FACTORS INFLUENCING THE EFFECTIVENESS OF HEALTH MANAGEMENT COMMITTEE'S: A CASE OF MACHAKOS COUNTY, KENYA

BY

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DECLARATION

This project report is my original work and has not been presented for an award in any other University.

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DEDICATION

To my loving husband Dr. Moses Mwangi Kimani and our two sons Kimani and Saitabau for their great support and encouragement through my studies and most especially this time as I went through the course.

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ACRONYMS AND ABBREVIATIONS

CHO- County Health Officer

DHIS- District Health Information System

DHMBs-District Health Management Boards

FBO- Finance Based Organization

GoK- Government of Kenya

HFMCs-Health facility management committees

HSRS-Health Sector Reform Secretariat

HSSF-Health Sector Services Fund

IMR-infant mortality rate

KDHS- Kenya Demographic and Health Survey

KHPF-Kenya Health Policy Framework

MOPHS-Ministry for Public Health and Sanitation

NGO-Non Governmental Organization

HCW-Health care workers

MCA-Member of county assembly

SPSS-Statistical package for social scientists

ABSTRACT

The potential for mechanisms such as Health facility management committees (HFMCs) to meet their goals has been limited by wider decentralization challenges such as insufficient transfer in practice of decision-making power to local levels for a range of functions, lack of clarity in responsibilities at local levels, and broader factors such as the prevailing political context, and inadequate access to financial resources. The health sector in Kenya has undergone a major transformation due to amongst other factors, changing patterns of service delivery, County government regulations, technological innovations, service quality movements, and pressures to improve health care and health wages. Kenya's new constitution, suggest a continued devolution of powers to senior managers in new County administrations and their hospitals. Alongside this shift there has been an increasing discourse in policy on the need for management skills, if not for professional management by health committees, but over the last twenty years this discourse has largely focused on senior management. The main objective of the study is to assess the factors that influence the effectiveness of health management committee in Machakos County, Kenya. The main variables are: health worker's perception of public health committees, local county politics, poor health financing, and poor health staffing. This study contributes to theory building and policy development on the concept of healthcare planning and management. The study assumed that all the healthcare workers are fully aware of the devolution of healthcare and that all the respondents provided their honest perceptions.Some of the areas covered in the literature review include the theoretical anchorage of the study, overview of healthcare services, the conceptual framework and summary of knowledge gaps.Cross sectional descriptive design was adopted in this study because it involves collection of cross-sectional data at one point in time. The population for the purpose of this study is the health sector members in Machakos County who are 1350. The study specifically targeted the health workers and the County health committee members. The study sought to adopt stratified random sampling due to the non-uniformity of the population. The study adopted one set of a semi-structured questionnaire which was personally administered by the researcher in order to avoid unsolicited responses. The researcher obtained informed consent from any subject used in the study and ensured that all subjects participated voluntarily. The researcher used both qualitative and quantitative analysis after collection of data from the field. Frequency distribution tables, mean, standard deviation and percentages were adopted. The relationship between the variables was tested using the Pearson correlation technique. An important finding is that the explanatory variables in the model result in the direct influence on the effectiveness of health care management committee. Specifically, the findings suggest that local county politics was the most important variable influencing effectiveness of health management committee in Kenya, followed by health financing, then health staffing and health workers perception. This study recommends that: the government of Kenya to come up with policies to control the external factors that interfere with health care management with a possible measure to cushion the entire HMC from political turbulence. In terms of practice, the study recommends that the Ministry of health approaches the HMC with political goodwill, proper funding and adequate workforce.

CHAPTER ONE :
INTRODUCTION

1.1Background of the Study

There is a recognized need to improve the quality and utilisation of services provided by public primary care facilities in developing countries (Oyuya, 2013). Health facility management committees (HFMCs) are considered one mechanism for leveraging such health system change, by encouraging direct engagement of communities in health facility activities (Oyaya, 2010). HFMCs in many developing country settings were initially introduced several decades ago, as part of wider reorganization of the health system based on principles of decentralisation, community participation and inter-sectoral collaboration (Oyaya, 2003). The establishment of structures closer to service users, and inclusion of community representatives in those structures, was aimed at ensuring local problems were more easily seen or voiced, and responded to (Abelso, 2006).

The potential for mechanisms such as HFMCs to meet their goals has been limited by wider decentralisation challenges such as insufficient transfer in practice of decision-making power to local levels for a range of functions, lack of clarity in responsibilities at local levels, and broader factors such as the prevailing political context, and inadequate access to financial resources (Abelso, 2006). Further challenges across many settings have included problems with the selection and functioning of committees, lack of clarity in roles and responsibilities, difficulty in sustaining voluntary membership over time, insufficient resources, inadequate representation of and links with the wider community, and inadequate interest in and support for involving communities among key health workers or managers (Standing & Chowdhury, 2008). There are also potential negative consequences with direct involvement of the public in health facility functioning, including real or perceived manipulation of communities or of health facilities and their funds by inappropriately selected or trained committee members, or by politicians and other locally prominent persons. Such challenges may in turn lead to inappropriate use of scarce health system funds, and deterioration in relations between the public and health systems(Goodman, 2011).

Kenya has been reforming its health sector for decades. A government policy introduced in the early 1980s identified the district as the most basic and effective unit for planning, development and delivery of public services; an approach that was supported through the 1990s and early 2000s through The Kenya Health Policy Framework of 1994, and the National Health Sector Strategic Plans of 1999–2004 and 2005–2010. These frameworks and plans included as a strategic imperative the creation of 'an enabling environment for increased private sector and community involvement in health sector provision and finance' ; with the latter implemented in part through strengthening the capacity of HFMCs, which include the facility in-charge and community members elected from the facility catchment area(Goodman, 2011).

Health system financing mechanisms in Kenya have also changed over time. Public health centres and dispensaries have always controlled relatively few resources: construction, qualified health staff, drugs and other equipment are all supplied from the centre in kind; while money which is supposed to come from the centre to cover other costs such as support staff, maintenance, allowances, fuel, and non-medical supplies has often failed to trickle down from central level to these facilities (Bossert, 2002). User fees were introduced as a source of additional health facility financing in the 1980s, with HFMCs overseeing expenditure of 75% of cash raised through user charges within facilities. In practice, facilities have often had to rely on these funds to cover costs of items that are supposed to be provided centrally (Conyers, 2007). As in other countries, user fees also had the negative effect of reducing access of health care for the poor (Bossert, 2002). In 2004 the '10/20' policy was introduced with the aim of reducing user fees in dispensaries and health centres to 10 and 20 Kenyan shillings respectively, but many facilities have not strictly adhered to this policy(Molyneux, 2012).

An innovative finance initiative with the potential to strengthen community accountability and improve financing of the lower levels of the health system is the Health Sector Services Fund (HSSF). Under HSSF, the Government and development partners contribute to a central fund, which is used to credit funds directly into approved facilities' bank accounts. At the facility level, HSSF funds are managed by an HFMC that includes community members from the facility catchment area. HSSF therefore provides

HFMCs with budgets to manage.HSSF was piloted in Coast Province starting in 2005(Goodman, 2011) and in 2010 national rollout began in phases. In October 2010, funds were credited to all 590 public health centres, with further roll out to dispensaries taking place in 2012. HSSF funds are intended to cover the facility's operational expenses according to financial guidelines set out by the Ministry for Public Health and Sanitation (MOPHS) (Oyaya, 2010). The Ministry continues to provide facility infrastructure, trained health workers, drug kits, and medical supplies directly to facilities.

1.1.1Health Management Committee and its influence on Health management committee

Different forms of HFMCs have been in place in Kenya since the 1980s (Oyaya, 2003). The National Health Sector Strategic Plans (Republic of Kenya, 2005) required all public health centres and dispensaries to establish committees, with the roles, responsibilities, and powers well outlined. A key role of facility committees was to oversee general operations and management of facilities. With user fees being an important revenue source for facilities in Kenya, this included overseeing the use of user fee revenues collected at the facility in order to increase community accountability in the way that facility funds were used.

To strengthen HFMC financial oversight roles, and preparedness for national implementation of HSSF, the financial aspects of committee roles and functions were clarified in 2007 and 2009, emphasizing HFMC responsibilities for planning, managing and accounting for facility expenditure (Ministry of public Health and Sanitation, 2010). The required composition of HFMCs was also modified in 2009 by Government Gazette (an official notice required for all new legislation), reducing the number of community committee members from ten to five. It instructed that the five community members selected should include: one person who has knowledge and experience in finance and administration and three women. Representatives from the provincial administration and local authority were also added to the total number of committee members (Agakhan, 2004).

Findings from an evaluation of the Coast pilot of HSSF suggested that HFMCs were generally functioning well and played an important role in facility operations. The breadth and depth of engagement had also reportedly increased after the introduction of direct funding of health facilities. Although HFMCs had previously been involved in management of user fee revenues, the total amount of funds they were managing increased with HSSF. To optimize their contribution, it was argued that efforts were needed to improve HFMC training, clarify their roles, and strengthen engagement with the wider community (Goodman, 2011).

Given the important role of HFMCs in HSSF, it is essential for national implementation that the committees are in place, and that they have the training and role awareness that iskey to their ability to manage budgets effectively. In this paper, we use a large scale quantitative facility based survey to describe HFMC's readiness for their financial management tasks in advance of national HSSF roll out, and to consider the relevance for other similar settings. Drawing on McCoy et al's review (Oyuya, 2013), a set of key factors could be quantitatively measured at the facility level and would affect the potential of HFMCs to effectively perform their new financial management roles. These factors comprise committee composition (selection, tenure, and constitution); operations of HFMCs (back accounts, training and meetings); HFMC links to the broader communities that they are expected to represent; awareness of HFMC roles among members, health workers managing facilities (in charges), and users; and HFMC members' motivation, job satisfaction, and relationships with in-charges (Oyaya, 2003). In describing and discussing our data on these issues, we contribute to the relatively small body of empirical data on mechanisms to strengthen community involvement in peripheral health facilities in low and middle income countries (Conyers, 2012).

1.2 Statement of the Problem

The health sector in Kenya has undergone a major transformation due to amongst other factors, changing patterns of service delivery, County government regulations, technological innovations, service quality movements, and pressures to improve health care and health wages. Kenya's evolving health policy context has much in common with that in many Anglophone African countries. The late 1980s saw the adoption of measures inspired mainly by the New Public Management rhetoric, such as the introduction of performance management and advocacy for the "empowerment" of managers. In 1992, in the public sector, District Health Management Boards (DHMBs) were created in the country's 71 districts. In theory at least these were responsible for: collaboration and coordination with other district-level health sector actors; planning and regulation of district health systems; and resource generation through the capacity to set user charges. The administrative roles of these boards were endorsed in subsequent National Health Sector Strategic Plans (for the periods 1999–2004 and 2005–2010) while the most recent policy initiatives, including those espoused in Kenya's new constitution, suggest a continued devolution of powers to senior managers in new County administrations and their hospitals. Alongside this shift there has been an increasing discourse in policy on the need for management skills, if not for professional management by health committees, but over the last twenty years this discourse has largely focused on senior management.

Previous studies have been done on health management committees in the Kenyan health sector (Legarde, 2008).Legarde(2008) asserts that most health committees in Kenya's are riddled by corruption and continual side shows while Oyaya (2003) claim that the entire health sector cannot embrace any good reforms without proper management structures that incorporates stakeholders. However, none of these studies clearly identify and assess the role of health management committees; a gap this study seeks to fill. So what are the factors that influence the effectiveness of the health management committee?

1.3 Purpose of the Study

The objective of the study is to assess the factors that influence the effectiveness of health management committee in Machakos County, Kenya.

1.4 Objectives

The objectives of the study were

1. To establish how health worker's perception of public health committees influences the effectiveness of health management committee in Machakos County
2. To assess how leadership influences the effectiveness of health management committee in Machakos County
3. To examine how health financing in fluencies the effectiveness of health management committee in Machakos County
4. To determine how health staffing influences the effectiveness of health management committee in Machakos County

1.5Research Questions

The research questions of the study were.

1. In what way does health worker's perception of public health committees influence the effectiveness of health management committee in Machakos County?
2. How does leadership influence the effectiveness of health management committee in Machakos County?
3. How does health financing influence the effectiveness of health management committee in Machakos County?
4. To what extent does health staffing influence the effectiveness of health management committee in Machakos County?

1.6 Significance of Study

This study contributes to theory building on the concept of project planning and management. The study also acts as a theoretical reference point for other counties and the entire East Africa .Scholars who wish to carry out further research in this area may review the study literature and establish gaps for further studies.

Health sector policy and quality policy in the field of project management and planning can be advanced from the findings of this study. The study helps in building the existing policy frameworks for project regulations and health performance mapping. This study should help improve County health care policy.

The findings of this study should help the senior County and government officials tasked with the planning and management of the healthcare projects to better their service delivery through emphasis on value addition. The entire health sector should gain from the findings of this study especially the challenges hindering the committees work. The findings of the study could also be co-opted by managers of private health structures such as Aga khan hospital, Avenue healthcare and many others.

1.7 Delimitations of the Study

The study was conducted in Machakos County A bigger sample would have been observed but this could have inflated the cost of the overall study. However a sample size of 100 health care workers was used as a representative sample in the study.

1.8 Limitations of the Study

Some Health officials declined to give information concerning their perception of HMC due to the fear of victimization. However the respondents were reassured of confidentiality. Time was also being a limiting factor since hospitals have their own tight schedules.

1.9 Assumptions of the Study

The study assumed that all the healthcare workers are fully aware of the devolution of healthcare and that all the respondents provided their honest perceptions.1.10 Operational Definition of Terms

County politics: debate or conflicting ideologies among county individuals who compete for power or authority

Effectiveness-capability of HMC to produce desired health service management

Financing issues: these refers to the resources range from funds to procure, funds to train staff, funds to develop the ICT platforms in hospitals, and ensure smooth running of all the healthcare sectors.

Health worker's perception: the opinions and views of the staff working at the hospitals regarding health care committees

Healthcare committee: a group that bring together health workers, county government and the community to assist in the management, development and review of health and safety policies

Healthcare management: leadership and direction to organizations that deliver health services, and to divisions, departments, units, or services within those organizations.

Healthcare service delivery-equal access to effective, safe and quality health services that are standardized

Staffing capacity: the healthcare sector relies a lot on the capacity and ability of the healthcare staff to handle patients using skills and knowledge acquired.

1.11 Organization of the Study

This research project report is organized into five chapters: that is chapter one, chapter two, chapter three, chapter four and chapter five. Chapter one entails the study background, problem statement, purpose of the study, objectives, significance, delimitations, limitations and assumptions of the study. Chapter two contains literature reviews relevant to the study. It also focuses on the theoretical framework and the conceptual framework. Chapter three highlights the study methodology with a key emphasis on design, population, sampling procedure, methods of data collection, validity, reliability of instruments, data analysis and ethical considerations. Chapter four focuses on the results collected from the field and a brief discussion while chapter five dwells on the detailed summary of findings, discussion, conclusions and recommendations.

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

This chapter deals with the available literature related to the study. Some of the areas covered include the theoretical anchorage of the study, healthcare state in Kenya and the conceptual framework. This review is very important since it highlights the scope of this study and further relates to other studies done in different parts of the world.

2.2 Overview of Healthcare Services

Current literature recognizes the importance of the processes which may determine our health and "the interconnected nature of people's complex lives and contextualizes biological health in its social, economic, cultural and psychological dimensions" (1994). The 'life span ' approach acknowledges human health and illness as an accumulation of conditions that begin early in life and sometimes even before birth, and recognizes these as dynamic and on a continuum of risk over the entire course of a lifetime (Institute of Medicine, 1996). Health, as such, is the sum of genetic determinism and a combination of physiological, psychological and environmental factors. And it is a statistical fact that people in less affluent countries experience higher rates of death and disease than those in richer countries (World Bank, 93). For example, Bangladesh launched a health protection scheme known as Shasthyo (SSK) in Tungipara of Gopalgonj district, Rangunia of Chittagong district, and Debahata of Satkhira district (Gaucho, 2010). A study was carried out during April-May 2012 by Gaucho (2010) to assess the capacity of the Health Management Committees and propose specific interventions for strengthening them for successful implementation of pilots. The study team visited three proposed pilots and also three other ongoing pilots such as Chowgacha, to conduct in-depth interview, FGD and few key informant interviews. The study found that although local level committees centering the Community Clinic (CC) were mostly functioning, they were not functional as expected. Only where local Committee leader was strong it made a difference. One of the important strengths of the committee is that all the members were local and they lived within the periphery of the CC. One serious weakness of the committee was that meetings were not held regularly and routinely and all members did not remain present in

all meetings. Moreover, there was no health management committee at any of the unions visited. There was however a health committee which was not effectively functioning except in cases where its chairman was interested. It was the only Union level Committee. As committee members, they had not received any training or orientation on the programmatic issues, and as such there remained some knowledge gaps inhibiting their full contribution.

Another study of health management committees in Honduras and Argentina by Jason & Derick (2011) revealed that Hospital Management Committee formed at the local level was effective or functional. However, the committee was too large to be effective. Moreover, as the committee was constituted by office order , there was ample opportunity to utilize the services of human resources in health, infrastructure, medicine and health equipment locally for the welfare of the local people. There was neither any representation of union and local community level nor of the local government representative from the UP level. For that reason the problems of grassroots level were not likely to be properly addressed.

Factors which are known to influence population health in lower income countries such as Peru, Cambodia, Ghana and Botswana include education levels, access to safe water and sanitation, environmental, social and cultural factors, as well as access to effective health services (Remer, 1991, cited in Moore, Castillo, Richardson, & Reid, 2003, p.280). With the increasing emphasis on globalization, demographic and epidemiologic change and more accessible technologies, developing countries are experiencing new dimensions of health and ill-health (Andrews, 2001; Correa-Rotter et al., 2004; Heiberg, 1996; Institute of Medicine, 1996). These dimensions are reflected in social, cultural and environmental change and the experience of the kinds of chronic health problems that come as a result of this change (Andrews, 2001; Bicknell & Parks, 1989). Already overburdened health systems in developing countries need better information to prioritize and target their limited resources (Ensor & Cooper, 2004; Nyamwaya, Nordberg, & Oduol, 1998; The Working Group on Priority Setting, 2000). Measuring access to and the quality of health care services in the developing world is difficult [as] health care is often

assumed to be responsible for improvements not accounted for by other factors (Bahrand, 1993, cited in Moore et al., 2003,)

In 1994, the Government of Kenya (GOK) approved the Kenya Health Policy Framework (KHPF) as a blueprint for developing and managing health services. It spells out the long-term strategic imperatives and the agenda for Kenya's health sector. The above policy initiatives aimed at responding to the following constraints: decline in health sector expenditure, inefficient utilization of resources, centralized decision making, inequitable management information systems, outdated health laws, inadequate management skills at the district level, worsening poverty levels, increasing burden of disease, and rapid population growth. Overall morbidity and mortality remain high in Kenya, particularly among women and children. An infant mortality rate (IMR) of 62 in 1993 increased by 12 percentage points to 74 in 1998 and was not significantly different (at 77) in 2003. The under-five mortality rate also rose from 110 deaths per 1,000 live births in the period 1993-1998 to 115 in the 1998-2003 period.

Maternal mortality in 2003 was estimated to be 414 maternal deaths per 100,000 live births, which is a decline from the 590 deaths estimated for 1998, but also with large sampling errors, which makes comparing the rates over time uncertain.

After malaria, the most common illnesses seen in outpatient clinics are diseases of the respiratory system, skin diseases, diarrhea, and intestinal parasites. Other frequent health problems include accidental injuries, urinary tract infections, eye infections, rheumatism, and other infections. Combined, these ten leading conditions account for nearly four-fifths of the total outpatient cases reported. This pattern has persisted for the past decade. Recurrent out breaks of highland malaria and widespread emergence of drug resistance strains have aggravated the problem of malaria.

The National Development Plan of 2002-2008 states that the health care system in its current form (at the time of the National Plan's preparation) does not operate efficiently. Some of the areas targeted in the plan include drugs, personnel, and facility utilization. Drugs, which account for 14 percent of the health budget, were deemed to be the most

promising area for improvement, particularly in drugs' selection and quantification. Staffing norms for key cadres would be developed for deployment purposes. The plan also calls for formulating a health manpower policy, to develop and retain human resources in the sector.

2.2.1Healthcare Perceptions and its influence on Health Management

A health center's performance depends on its capacity to anticipate and adjust not only to rapid technological transformation, but also to changes in the attitudes of employees, investors and other stakeholders (Kitchen, 2010). Moral desires expressed by employees and stakeholders are embodied in capital, consumer, and labor markets. Marketplace participants make trade-offs between their moral desires and desires for lower-priced goods, better investment returns, and so on. The aggregate product of participants' moral desires in their choices as investors and employees represents "morality in markets" and has the potential to impact the outcome of the healthcare marketplace. Examples of marketplace morality include employees' desires to work for socially responsible hospitals (Brady & Wood, 2001).

Public perception of hospitals shapes public debate and directly impacts not only patient decisions on where to seek treatment, but their expectations regarding the quality of service they will receive (Lamboray, 2008). In addition to measuring patient experience, an effective health care system operates by regularly assessing the public's perceptions in order to manage their reputation and understand what it will take to exceed expectations. From most studies, the majority of complaints centered on long delays at the service points, poor maintenance of infrastructures and expensive bills(Lamboray, 2008).Suggested measures to reverse these negative perceptions include improved staffing, personnel training on attitude to patients, upgrading of facilities, reducing the cost of services and curbing of unnecessary delays as well as better funding of the health sector(Lamboray, 2008).

Based on a social contracts analysis, Dunfee (1998) has argued that the existence of morality within markets creates certain obligations for corporate management. While managers have a basic duty to undertake actions to maximize service delivery in the health sector, they also have an obligation to respond to and anticipate existing and changing marketplace morality relevant to the health sector. A failure to do so may have a significant negative impact on employee attitudes and opinions (Kitchen, 2010).

2.2.2 Leadership and its influence on Healthcare Management

Organizationally, decentralization means a choice between different types of public institution, which vary in terms of: the areas over which they have jurisdiction, the functions delegated to local institutions; and the way decision-makers are recruited, so producing institutions (Ndiaye, 2009). There is little agreement about the optimum size of areas, either in terms of population or territory. Areas cannot be delimited without consideration being given to the powers to be exercised at each level (Lamboray, 2008). The specification of functions always assumes certain things about who will exercise the delegated powers. The two issues cannot be separated. Five structures of decentralization are distinguished, each of which could in principle be created at regional, district and village/community level: the multi-purpose local authority, the single-purpose council, the hybrid council, the single purpose executive agency, the management board, Field administration, health teams, and interdepartmental committees (Ndiaye, 2009). Whatever the institutions used for decentralization, the choice of structures and the ensuing process of decision-making will be highly charged politically (Lamboray, 2008). The choice of representative Government as a means of delivering health services locally builds constitutional politics into the decision-making process, especially the recruitment of office-holders and the choice of policy priorities. In PNG, for example, decentralization was found to be associated with increased politicization. Devolution opens up opportunities for corruption and political patronage though these are by no means the exclusive preserve of local government, being found in other forms of decentralization (Ndiaye, 2009).

Power politics will be present whatever the organizational form chosen. As in Senegal, health committees can fall prey to political party factions, which lead to health problems'

taking second place to `personal quarrels' (Ndiaye, 2009, p.112) .This is a risk with whatever method of recruitment to office is used. India's Community Health Volunteers were selected by doctors in the primary health centres from among candidates nominated by the community. This did not prevent party politicians and elected representatives intervening in, politicizing and, in some cases, controlling the selection (backed by sanctions against doctors such as threats of transfer) in order to penetrate village life, reinforce a local client's obligations, or secure the dominance of a political faction(Jobert, 2005, pp.15-16). All forms of participation are capable of intensifying social and political conflict. Participation is widely recognized as a problem in poor countries because of political inequality and dependency, illiteracy, poverty, poor communications, physical insecurity, professional and bureaucratic hostility, political centralization and tokenism.

Communities are not socially homogenous and the greater the inequality the more difficult participation is likely to be. Programmes aimed at strengthening the position of the poor may exacerbate conflicts with local and national elites, which may have to be co-opted before a program can run successfully. Community leaders do not always act to the benefit of all. The early phases of committee management of health centres in Kisantu, Zaire between 1979 and 1981, found members seeking privileges and recognition from participation. Only later did they get down to managing healthcare delivery (Lamboray and Laing, 2008).Government planners and community workers do not necessarily share the same goals (Rifkin, 2006, a).Without doubt, the most serious mistake any reformer can make is to assume decentralization to be a managerial exercise devoid of political cause and consequence.

2.2.3 Health Financing and its Influence on Healthcare Management

There are different kinds of health system in the world. Since the end of the 1970s, almost all countries have embarked on sustained processes of reform, in which common themes recur. One of the more prominent of these is the promotion of competition. Health systems are complex systems and reforming them is equally complex. Health care may be

provided in hospitals or in local practice, and then by specialists or by generalists; hospitals may be publicly or privately owned and may operate either for profit or not for profit; different doctors will be paid in different ways, and usually by a mixture of methods. Health care may be financed through general taxation or social insurance, or indeed from private income, and usually it is paid for by some combination of all three. Health finance may be controlled by central or sub central governments, and administered by health authorities or sickness funds. There is some consensus that there are essentially two major types of public health care system in the world: national health services, funded by general taxation; and social insurance systems, funded by payroll contributions.

National health services are further characterized by universal coverage, guaranteed by public organizations such as health authorities if not by local or regional governments, and by public ownership of health care facilities. In social insurance systems, health care is delivered in private facilities and by entrepreneurial physicians paid according to services provided; coverage is segmented, guaranteed by sickness funds organized according to region, occupation or workplace. In Western Europe, national health systems predominate in the north, south and west (Denmark, Sweden and the UK, Italy and Greece, Spain and practice, Portugal), and social insurance systems in the center (there and then by specialists or by generalists; hospitals may be Benelux countries, France, Germany and Austria).

Different kinds of system have different performance outputs or effects. Tax-based systems allow a greater degree of financial equity among users, although the degree of choice of provider allowed by social insurance systems trousers, coupled with fee-for-service payment systems which encourage providers to supply high levels of service of high quality, appears to result in higher levels of user satisfaction. However, the factors which make for high performance on some indicators make for corollary problems on others. Where there is no registration or gate keeping function for primary care, for example, as in France and Germany, the instruments of competition among doctors (higher rates of prescription and hospital referral, and greater investment in and use of medical technology) represent a significant cost pressure. In practice, social insurance

systems tend to consume a relatively high level of financial resources. In 1985, for example, health spending in France and Germany was 8.5 and 8.7% of the gross domestic product (GDP) respectively. Italy spent significantly less (7.0% GDP), the UK much less (6.0%) while the relevant Swedish figure is complicated by the inclusion of social care in public health budgets. In general, among major European countries, spending is least where centralized control of health budgets is greatest unlike in Africa. But if too much competition seems to make things too expensive, too much control affects service quality: 'Waiting lists, inefficient management of health services, and limitations in the choice of provider are the most common problems reported by African countries with National Health Service systems. On the other hand, oversupply and overconsumption are the main problems reported by those with social security systems, and the financing and insurance functions of social security systems raise some concerns about their equity'. This suggests that different kinds of health financial systems generate different kinds of problems; the further implication is that these are likely to be addressed by different countries in different ways.

2.2.4 Health Staffing and its influence on Healthcare Management

An association between hospital staffing and health care suggests that fewer infections occur in hospitals in which staff caters for fewer patients (Holden et al, 2010). The higher rate of infections in hospitals in which nurses care for more patients seems to be related, at least in part, to the high nurse burnout associated with heavier patient caseloads (Holden et al, 2010). Nurse burnout has been linked to job dissatisfaction and overall quality of patient care, but not to "nursing-sensitive" clinical outcomes. Burnout has been associated with self-reported medical errors among surgeons and internal medicine residents. Holden et al (2010) reported that external mental demands, such as interruptions, divided attention, and feeling rushed, are associated with burnout and the increased likelihood of perceived medication-dispensing errors in pharmacists. The cognitive detachment associated with high levels of burnout may result in inadequate hand hygiene practices and lapses in other infection control procedures among registered health practitioners (Hugonnet, 2007).

Increasing a nurse's workload by 1 patient was associated with increases in both urinary tract and surgical site infections (Hugonnet,, 2007). Increases in both urinary tract and surgical site infections were largely attributed to differences in nurse burnout; every 10% increase in burned-out nurses in a hospital increased the rate of urinary tract infections by nearly 1 per 1,000 patients and the rate of surgical site infections by more than 2 per 1,000 patients (Hugonnet, 2007). Although hospitals with low staffing levels tend to have higher rates of poor patient outcomes, increasing staffing levels is not easy. Major factors contributing to lower staffing levels include the needs of today's higher acuity patients for more care and a nationwide gap between the number of available positions and the number of registered health practitioners or nurses (RNs) qualified and willing to fill them (Hugonnet,2007).

2.3Theoretical Framework

This study is anchored on the contract theory by Sunder (1997). Sunder (1997) in his study, explain the relations of projects with stakeholders. Each party (organization or agent as a stakeholder) plays different roles for other parties. Because organizations are bound together by the contracts each agent has with different organizations they play a crucial role on contract parties. These links between projects and agents mean that every organization has responsibility to other agents and organizations. Organizations balance the benefits of each party by using managerial tools and actions such as technical committees, and communicate their actions through annual reports and websites. Social accounting has an impact on the way organizations manage contracts. Sunder (1997) has proposed a broader definition on the role of organizations, describing them as being a "set of contracts" among employees, customers, managers, shareholders, suppliers, auditors etc. This definition directs projects to be socially responsible. Hence projects like the health delivery are social agents contracting with other agents, as a part of chain; their aim goes beyond simple service-maximization. Therefore, each individual in a health committee either voluntarily or involuntarily plays the role of an agent.

The concept of healthcare management committee is also anchored on game theory (Lynch, 2009). Game theory can be defined as part of a large body of theory providing a formal language to describe conscious, goal-oriented, decision making processes involving one or more players (Fenton, 2000). The solution concepts derived from game-

theory may be thought of as normative or descriptive views of multi-person decision-making (Fenton, 2000). Game theory may also be described as the analysis of rational behavior in situations involving interdependence of outcomes (Lynch, 2009).

The essence of game theoretic models is two or more players who have a range of actions or similar freedom to a set of choices, and also have certain information. Each player has a set of preferences for the diverse possible outcomes, and the results of the interaction depend on all the players' decisions (Fenton, 2000). Put another way, game-theoretic models have six common features: conflicting parties, choices, information, desired outcomes, results of choices and outcomes dependent on choices of all participants (Pascale et. al., 2000). Similarly adoption of a strategy is a choice for every organization despite the fact that every entity or firm has choices to make in terms of strategy formulation and implementation (Zou, 2002). Adoption of blue ocean strategy by one firm amidst many others; and its subsequent implementation is therefore expected to give it a competitive advantage. Game theory provides a set of tools and components that may be used to develop logically consistent models of rational human behavior (Zou, 2002). These models allow researchers to discount explanations of behavior where people act against their own objectives, neglect opportunities, or ignore strategic behavior of other parties (Zou, 2002).

Most of game theory is not meant to be purely normative (describing the ideal choices people should make) as an equilibrium strategy is only ideal if other players believe that players will act in certain ways that would require the theory to be descriptive (describing the actual choice of others) (Fenton, 2000). Game theory is also not purely descriptive (Camerer, 1991). Lynch (2009) suggests that game theory is analytic: analysis of the formal implications of various levels of mutual rationality in strategic situations, i.e., what to do when certain assumptions are met. The latter however may not be the case. Mullins (2002) argues for a practical approach to game theory which she refers to as asymmetrically normative. Here game theory tells players what they should do (normatively) if other players behave in typical ways (descriptive).

Game theoretic reasoning is a decision rule or algorithm that selects an equilibrium strategy (Mintzberg, 1991). Doubt has however been expressed over game-theoretic

reasoning as an appropriate description of how people or firms decide which strategies to use. Criticisms include the use of rules that require (in the context of strategy implementation in firms) firms to believe that others are using the same rules (which participating firms would doubt) and firms to maintain the assumption that all other firms are rational, even after they make irrational choices (Welch & Welch, 2005). Note that equilibrium analysis is the determination of equilibrium points. Game theory reasoning posits that players (firms) discover equilibrium by introspection, a process that may be unnatural and difficult in practical situations (Mintzberg, 1991). Introspection includes mentally (or computationally) simulating outcomes of various choices, eliminating choices that do not yield the best outcomes, or adjusting them until a set of mutually best outcomes are achieved. If players have common knowledge of a game's pay-off and that all players are rational, then the introspection will result in convergence to equilibrium. Common knowledge is information that everyone knows. Although common knowledge is sufficient for justifying equilibrium, it is not a necessary condition (Camerer, 1991).

There are several alternatives to the strict rational requirements of introspection. One such alternative are Justifiable strategies which are optimal choices for `some' belief on what the other players will do, where the belief may not necessarily come from introspection of the other players thinking. Another alternative are the rationalizable strategies that are where players believe others will use justifiable strategies (Camerer, 1991). These simpler rules of justifiability and rationalizability are applicable to many business strategy situations where firms make choices in unique situations where pay-off and competitor behavior are uncertain, with firms having little experience to learn from (Mullins, 2002). Three other approaches, communication, evolution and adaption, may produce equilibria in games as a substitute to game-theoretic reasoning (introspection). Communication is when firms announce their intentions.

These pre-play announcements are typically nonbinding and have no penalty if not followed (Burgelman, 1983). Often referred to as cheap talk, examples include pre-announcements of new product releases or changes in pricing. Cheap talk may encourage equilibration by strengthening players' beliefs on what others will do. Pre-play

communication may remove each firm's doubts about the reasoning process that the rival is going through (Golan, 2000).

2.4 Conceptual Framework

The conceptual framework displaying the interaction of the variables is as shown below.

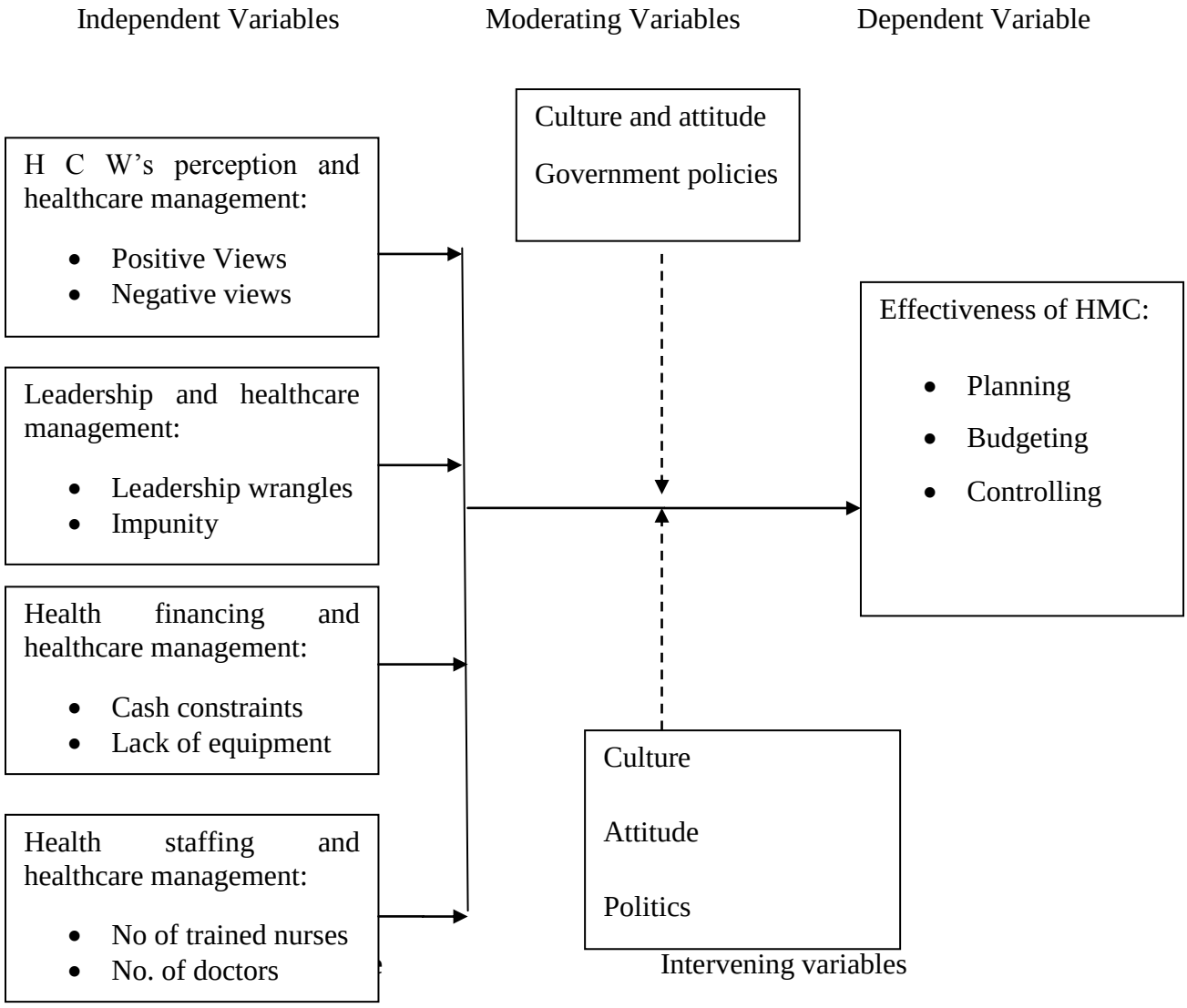

Figure 1. Conceptual Framework

The conceptual framework has been developed to provide clear links of dependent and independent variables as they relate to each other in this research. The independent variables indicate the factors that influence the effectiveness of Health management committees in Machakos County.

The dependent variable is the effectiveness of health management. The moderating variable is the government policies which have an impact on performance. The moderating variable is government policies while the intervening variable is staff attitudes and culture which have an impact on service delivery.

2.5 Summary of Knowledge Gaps

The key to success in any project is an integrative view of the implementation process (Raps & Kauffman, 2005). Successful implementation of a project is a task that needs focus strategy and commitment from the involved members. The problem in project planning and management is illustrated by the unsatisfying low success rate (only 10 to 30 percent) of intended projects (Zou, 2002).

The original mission is somehow dissipated as the project moves into implementation and the initial momentum dies before the expected results are realized. The management risk relevant to project execution is critical in the health sector than in any other sector. Hence role of health committees in the health projects is vital. Literature review indicates that there is limited information on the role of Health management committees in Kenya and there is need to carry out a study on factors influencing the role of HMC'S in Machakos County.

CHAPTER THREE
RESEARCH METHODOLOGY

3.1 Introduction

This chapter discusses the methodological orientation of the study. It provides details on study design; study site, sample population and the sample size, data collection instrument and methods for data processing and analysis. It also contain a discussion on the reliability and validity of the research instruments.

3.2 Research Design

Cross sectional descriptive design was adopted in this study. This design was suitable for this study because it involved collection of cross-sectional data at one point in time. It did not require time series over several monitoring rounds of data. Zikmund (2003) says surveys provide quick, inexpensive, efficient and accurate means of accessing information about the population. According to Kothari (2004), descriptive research studies are concerned with describing the characteristics of a particular individual or group of people.

3.3 Target Population

A population refers to an entire group of individuals, events or objects that have a common observable characteristic (Orodho, 2003). A population describes the parameters whose characteristics the research attempts to describe. The population for the purpose of this study was the health sector members in Machakos County. The study specifically targeted the health workers and the County health committee members. The total population of health workers in Machakos County is estimated to be 1350 (DHIS, 2014).

3.4 Sampling Procedure

The study adopted stratified random sampling as shown below. This sampling technique was adopted due to the non-uniformity of the population. However, the study adopted Krejcie and Morgan (1970) formula to obtain the sample size for the health workers.

Table 3.1: Sample Size

Description	Population Size	Sample Size	Remarks
Health workers	1350	50	Simple random
Committee members	50	42	Krejcie and Morgan (1970)
Total		92	

3.5 Methods of Data Collection

The study adopted one set of a semi-structured questionnaire in order to avoid unsolicited responses. The questionnaire contained two parts; first part dealt with demographic information while the second part dealt with role of health committee members. Before actual data collection process the researcher obtained a reference letter from the university which acted as an introduction to the various respondents.

The study relied on both primary and secondary data. The semi-structured questionnaire was personally administered by the researcher. Additional information was obtained through observation which involved observing the behavior under study as it occurred in its natural setting without any manipulation by the researcher. In documenting the information, notes were used.

3.6 Validity of the Research Instrument.

A research is valid only if it actually studies what is set out to study and if studies are verifiable. Orodho (2009) further focused on the degree on which results from analysis of data actually represents the phenomenon under investigation.

To ascertain content validity the instrument was thoroughly discussed with experts in the subject matter but especially with the supervisor.

3.7 Reliability of the Research Instruments.

According to Eshiwani (1996), pilot testing is important in the research process because it reveals vague questions and unclear instructions in the instrument. It also captures important comments and suggestions from the respondents that will enable the researcher to improve efficiency of the instrument, adjust strategies and approaches to maximize the response rate. Pretesting was conducted by administering ten questionnaires in Mbagathi district hospital. The researcher used this information to adjust the instrument as found necessary.

3.8 Methods of Data Analysis

The researcher used both qualitative and quantitative analysis after collection of data from the field. More emphasis was on qualitative analysis as some data collected did not require quantifiable information but simply analyzing information in a systematic way in order to come to some useful conclusion and recommendations. In quantitative analysis data was analyzed using descriptive statistics. Frequency distribution tables, mean, standard deviation and percentages were adopted to present the data because they were easy to read and interpret. The relationship between the variables was tested using the Pearson correlation technique.

3.9 Operational Definition of Variables

Table 3.2: ***Operational Definition of Variables***

Objectives	Indicators	Measurement	Scale	Type of analysis	Tools of analysis
To assess if Health Care worker's perceptionof public health committees influence the effectiveness of health management committee	**Independent**				
	Perception of HCW	Positive views	Praise for improved healthcare	Ordinal	Descriptive Mean
		Negative views	Complaints about healthcare	Ordinal	Descriptive Mean
To assess if local County politics influence the effectiveness of health management committee	Leadership wrangles	Level of team work	Ordinal	Descriptive	Mean
	Impunity	No. of political executions/decisions	Ordinal	Descriptive	Mean
To assess if poor health financing influence the effectiveness of health management committee	Cash constraints	The deficit amounts needed	Ordinal	Descriptive	Mean
	Lack of equipment	No. Of equipments lacking	Ordinal	Descriptive	Mean
To assess if health staffing influence the effectiveness of health management committee	No. Of trained nurses	Quantity of trained nurses	Nominal	Descriptive	Mean
	No. Of Doctors	Quantity of doctors	Nominal	Descriptive	Mean
	Dépendent				
To assess the effectiveness of HMC	Proper planning,budgetting and controlling.	Availability of annual work plans, control mechanisms and budgets	Ratio	Descriptive	Mean percentage

3.10 Ethical Considerations

Researchers whose subjects are people or animals must consider the conduct of their research and give attention to ethical issues associated with carrying out their research (Kombo and Tromp, 2006). Only people conducting the survey know the identity of the participants. The researcher obtained informed consent from any subject used in the study and ensured that all subjects participated voluntarily. The researcher fully explained the research in advance and debriefed the subjects afterwards. Researcher accepted individual responsibility for the conduct and consequences of this research and maintained openness and honesty in dealing with research subjects.

CHAPTER FOUR :
DATA ANALYSIS, PRESENTATION AND INTERPRETATION

4.1 Introduction

This chapter presents the results based on the study and discusses its interpretation. The chapter begins by presenting these findings highlighting the key factors influencing the effectiveness of health management committee. This is presented and discussed in line with the objectives of this study. The analysis tends to answer the following research objectives:

1) To establish how health worker's perception of public health committees influence the effectiveness of health management committee in Machakos County.
2) To assess how leadership influence the effectiveness of health management committee in Machakos County.
3) To examine how health financing influence the effectiveness of health management committee in Machakos County.
4) To determine how health staffing influence the effectiveness of health management committee in Machakos County.

4.2 Ccharacteristics of the respondents

Out of the questionnaires distributed, only eighty were fully filled with relevant information worth entering and analyzing. This represents a response rate of 86.96%.

4.2.1 Gender of the respondents.

Among the respondents, the female and male shared the platform unequally on a 40%and 60% basis respectively. This basically implies that the number of male respondents was higher than that of their female counterparts. This result implies that the health sector in Machakos county is male dominated.

Table 4.1: ***Gender of Respondents***

	Frequency	Percent	Cumulative Percent
Female	32	40.0	40.0
Male	48	60.0	100.0
Total	**80**	**100.0**	

4.2.2 Age of the Respondents

Forty percent of the respondents were aged 30-39 years while only 18% of the respondents were aged 50-59 years. Those aged 18-29 years were 20% while those aged 40-49 years were 22%. Approximately most of the respondents (82%) were below 40 years thus a young and energetic workforce that is able to fast track health care delivery.

Table 4.2: ***Age in Years***

	Frequency	Percent	Cumulative Percent
18-29	16	20.0	20.0
30-39	32	40.0	60.0
40-49	18	22.0	82.0
50-59	14	18.0	100.0
Total	**80**	**100.0**	

4.2.3 Highest level of education attained.

Fifty percent (40) of the respondents were certificate holders while a close 40% (32) of the respondents had diploma qualifications. Only 5% (4) had degree qualifications while another 5%(4) had master's qualifications. This result clearly implies that all of the respondents were literate and could thus comprehend the basics of healthcare management.

Table 4.3: ***Education Attained***

	Frequency	Percent	Cumulative Percent
Certificate	40	50.0	50.0
Diploma	32	40.0	90.0
Degree	4	5.0	95.0
Masters	4	5.0	100.0
Total	**80**	**100.0**	

4.2.4 Duration the respondent has worked.

Forty two percent of the respondents had worked in their current positions for less than two years, forty eight percent (38) for two to four years while only ten percent (8) had worked for four to six years. The majority of the respondents (90%) had worked for more than four years which validated the information collected on the basis of experience of the respondents within the respective health facilities since the concept of health management committee is a new managerial strategy instigated by devolution.

Table 4.4: Duration the Respondent has worked in the Current Position

	Frequency	**Percent**	**Cumulative Percent**
Less than 2 Years	34	42.0	42.0
2-4 Years	38	48.0	90.0
4-6 Years	8	10.0	100.0
Total	**80**	**100.0**	

4.3Factors influencing Effectiveness of Health Management Committee

The study sought to determine the factors that influence the effectiveness of health management committee. The four factors studied include health workers perception, local county politics, health financing and health staffing. The results are discussed below.

4.3.1 Health workers perception and Health care management

Table 4.5 presents findings of perception on perception factors that derail the effectiveness of health care management; a more detailed discussion of the findings is presented later.

Table 4.5: Health Workers Perception and the Health Care Management

Factor	Response	Percentage	Mean	Standard
A lot of healthcare problems arise from mismanagement at county level	Strongly Agree	27.27	2	0.77
	Agree	45.45		
	Neutral	27.27		
	Total	100		
Previous control of healthcare by national government was better	Strongly Disagree	36.36	2.7	1
	Disagree	36.36		
	Neutral	18.18		
	Agree	9.09		
	Total	100		
There are very many reported cases regarding procurement bottlenecks for hospital essentials	Strongly agree	45.45	1.8	0.98
	Agree	36.36		
	Neutral	9.09		
	Disagree	9.09		
	Total	100		
Current system of healthcare management is full of corruption and nepotism	Agree	54.54	2.6	0.81
	Neutral	27.27		
	Disagree	18.18		
	Total	100		
Best practices in healthcare management has been realized after devolution	Strongly Agree	27.27	2.0	0.89
	Agree	54.54		
	Neutral	9.09		
	Disagree	9.09		
	Total	100		
Dilapidated hospital services exist currently compared to pre-devolution	Agree	17.31	2.4	0.79
	Neutral	64.51		
	Disagree	18.18		
	Total	100		
	Neutral	27.27		
	Disagree	18.18		
	Total	**100**		

From the findings presented in Table 4.5, the respondents agreed that a lot of healthcare problems arise from mismanagement at county level, the mean was 2. This contradicts the government regulations to ensure cost cutting and increased efficiency. The respondents were also asked to rate if previous control of healthcare by national government was better. They disagreed.

The mean of the responses was 2.7 denoting disagreement; checks and balances are essential to ensure right applications to the health management processes.

Asked whether there are very many reported cases regarding procurement bottlenecks for hospital essentials, respondents agreed; the mean response was 1.8. This is in line with high procurement stakes associated with the healthcare services and products. Current system of healthcare management is full of corruption and nepotism. The respondents answer to later have a mean of 2.6 which denoted neutrality. Slightly more than half of the respondents agreed that Current system of healthcare management is full of corruption and nepotism with the rest being neutral or disagreeing.

Another factor was that the best practices in healthcare management has been realized after devolution; the mean was 2, indicating that the respondents agreed. Using the best practices in healthcare management can help increase effectiveness of HMC. Asked whether dilapidated hospital services exist currently compared to pre-devolution, the mean was 2.4 indicating that respondents agreed. This basically implies that political interests override strategic plans thus leading to corruption thus dilapidated hospital services.

4.3. Leadership and the Health care management

Table 4.6 presents findings of perception on leadership that derail the health care management; a more detailed discussion of the findings is presented later.

Table 4.6: Leadership and Health Care Management

Aspect	Response	Percentage	Mean	Standard
Persistent leadership wrangles in the HMC hampers teamwork	Strongly	72.72	1.2	0.47
	Agree	27.27		
	TOTAL	100		
Existence of many politicians in the HMC affects budgeting	Agree	27.27	3.1	0.99
	Neutral	36.36		
	Disagree	27.27		
	Strongly	9.09		
	TOTAL	100%		
HMC is riddled with impunity that hampers proper execution	Disagree	18.18	4.8	0.40
	Strongly	81.815		
	TOTAL	100		
HMC makes political decisions rather than logical decisions	Strongly	72.72	1.3	0.47
	Agree	27.27		
	TOTAL	100		
The HMC operates at the whim of the governor and MCAs	Neutral	18.18	4.2	0.75
	Disagree	45.45		
	Strongly	36.36		
	Total	**100**		

All the respondents strongly agreed that persistent leadership wrangles in the HMC hampers teamwork in the area. The mean score was 1.2 denoting strong agreement. Asked whether the existence of many politicians in the HMC affects budgeting, the mean score was 3.1 denoting neutral. The respondent strongly disagreed HMC is riddled with impunity that hampers proper execution, the mean score was 4.8.

Asked whether HMC makes political decisions rather than logical decisions, the respondents strongly agreed; with a mean of 1.3.However, the respondents disagreed that the HMC operates at the whim of the governor and MCAs; the mean was 4.2.

4.3.4 Health Staffing and the Health care management

Table 4.7 presents findings of perception on staffing factors that derail the health care management; a more detailed discussion of the findings is presented later.

Table 4.7: Health Staffing and Health Care Management

Factor	Response	Percent	Cumulative Percent
Nurses are properly trained in the basic healthcare skills	Yes	19.35	19.35
	No	80.65	100.0
Majority of the nurses are equipped with WHO training	Yes	32.26	32.26
	No	67.74	100.0
Health financing determines the success of healthcare management	Yes	87.10	87.10
	No	12.90	100.0
Healthcare is understaffed	Yes	32.26	32.26
	No	67.74	100.0

From the findings above, over 80% of the respondents declined that nurses are properly trained in basic health skills, thereby casting doubt on the success of the health care management committees since the nurses are one of the core implementers of effective healthcare.

When asked whether majority of the nurses are equipped with WHO training, more than half of the respondents (67%) declined implying that most of the nurses are not well equipped with the WHO training. This further casts doubt on the effectiveness of the healthcare management committees.

Majority of the respondents (87%) confirmed that indeed health financing determines the success of the healthcare management, with only a small number (12%) declining. However, only 32% of the respondents accepted that healthcare is understaffed indicating that over half of the respondents did not feel overstretched with work at the health centers.

4.3.5 Health Financing and the Health care management

This section was meant to establish the electricity challenges to school laptop implementation. The respondents were given factors and asked to rate them, 1 indicating strong agreement, and 5, strong disagreement**.** The findings are presented in Table 4.8; a detailed discussion is discussed after that**.**

Table 4.8: Health Financing and Health Care Management

Factor	Response	Percentage	Mean	Standard
The cash constraints in this area slacken healthcare projects	Strongly	27.27	1.9	0.70
	Agree	54.45		
	Neutral	27.27		
	TOTAL	100		
Revenue allocated is never adequate for minimal healthcare services	Strongly	58.06	1.5	0.52
	Agree	41.94		
	TOTAL	100		
The HMC members are too expensive and not sustainable	Agree	27.27	3.1	0.91
	Neutral	36.36		
	Disagree	27.27		
	Strongly	9.09		
	TOTAL	100		
The acquisition of new hospital equipment is impossible with meager funds	Agree	54.54	3.1	0.94
	Neutral	18.18		
	Disagree	27.27		
	Total	100		
The cost associated with hiring and maintaining hospital staff keeps rising	Strongly	9.67	2.1	0.6
	Agree	80.64		
	Neutral	6.46		
	Strongly	3.23		
	TOTAL	**100**		

The respondents agreed that the cash constraints in this area slacken healthcare projects; the mean response was 1.9, denoting agreement. The respondents strongly agreed that indeed revenue allocated is never adequate for minimal healthcare services; the mean score was 1.5. Good organizational finance involves analysis of value addition by any new project.

Asked if the HMC members are too expensive and not sustainable, the respondents were not sure; the mean response was 3.1 denoting that they were neutral. The respondents disagreed that the acquisition of new hospital equipment is impossible with meager funds, the mean score was 3.1 denoting disagreement. However, when asked if the cost associated with hiring and maintaining hospital staff keeps rising, the mean score was 2.1 denoting agreement. This implies that staff cost is a very important factor in healthcare management.

4.4 Regression Analysis

Table 4.9 presents the regression analysis.

Table 4.9: Regression Analysis

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	-3.622	7.158		-0.108	.78
	Does leadership influence implementation of health care management	3.944	.438	.468	4.984	.046
	Do health workers perception influence implementation of health care management	7.667	.395	.141	5.587	.045
	Ever considered influence of health staffing on implementation of health care management	4.667	.295	.183	3.421	.041
	Do health financing influence implementation of health care management	2.833	.163	.185	6.337	.023

The beta coefficients give the rate of deviations or change on the dependent variable (implementation of the laptop project) that was produced by a change on the independent variables. Here, leadership takes a lead with 0.468 deviation followed by health financing

at 0.185, then health staffing at 0.183 and health worker's perception at 0.196. The researcher thus concluded that leadership, health financing, and health staffing had the major impact on effectiveness of HMC.

4.4.1 The Coefficient of Determination

Table 4.10 below presents the Coefficient of determination.

Table 4.10: The Coefficient of Determination

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.541(a)	.395	.158	11.474

In data analysis, the larger the R the stronger the relationship between the dependent variable versus independent variables. R Square, the coefficient of determination, is the squared value of the multiple correlation coefficients. Here, it showed that about half the variation in the relationship is explained by the model. The value of R was 0.541 and R square was 0.158(15.8%) as shown in the table above. Since the value of R square is less than 50%, the researcher deduced that the proportion of variation associated to the independent variables had a moderate effect.

CHAPTER FIVE :
SUMMARY OF THE FINDINGS, DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter gives a summary of the findings and an analysis of the results and findings focusing on the objectives, research hypothesis/ questions, recommendations and the various areas to focus on for further research.

5.2 Summary of Findings

This paper attempts to determine the factors influencing effectiveness of health management committee. An important finding is that the explanatory variables in the model result in the direct influence on the effectiveness of health care management committee. The paper also provides preliminary evidence regarding the relative importance of the explanatory variables on effectiveness of health management committee in Kenya.

The result of automated data analysis statistical package for social scientists (SPSS) reveals that local county politics, financial constraints, health staffing and health worker's perception can be held responsible for influencing effectiveness of health management committee. Specifically, the findings suggest that local county politics was the most important variable influencing effectiveness of health management committee in Kenya. Political goodwill is lacking in the Kenyan health sector, both from the government and the opposition.

The adjusted R squared coefficient (0.158) which is the coefficient of determination indicates that the explanatory variables accounted for 15.8% of the effectiveness of HMC. This could be described as a moderate effect but the outcome of such a magnitude could cripple the entire county health care management.

5.3 Discussion of Findings

The study sought to determine the factors that influence the effectiveness of health management committee. The four factors studied included health workers perception, leadership, health financing and health staffing. For the health worker's perception, the respondents agreed that a lot of healthcare problems arise from mismanagement at county

level. The respondents disagreed that previous control of healthcare by national government was better. Asked whether there are very many reported cases regarding procurement bottlenecks for hospital essentials, respondents agreed. The respondents were neutral on whether the current system of healthcare management is full of corruption and nepotism. Slightly more than half of the respondents agreed that current system of healthcare management is full of corruption and nepotism with the rest being neutral or disagreeing. The respondents agreed that the best practices in healthcare management have been realized after devolution. Asked whether dilapidated hospital services exist currently compared to pre-devolution, the respondents agreed.

For the leadership, the respondents strongly agreed that persistent leadership wrangles in the HMC hampers teamwork in the area. Asked whether the existence of many politicians in the HMC affects budgeting, the respondents were neutral. The respondents strongly disagreed that HMC is riddled with impunity that hampers proper execution. Asked whether HMC makes political decisions rather than logical decisions, the respondents strongly agreed. However, the respondents disagreed that HMC operates at the whim of the governor and MCAs.

For health financing, the respondents agreed that the cash constraints in the area slacken healthcare projects; the mean response was 1.9, denoting agreement. The respondents strongly agreed that indeed revenue allocated is never adequate for minimal healthcare services. Asked if the HMC members are too expensive and not sustainable, the respondents were not sure or neutral. The respondents disagreed that the acquisition of new hospital equipment is impossible with meager funds. However, when asked if the cost associated with hiring and maintaining hospital staff keeps rising, they agreed.

For health staffing, over 80% of the respondents declined that nurses are properly trained in basic health skills, thereby casting doubt on the success of the health care management committees since the nurses are one of the core implementers of effective healthcare. When asked whether majority of the nurses are equipped with WHO training, more than

half of the respondents declined implying that most of the nurses are not well equipped with the WHO training. This further casts doubt on the effectiveness of the healthcare management committees. Majority of the respondents (87%) confirmed that indeed health financing determines the success of the healthcare management, with only a small number (12%) declining. However, only 32% of the respondents accepted that healthcare is understaffed indicating that over half of the respondents did not feel overstretched with work at the health centers.

5.4 Conclusions

The number of male respondents was higher than that of their female counterparts. This was not preplanned but occurred randomly. Approximately most of the respondents were below 40 years thus a young and energetic workforce .Approximately all of the respondents were literate and with a fast hand grasp of basic healthcare management issues.

Based on the results of the regression analysis, health leadership take a lead followed by health financing, then health staffing and health workers perception in terms of deviations on the effectiveness of HMC. The researcher thus concluded that health leadership, health financing, and health staffing had the major impact on effectiveness of the HMC. However, since the value of R square is less than 50%, the researcher deduced that the proportion of variation associated to the independent variables had a moderate effect.

5.5 Recommendations

Its recommended from this study that the government of Kenya needs to come up with policies to control the external factors that interfere with health care management with a possible measure to cushion the entire HMC from political turbulence. The study further recommends that the Ministry of health develops a policy framework that outlines the effectiveness parameters for each county HMC. Conclusively, government should implement policies that will check on health procurement policy manipulation, regulate staff hiring and improve standards of management.

This study also recommends of the introduction and critical analysis of theories relating to health care management with the focus being on game theory, stakeholder theory and financing theory.

In terms of practice, the study recommends that the Ministry of health approaches the HMC with political goodwill, proper funding and adequate workforce. Moreover, the government should build the capacity of the HMC to better prepare them to handle the management challenges.

5.6 Suggested areas for further research

From the study, the researcher recommends further studies on:

1. The impact of county politics on effectiveness of health management committee in Kenya.
2. Strategic framework for the implementation of health care management committees in Kenya.

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APPENDICES

Appendix I: Letter from the University

The County Health Administrator,

…….

Dear Sir/Madam

RE: PERMISSION TO CARRY OUT RESEARCH IN YOUR HOSPITAL.

I am a student pursuing Master of Arts degree in Project planning and management student. I am required to submit as part of my course work assessment a research project report on "FACTORS INFLUENCING THE EFFECTIVENESS OF HEALTH MANAGEMENT COMMITTEE IN HEALTHCARE SERVICE DELIVERY: A CASE OF MACHAKOS COUNTY, KENYA." To achieve these objectives of the study, nurses from your county nurses and HMC members have been selected to participate in this study. The information will be used purely for academic purpose and your firm will not be mentioned in the report. Findings of the study shall upon request, be availed to you.

Thank you in advance,

Yours faithfully,

……..

Bernice Sialaal

REG NO L50/60283/2013

Appendix II: Questionnaire for Nurses and HMC Members.

Section A: Background information

Please insert/tick (√) details or circle the appropriate category for you.

Male	
Female	

1. Sex:

2. Age:

18- 29 yrs	
30-39	
40-49	
50-59	
60+	

3. Your highest educational qualification:

Certificate	
Diploma	
Degree	
Masters	
Other	

4. Number of years you have served in your current position.

Less than 2 yrs	
2-4 yrs	
4-6 yrs	
Over 6 yrs	

Section B: Health Care worker's perception and Health care management

5. Please react to the following statements about healthcare management by indicating whether you strongly agree, Agree, Disagree or strongly disagree. Please tick (√) against each statement your best opinion.

Factors	**Strongly Agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
A lot of healthcare problems arise from mismanagement at county level					
Previous control of healthcare by national government was better					
There are very many reported cases regarding procurement bottlenecks for hospital essentials					
Current system of healthcare management is full of corruption and nepotism					
Best practices in healthcare management has been realized after devolution					
Dilapidated hospital services exist currently compared to pre-devolution					

Section C: Local county politics and the Healthcare management

6. Please react to the statements by indicating whether you strongly agree, Agree, Disagree or strongly disagree?

Factors	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Persistent leadership wrangles in the HMC hampers teamwork					
Existence of many politicians in the HMC affects budgeting					
HMC is riddled with impunity that hampers proper execution					
HMC makes political decisions rather than logical decisions					
The HMC operates at the whim of the governor and MCAs					

Section D: Health Financing and Healthcare Management

7. Please react to the statements by indicating whether you strongly agree, Agree, Disagree or strongly disagree with the following factors?

Factors	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
The cash constraints in this area slacken healthcare projects					
Revenue allocated is never adequate for minimal healthcare services					
The HMC members are too expensive and not sustainable					
The acquisition of new hospital equipment is impossible with meager funds					

The cost associated with hiring and maintaining hospital staff keeps rising					

Section E: Health staffing and Healthcare management

8. Nurses are properly trained in the basic healthcare skills? Yes [ ] No [ ]
9. Majority of the nurses are equipped with the training recommended by WHO? Yes [ ] No [ ]
10. How many doctors in your hospital are there full-time? _____
11. Do you think number of doctors determines the success of the healthcare in the county? Yes [ ] No [ ]
12. Do you consider the county healthcare as understaffed?

    Yes [ ] No [ ]

13. If yes, why?

Comment	**(Tick)**
Few doctors	
Few nurses	
Few Cos	
General understaffing	
Other:	

14. Do you think healthcare staffing is handled adequately by HMC?

    Yes [ ] No [ ]

15. If No, how explain why?

_____

_____

_____

16. On a scale of 1-5, kindly rate the level of healthcare staffing management done by the HMC.

Factor	**Tick**
1.Perfect	
2.Good	
3.Average	
4. Poor	
5.Very poor	

Thank you for completing this questionnaire. Your participation is very much appreciated.