly Agree, **4**=Agree, **3**=Not sure, **2**=Disagree, **1**=Strongly Disagree

Item	**5**	**4**	**3**	**2**	**1**
There has been readjustment in the mobilization of resources (Funds, human resource, materials) for the access to primary care services					
The reorganization of IFO Camp led to changes in resource mobilization which have been effective in the access to primary care services					
Due to the reorganization of primary care services in IFO Camp, the current resources allocated are sufficient for effective service access to primary care services					
Due to reorganization of IFO Camp, the current resource allocated resulted in optimal utilization					
Reorganization of IFO Camp led to resource readjustment (staff reduction, reduction in supplies) which improved access to primary care services is effective					
Reorganization of primary care services in IFO Camp led to improvement in accountability of resources allocated					

10. Using the scale of 1 to 5 in the table below, please indicate the extent to which you agree or disagree to the items with regard to effect of **stakeholders' influence on the reorganization** on the access to primary care services during the transition period in IFO Camp.

NB: **5**=Strongly Agree, **4**=Agree, **3**=Not sure, **2**=Disagree, **1**=Strongly Disagree

Item	**5**	**4**	**3**	**2**	**1**
The reorganization of primary care services required policy support from the government to ensure effective access to primary care services					
The instituted management process ensured that the reorganization of primary care services is in line with the Kenya Health Policy					
The government of Kenya's involvement in the re-organization of primary care services influenced effective service delivery during transition period					
The Donor's involvement in the re-organization of primary care services influenced effective service delivery during transition period					
Community leadership was involved during the reorganization of IFO Camp enhancing access to primary care services during transition period					
IP/Service providers facilitated the reorganization of primary care services ensuring better access to primary care services during the transition period					
Implementation of the access to primary care services during the transition period is inclusive of all stakeholders					

Major decisions by stakeholders on health care influenced access to primary care services during the transition period in IFO Camp.					

11. Using the scale of 1 to 5 in the table below, please indicate the extent to which you agree or disagree to the items with regard to effect of **management processes** on the access to primary care services during the transition period in IFO Camp.

NB: **5**=Strongly Agree, **4**=Agree, **3**=Not sure, **2**=Disagree, **1**=Strongly Disagree

	5	**4**	**3**	**2**	**1**
Joint analysis by the management before and during the reorganization ensure effective access to primary care service during the transition period					
The re-organization analysis that was carried out incorporated measures that provide useful information about effective access to primary care services					
Periodic detailed re-organization analysis help in identifying inefficiencies that arise in access to primary care services during transition period and developing strategies for resolving them					
Proper joint planning for the reorganization of IFO Camp ensure effective access to primary care services during the transition period					
Effective re-organizational planning of IFO Camp helped the management to appropriately allocate the available resources for access to primary care services during the transition period					
Through effective re-organizational planning, primary care givers have managed to envision possible risks in service delivery hence developing contingency plans to deal with them					
Effective joint coordination of activities during the reorganization ensured effective access to primary care services during the transition period					
Re-organization has ensured good coordination between employees in IFO Camp leading to improved access to primary care services during transition period					
Re-organization has improved coordination between IFO Camp and its stakeholders leading to improved access to primary care services during transition period					
Effective joint monitoring of the reorganization process ensure better access to primary care services during the transition period					
Effective monitoring ensured that re-organization of primary care services was implemented as planned leading to improved access to primary care services during transition period					

********END******

THANKS FOR YOUR TIME

Appendix 3: In-depth Interview Guide for IFO Camp Leaders

Questions

A. Your position in IFO Camp: **……**

B. Period you have worked as a Leader in in IFO Camp:

Less than a year [ ] 1 – 5 years [ ] 6 – 10 years [ ]

11 – 15 years [ ] 16 – 20 years [ ] above 20 years [ ]

1. How do consolidation of services in IFO Camp influence access to primary care services during transition period?
2. How do key re-organization of pre-existing service structures in IFO Camp influence access to primary care services during transition period?
3. Explain how the structural reorganization ensures continuity of primary care services
4. Explain how resource readjustment in terms of mobilization, allocation, effectiveness, and accountability led to access to primary care services in IFO Camp during the transition period
5. How does management processes like analysis, planning, coordination, and implementation on the access to primary care services during the transition period in IFO Camp?

   =Comment on community leadership's involvement in the reorganization of primary care services in IFO Camp

   =Comment on government of Kenya's involvement

   = Comment on Donor's involvement in the reorganization of primary care services in IFO Camp and access to primary care

   = comment on IP/Service providers' facilitation in the reorganization of primary care services in IFO Camp and influenced service delivery during the transition period

   = Comment on major decisions by stakeholders on health care influenced service access to primary serviced in IFO Camp during the transition period

Appendix 4: In-depth Interview Guide for Facility In-Charges

Questions

A. Name of your Health Facility: **……**

B. Type of health facility:

Hospital	[ ]	Health Centre (type III)	[ ]
Health Centre (type II)	[ ]	Health Centre (type II)	[ ]

Other (specify): …….

C. Period you have worked in the current Health Facility:

D. Less than a year [ ] 1 – 5 years [ ] 6 – 10 years [ ]

E. 11 – 15 years [ ] 16 – 20 years [ ] above 20 years [ ]

1. How do consolidation of services in IFO Camp influence access to primary care services during transition period?
2. How do key re-organization of pre-existing service structures in IFO Camp influence access to primary care services during transition period?
3. Explain how the structural reorganization ensures continuity of primary care services
4. Explain how resource readjustment in terms of mobilization, allocation, effectiveness, and accountability led to access to primary care services in IFO Camp during the transition period
5. How does management processes like analysis, planning, coordination, and implementation on the access to primary care services during the transition period in IFO Camp?

   =Comment on community leadership's involvement in the reorganization of primary care services in IFO Camp

   =Comment on government of Kenya's involvement

   = Comment on Donor's involvement in the reorganization of primary care services in IFO Camp and access to primary care

   = comment on IP/Service providers' facilitation in the reorganization of primary care services in IFO Camp and influenced service delivery during the transition period

   = Comment on major decisions by stakeholders on health care influenced service access to primary serviced in IFO Camp during the transition period

Appendix 5: In-depth Interview Guide for the Sub-County Official

Questions

1. How do consolidation of services in IFO Camp influence access to primary care services during transition period?
2. How do key re-organization of pre-existing service structures in IFO Camp influence access to primary care services during transition period?
3. Explain how the structural reorganization ensures continuity of primary care services
4. Explain how resource readjustment in terms of mobilization, allocation, effectiveness, and accountability led to access to primary care services in IFO Camp during the transition period
5. How does management processes like analysis, planning, coordination, and implementation on the access to primary care services during the transition period in IFO Camp?

   =Comment on community leadership's involvement in the reorganization of primary care services in IFO Camp

   =Comment on government of Kenya's involvement

   = Comment on Donor's involvement in the reorganization of primary care services in IFO Camp and access to primary care

   = comment on IP/Service providers' facilitation in the reorganization of primary care services in IFO Camp and influenced service delivery during the transition period

   = Comment on major decisions by stakeholders on health care influenced service access to primary serviced in IFO Camp during the transition period

   =What role has the County Government has played in the reorganization of IFO Camp to ensure effective service delivery during the transition period?

Appendix 6: In-depth Interview Guide for UNHCR Technical Team

Questions

1. How do consolidation of services in IFO Camp influence access to primary care services during transition period?
2. How do key re-organization of pre-existing service structures in IFO Camp influence access to primary care services during transition period?
3. Explain how the structural reorganization ensures continuity of primary care services
4. Explain how resource readjustment in terms of mobilization, allocation, effectiveness, and accountability led to access to primary care services in IFO Camp during the transition period
5. How does management processes like analysis, planning, coordination, and implementation on the access to primary care services during the transition period in IFO Camp?

   =Comment on community leadership's involvement in the reorganization of primary care services in IFO Camp

   =Comment on government of Kenya's involvement

   = Comment on Donor's involvement in the reorganization of primary care services in IFO Camp and access to primary care

   = comment on IP/Service providers' facilitation in the reorganization of primary care services in IFO Camp and influenced service delivery during the transition period

   = Comment on major decisions by stakeholders on health care influenced service access to primary serviced in IFO Camp during the transition period

   =What role has the UNHCR played in the reorganization of IFO Camp to ensure effective service delivery during the transition period?

Appendix 7: Krejcie & Morgan (1970) Table for Sample Size Determination

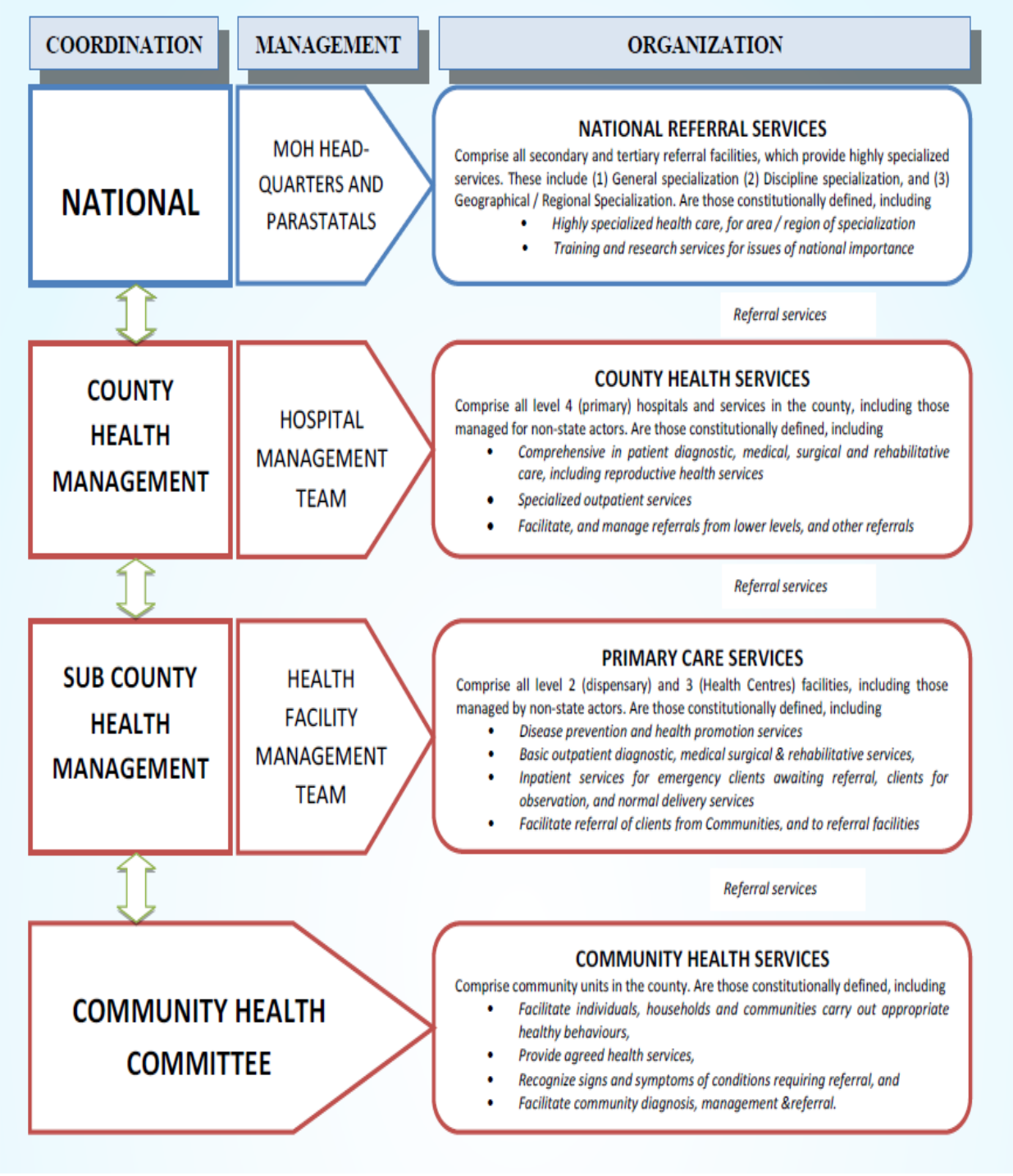
Table 3.1

Table for Determining Sample Size of a Known Population

N	S	N	S	N	S	N	S	N	S
10	10	100	80	280	162	800	260	2800	338
15	14	110	86	290	165	850	265	3000	341
20	19	120	92	300	169	900	269	3500	346
25	24	130	97	320	175	950	274	4000	351
30	28	140	103	340	181	1000	278	4500	354
35	32	150	108	360	186	1100	285	5000	357
40	36	160	113	380	191	1200	291	6000	361
45	40	170	118	400	196	1300	297	7000	364
50	44	180	123	420	201	1400	302	8000	367
55	48	190	127	440	205	1500	306	9000	368
60	52	200	132	460	210	1600	310	10000	370
65	56	210	136	480	214	1700	313	15000	375
70	59	220	140	500	217	1800	317	20000	377
75	63	230	144	550	226	1900	320	30000	379
80	66	240	148	600	234	2000	322	40000	380
85	70	250	152	650	242	2200	327	50000	381
90	73	260	155	700	248	2400	331	75000	382
95	76	270	159	750	254	2600	335	1000000	384

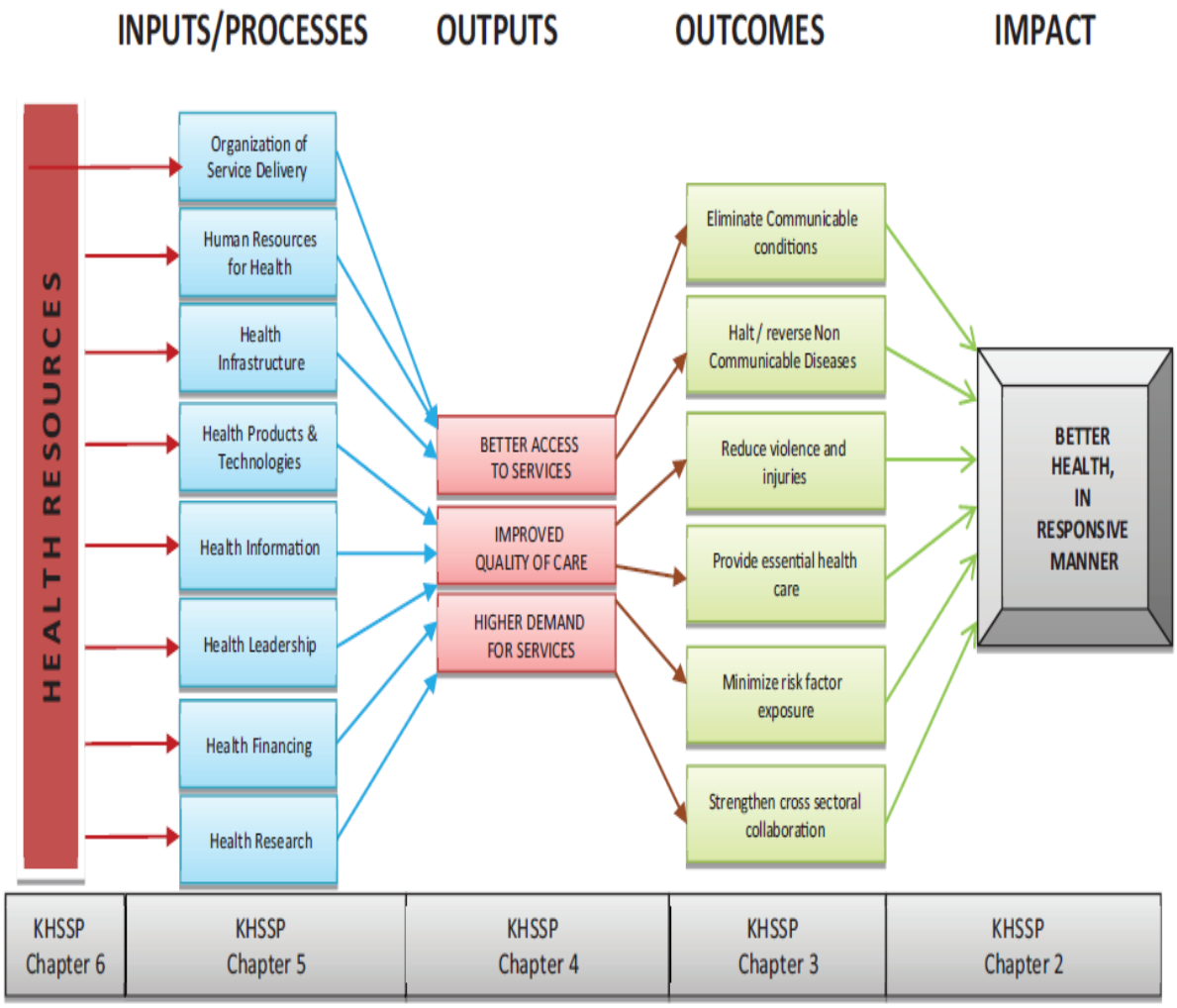
Note: N is Population Size; S is Sample Size *Source: Krejcie & Morgan, 1970*

Appendix 8: Organization of Service Delivery



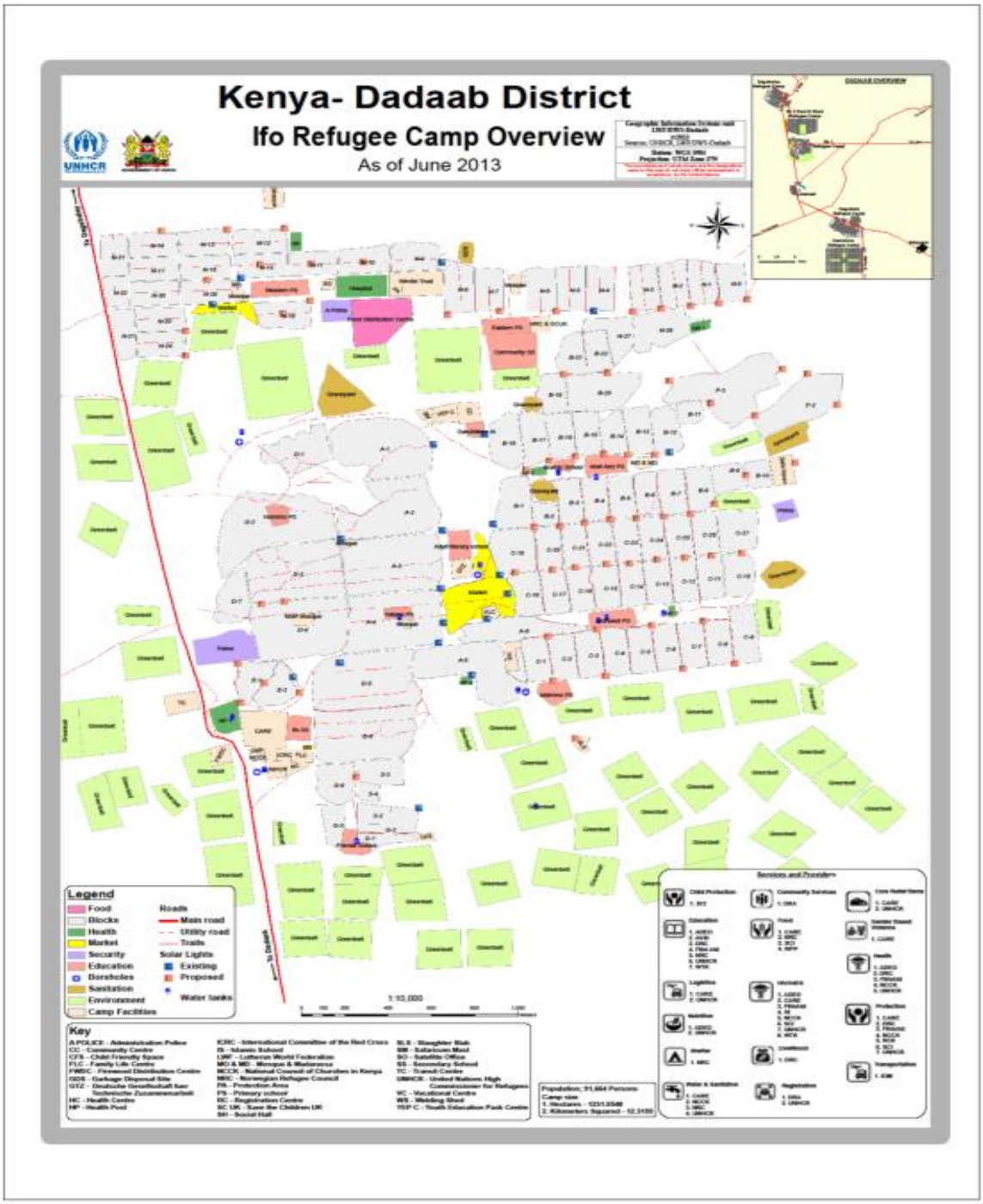
Source: Kenya Health Policy 2012 - 2030

Appendix 9: Framework for Implementation



Source: Kenya Health Sector Strategic Plan 2014 -2018

Appendix 10: Map of IFO 1 Camp



Appendix 11: Ethical Clearance from the University

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

25TH FEBRUARY 2019 KEMU/SERC/HSM/9/2019

Reggie Ann Jaji
HSM-3-1755-1/2014

Dear Reggie,

RE: ETHICAL CLEARANCE OF A MASTERS' RESEARCH THESIS

Your request for ethical clearance for your Masters' Research Thesis titled **"Influence of Institutional Reorganization on the delivery of Primary Care Services in a Transition period: A case of IFO Camp, Dadaab Refugee Complex, 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:

6. All co-investigators must be kept informed of the status of the project.
7. 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.
8. 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.

Appendix 12: Research Authorization from Ministry of Education

MINISTRY OF EDUCATION

STATE DEPARTMENT OF EARLY LEARNING AND EDUCATION

Telegram: "SCHOOLING" Garissa
Telephone: 046-210-2458, Garissa.
Fax: 046-210-2002
Email:cdegarissacounty@gmail.com
When replying please quote

REF: NEP/ED/6.26/VOL.III (105)

COUNTY DIRECTOR OF EDUCATION
GARISSA
P. O. Box 8-70100
GARISSA

DATE:11th April , 2019

REGGIE ANN JAJI,
KENYA METHODIST UNIVERSITY
PO.BOX 267-60200
MERU.

RE: RESEARCH AUTHORIZATION

Reference is made to your letter **REF NACOSTI/P/19/49582/28978** dated 1st April, 2019 from Director General /CEO on application for authority to carry out research on **"Influence of intuitional reorganisation on the delivery of primary care services in a transition period: A case of IFO camp ,Dadaab refugee complex, Kenya ."** in period ending1st April , 2020.

Am pleased to inform you that you have been authorized to undertake your research in Garissa County.

FOR COUNTY DIRECTOR OF EDUCATION GARISSA

HASSAN GURE KORE
FOR: COUNTY DIRECTOR OF EDUCATION
GARISSA.

Appendix 13: County Commissioner's Approval

THE PRESIDENCY

MINISTRY OF INTERIOR & CO-ORDINATION OF NATIONAL GOVERNMENT

Telegrams: "COUNTY" GARISSA.
Telephone: Garissa
ccgsacounty@gmail.com

OFFICE OF THE
COUNTY COMMISSIONER
P.O BOX 1-70100
GARISSA COUNTY

When replying please quote

REF.NO: CC/EDU/7/3/(134)

11 April, 2019

Reggie Ann Jaji
Kenya Methodist University
P. O. Box 267-60200
MERU.

RE: RESEARCH AUTHORIZATION

Refer to your letter Ref. No. NACOSTI/P/19/49582/28978 dated 3rd April, 2019 from Director General/CEO on application for authority to carry out research on "***Influence of institutional reorganization on the delivery of primary care services in a transition period: A case of IFO camp, Dadaab Refugee Complex, Kenya"*** for the period ending 1st April, 2020.

I am pleased to inform you that you have been authorized to undertake your research in Garissa County.

S. K Njuguna
For: County Commissioner
GARISSA COUNTY.

Appendix 14: NACOSTI Approval

NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

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

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

Ref. No. **NACOSTI/P/19/49582/28978** Date: **3rd April 2019**

Reggie Ann Jaji
Kenya Methodist University
P.O. Box 267- 60200
MERU.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ***"Influence of institutional reorganization on the delivery of primary care services in a transition period: A case of IFO camp, Dadaab Refugee Complex, Kenya"*** I am pleased to inform you that you have been authorized to undertake research in **Garissa County** for the period ending **1st April, 2020.**

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

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

CHARITY MUSEMBI
FOR: DIRECTOR-GENERAL/CEO

Copy to:

The County Commissioner
Garissa County.

Appendix 15: Research Authorization from Ministry of Health

COUNTY GOVERNMENT OF GARISSA

MINISTRY OF HEALTH

Tel: 046 – 2102349
Fax: 046 - 2103254 /2103166
E-mail: abduldm45@gmail.com

Medical Headquarters
Garissa County
P O Box 40-70100
GARISSA-KENYA

When replying please quote
Ref No: CGG/CDHA/VOL. I (15)

15th April 2019

TO:
REGGIE ANN JAJI
KENYA METHODIST UNIVERSITY
P O Box 267 – 60200
MERU

Dear Ann

RE: AUTHORIZATION TO CONDUCT RESEARCH IN GARISSA COUNTY

Approval has been granted for you to conduct the research on ***"Influence of institutional reorganization on the delivery of primary care services in a transition period: A case of IFO Camp, Dadaab Refugee Complex," Garissa County, Kenya*** in accordance with the formal research approval on **3rd April 2019**.

Upon completion of the study, the investigator shall provide a summary of findings as well as pragmatic recommendations if any, to the County Department of Health.

For any information or data required, kindly liase with **Mr. Abdi Shale Abdi Tel No. 0720756720** or **Yussuf Ali Hassan Tel No. 0727350430.**

Any assistance accorded to her will be highly appreciated.

Thank you.

Abdullahi Daud.
Director of Health Administration and Finance.
Garissa County