

FUNCTIONAL DEVOLUTION AND ACCESS TO MATERNAL HEALTHCARE SERVICES: EVIDENCE FROM MARSABIT COUNTY, KENYA

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ABSTRACT

Statement of the Problem: Kenya's devolution of healthcare was intended to improve responsiveness and bring essential services closer to communities. In Marsabit County, however, the benefits of transferred service-delivery functions are constrained by a vast geographical area, dispersed pastoralist settlements, transport limitations, healthcare-worker shortages, and uneven facility capacity. These conditions make it important to establish whether functional devolution has translated into improved access to maternal healthcare rather than merely transferring responsibility from the national to the county level.

Purpose of the Study: The study examined the effect of functional devolution on access to maternal healthcare services in Marsabit County, Kenya.

Research Methodology: The study used a cross-sectional mixed-methods design. The target population comprised 9,600 women of reproductive age seeking maternal healthcare services in four county-managed Level Four hospitals. A sample of 384 respondents was selected proportionately through stratified random sampling. Quantitative data were collected using structured questionnaires and complemented by key informant interviews with healthcare stakeholders. Descriptive statistics were used to summarize respondents' perceptions, while correlation and multiple regression analysis were used to test the relationship between functional devolution and maternal healthcare access. The functional-devolution coefficient was interpreted from the thesis multiple-regression model controlling for fiscal, governance, and administrative devolution.

Findings: The detailed Chapter Four results showed mixed but generally positive evidence. Regarding the overall contribution of functional devolution, 43.49% of respondents agreed or strongly agreed that it had improved access to maternal healthcare, 27.08% were neutral, and 29.42% disagreed or strongly disagreed. Positive perceptions were also recorded for better maternal healthcare services (41.92%), improved quality of care (38.29%), and increased antenatal and postnatal attendance (39.84%). The bivariate association between functional devolution and maternal healthcare access was positive but weak ($r = 0.089$). In the multivariate model, functional devolution recorded a positive and statistically significant coefficient ($\beta = 0.077$, $p = 0.015$), the largest reported coefficient among the four devolution dimensions.

Conclusion: Functional devolution has made a positive contribution to maternal healthcare access in Marsabit County, particularly through improvements in service delivery, perceived quality, and utilisation of antenatal and postnatal services. Nonetheless, the gains remain uneven because geographical and health-system constraints continue to restrict access for women in remote and pastoralist communities.

Recommendation: Marsabit County should strengthen primary healthcare facilities, mobile clinics, community outreach, ambulance and referral systems, and service-delivery capacity in hard-to-reach areas so that devolved maternal healthcare functions translate into more equitable access.

Keywords: *Functional Devolution, Maternal Healthcare, Access, Devolved Health System, Marsabit County, Kenya*

1. INTRODUCTION

Devolution is a form of decentralization through which authority, functions, responsibilities, and resources are transferred from the central government to sub-national governments. In Kenya, the 2010 Constitution established a devolved system in which county governments acquired substantial responsibility for the delivery and management of health services. The reform was expected to make public services more responsive to local priorities, reduce long-standing spatial inequalities, and bring decision-making closer to communities (Constitution of Kenya, 2010; McCollum et al., 2018). Within health, devolution is particularly important for services that depend on continuous contact between communities and frontline facilities, including maternal healthcare.

Maternal healthcare comprises the services required by women during pregnancy, childbirth, and the postnatal period. Effective access depends on more than the formal existence of a facility. Women must be able to reach services within reasonable time, obtain appropriate antenatal and delivery care, receive essential medicines and skilled attention, and experience acceptable and good-quality care. Petchenksy and Thomas (1981) conceptualize access as a fit between the population and the health system, involving dimensions such as availability, accessibility, affordability, acceptability, and adequacy. These dimensions are especially relevant in remote counties because transferring a service function does not by itself eliminate distance, transport, staffing, or quality barriers.

Functional devolution refers to the transfer of specific service-delivery responsibilities to sub-national governments. In Kenya, county governments are responsible for frontline functions such as primary healthcare, maternal and child healthcare, public health programmes, and community health services. The underlying expectation is that county control of these functions should enable health systems to respond to local conditions, strengthen primary care, and improve maternal healthcare utilisation. Decentralization research nevertheless shows that positive outcomes depend on the capacity of local governments to finance, coordinate, staff, and manage the functions transferred to them (Abimbola et al., 2019; Kilonzo et al., 2017).

Marsabit County provides a critical setting for examining this issue. The county's large geographical area, dispersed settlements, pastoralist livelihoods, limited transport infrastructure, and uneven distribution of health resources can make routine maternal care difficult to obtain. In such a context, the question is not simply whether health functions have

been devolved, but whether county-level delivery of those functions has measurably improved women's access to maternal healthcare. The thesis from which this article is drawn examined four dimensions of healthcare devolution—fiscal, governance, administrative, and functional devolution. This article isolates the functional-devolution objective because it directly addresses frontline service delivery and, in the thesis regression model, recorded the largest positive coefficient among the four dimensions.

2. STATEMENT OF THE PROBLEM

Healthcare devolution was expected to correct unequal service distribution by allowing counties to organize and deliver services in response to local needs. Yet the transfer of responsibility can produce uneven results where local health systems face capacity, staffing, infrastructure, and logistical constraints. Evidence from Kenya suggests that devolution has expanded opportunities for local planning and service delivery, but progress varies across counties and may be weaker in marginalized and geographically difficult areas (Kimathi, 2017; McCollum et al., 2018).

The challenge is particularly important for maternal healthcare in Marsabit County. Women living in remote and pastoralist communities may still face long distances to health facilities, limited transport and referral options, shortages of healthcare workers, and inconsistent availability or quality of services. Consequently, the formal transfer of primary healthcare, maternal and child health, public health, and community health functions to the county does not necessarily demonstrate that women can obtain timely and appropriate maternal care. Previous studies have often examined decentralization broadly or focused on better-resourced counties, leaving limited quantitative evidence on the effect of functional devolution on maternal healthcare access in a marginalized arid and semi-arid county. This study therefore focused on whether the functional dimension of healthcare devolution has improved access to maternal healthcare services in Marsabit County.

3. RESEARCH OBJECTIVE

To examine the effect of functional devolution on access to maternal healthcare in Marsabit County.

4. RESEARCH HYPOTHESIS

H₀: Functional devolution has no statistically significant influence on access to maternal healthcare services in Marsabit County.

5. LITERATURE REVIEW

Theoretical Foundation

This article is anchored primarily in Decentralization Theory, associated with the work of Rondinelli (1981) and Bossert (1998). The theory explains the redistribution of political, administrative, fiscal, and functional authority from central government to lower levels of government. Its central proposition is that local governments, because they are closer to citizens and their service environments, may possess better information about local needs and can therefore allocate resources and organize service delivery more responsively. In the health

sector, this proposition implies that county governments should be able to adapt primary healthcare, community services, maternal and child health programmes, and referral arrangements to the characteristics of the populations they serve.

Functional devolution represents the service-delivery expression of this theory. Transferring maternal and primary healthcare functions to county governments should shorten decision chains, enable local prioritisation, and support service designs suited to local conditions. However, Decentralization Theory also recognizes important implementation risks. Local authorities may lack technical capacity, adequate personnel, infrastructure, or reliable financial resources; decentralization may therefore shift responsibility without providing the conditions necessary to perform the transferred functions effectively (Bossert, 1998; Abimbola et al., 2019). These limitations are especially relevant to Marsabit County, where service delivery must cover a large and sparsely populated area.

Andersen's Behavioral Model of Health Service Use (Andersen, 1995) provides a complementary lens for interpreting utilisation outcomes. The model emphasizes predisposing, enabling, and need factors. Functional devolution can be understood as an enabling health-system factor because it can change the availability and proximity of services, the organisation of primary care, outreach to communities, and the effectiveness of referral systems. From this perspective, functional devolution should improve maternal healthcare utilisation only when the transferred service functions actually reduce the barriers that women face in reaching and using care.

Empirical Review

Empirical evidence on functional health decentralization is mixed. Wahome (2019), examining maternal healthcare under devolution in Nyandarua County, found that county-level control contributed to improved physical access through expansion of healthcare infrastructure and greater availability of maternal services. The study nevertheless reported continued constraints associated with shortages of skilled personnel and essential supplies. The findings suggest that functional devolution can improve proximity to care, but that the quality and continuity of maternal services depend on complementary health-system capacity.

Kilonzo et al. (2017), examining referral maternal healthcare in Kisumu and Uasin Gishu counties in Western Kenya, found considerable satisfaction among service users following devolution, while also showing that improved access could not be attributed to devolution alone. The study linked gains to a combination of devolved services and complementary developments such as improved transport, health campaigns, and reallocation of resources. This evidence is important because it shows that functional devolution can create better access conditions, but the realized benefit depends on the wider service environment in which county functions operate.

Kenyan studies reinforce this conditional interpretation. McCollum et al. (2018) showed that devolution can strengthen local ownership and priority setting, but the translation of local authority into equitable health outcomes depends on governance relationships and implementation capacity. Tsofa et al. (2017) found that changes in county responsibility for essential medicines and supplies were affected by role clarity, administrative capacity, and

procurement processes. These findings are important to maternal health because the ability of county-managed facilities to provide safe services relies on functional links between staffing, commodities, referral networks, and community outreach.

The literature therefore supports the expectation that functional devolution may improve maternal healthcare access, but it also reveals three gaps addressed by this paper. First, many studies assess devolution at an aggregate health-system level rather than isolating service-delivery functions that directly affect maternal care. Second, much of the evidence is descriptive or qualitative, with fewer studies quantitatively testing the relationship between functional devolution and access. Third, marginalized and geographically vast counties such as Marsabit remain underrepresented, despite the distinctive service-delivery challenges created by distance, dispersed settlement patterns, and pastoralist mobility.

6. CONCEPTUAL FRAMEWORK

The conceptual framework treats functional devolution as the independent variable and access to maternal healthcare services as the dependent variable. Functional devolution is reflected in the delivery of primary healthcare, maternal and child health services, community health and outreach, and referral/service-delivery capacity. Access is reflected in service availability, geographical accessibility, financial affordability, quality and acceptability, and use of antenatal and postnatal care. The framework assumes that stronger performance of devolved service functions should reduce barriers to care and improve women's ability to obtain maternal healthcare when needed.

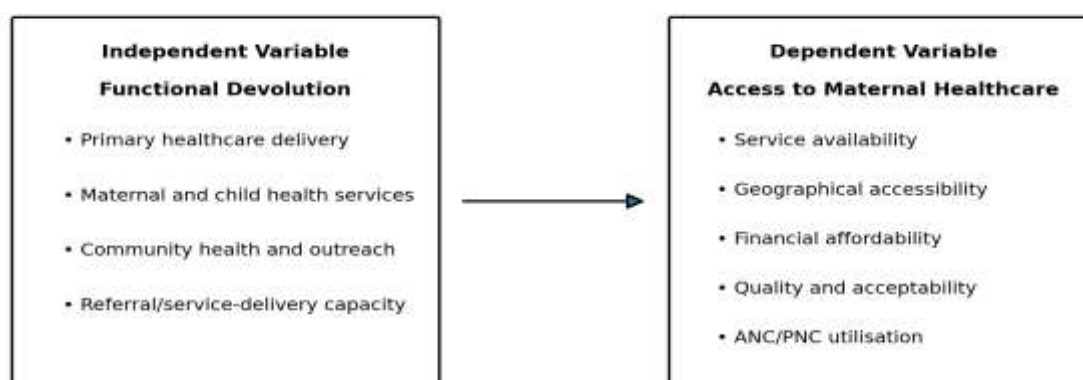


Figure 1: Conceptual Framework

7. RESEARCH METHODOLOGY

The study adopted a cross-sectional mixed-methods approach to examine the relationship between healthcare devolution and access to maternal healthcare services in Marsabit County. The quantitative component provided the principal evidence used in this article, while key informant interviews with healthcare stakeholders were used in the thesis to provide contextual interpretation of the quantitative findings.

The target population comprised 9,600 women of reproductive age who sought maternal healthcare services in four county-managed Level Four hospitals: Marsabit County Referral Hospital, Moyale Sub-County Hospital, Laisamis Sub-County Hospital, and North Horr Sub-County Hospital. The annual population distribution used in the study was 4,000, 3,200, 1,600, and 800 women respectively. Using Yamane's sample-size formula at a 5% margin of error, the study obtained a sample of 384 respondents. Stratified random sampling was used to ensure proportional representation across the four hospitals, yielding samples of 160 respondents from Marsabit County Referral Hospital, 128 from Moyale Sub-County Hospital, 64 from Laisamis Sub-County Hospital, and 32 from North Horr Sub-County Hospital.

Primary quantitative data were collected using structured questionnaires containing closed- and open-ended questions. Interviews were also conducted with county health officials and healthcare practitioners to obtain institutional perspectives on devolved service delivery. The questionnaire was piloted using 38 women who were excluded from the final study sample. The thesis specified a Cronbach's alpha threshold of 0.70 for internal consistency and used expert and supervisor review to support content validity.

Quantitative data were analysed using SPSS. Frequencies and percentages were used to describe respondents and their perceptions of functional devolution. The study also used correlation analysis and multiple regression. For this article, the key inferential statistic is the coefficient for functional devolution from the thesis multiple-regression model, in which fiscal, governance, administrative, and functional devolution were entered jointly to predict the Maternal Healthcare Access Index. Thus, the reported functional-devolution coefficient represents its independent association with maternal healthcare access while the other devolution dimensions are held constant.

The thesis factor-screening stage retained improvement in maternal healthcare quality and increased antenatal and postnatal attendance as the principal indicators used to construct the functional-devolution regression score. Other perception items were retained for descriptive interpretation but did not enter the final composite. This distinction is maintained in the present article so that the descriptive findings are not treated as identical to the regression construct.

Table 1: Target Population and Sample Distribution

Health Facility	Target Population	Sample Size	Share (%)
Marsabit County Referral Hospital	4,000	160	42
Moyale Sub-County Hospital	3,200	128	33
Laisamis Sub-County Hospital	1,600	64	17
North Horr Sub-County Hospital	800	32	8
Total	9,600	384	100

Source: Thesis fieldwork design (2026).

8. RESULTS AND DISCUSSION

Response Rate and Respondent Profile

All 384 targeted respondents participated in the study, producing a reported response rate of 100%. The respondent profile provides context for interpreting maternal healthcare access in Marsabit County. Women aged 26–35 years constituted the largest age category (39.84%), followed by those aged 36–45 years (28.13%) and 18–25 years (27.34%). Most respondents were married (78.91%). Educational attainment was generally low: 39.58% had primary education and 26.04% had no formal education, while only 8.85% had college or university education. Farmers (30.73%) and unemployed respondents (30.47%) formed the largest occupational groups. These characteristics are important because education, household resources, and livelihood activities can influence women's ability to navigate health information, meet transport costs, and attend maternal healthcare services (Andersen, 1995).

Table 2: Demographic Characteristics of Respondents (N = 384)

Characteristic / Category	Frequency	Percentage (%)
Age: 18–25 years	105	27.34
Age: 26–35 years	153	39.84
Age: 36–45 years	108	28.13
Age: 46 years and above	18	4.69
Marital status: Single	46	11.98
Marital status: Married	303	78.91
Marital status: Widowed	21	5.47
Marital status: Divorced	14	3.65
Education: No formal education	100	26.04
Education: Primary education	152	39.58
Education: Secondary education	98	25.52
Education: College/University	34	8.85
Occupation: Farmer	118	30.73
Occupation: Business	65	16.93
Occupation: Employed	39	10.16
Occupation: Unemployed	117	30.47
Occupation: Other	45	11.72

Source: Field Data (2026).

Functional Devolution and Maternal Healthcare Access

The study assessed functional devolution using respondents' perceptions of service accessibility, quality and effectiveness of county-managed maternal healthcare services, utilisation of antenatal and postnatal services, and the overall contribution of devolved service-delivery functions. The detailed Chapter Four frequencies show a mixed pattern rather than uniformly positive change. This is substantively important: functional devolution appears to have generated observable gains in some aspects of maternal healthcare while significant access barriers remain.

Table 3: Respondents' Perceptions of Functional Devolution (N = 384)

Statement	Disagree / Strongly Disagree (%)	Neutral (%)	Agree / Strongly Agree (%)
Services are more accessible	38.02	24.48	37.50
Facilities provide better maternal services	30.73	27.34	41.92
Quality of maternal healthcare has improved	32.56	29.17	38.29
ANC and PNC attendance has increased	34.90	25.26	39.84
Functional devolution has improved access	29.42	27.08	43.49

Source: Field Data (2026), aggregated from the detailed Chapter Four response categories.

Accessibility of Maternal Healthcare Services

On whether maternal healthcare services had become more accessible following functional devolution, 37.50% of respondents agreed or strongly agreed, 38.02% disagreed or strongly disagreed, and 24.48% were neutral. The near balance between positive and negative responses indicates that physical access gains were not experienced uniformly. County management may have expanded the reach of some maternal services, but Marsabit's large area, dispersed settlements, poor transport links, and limited number of facilities continue to affect women in remote locations. This pattern is consistent with Wahome (2019), who found that functional devolution can improve proximity to maternal health services but that local infrastructure and resource constraints determine the extent of the gain.

Perceived Improvement in Facility-Based Maternal Healthcare

A larger share of respondents expressed a positive view of the services provided by health facilities after devolution: 41.92% agreed or strongly agreed that facilities provided better maternal healthcare, compared with 30.73% who disagreed or strongly disagreed and 27.34% who were neutral. This suggests that county assumption of frontline service-delivery responsibilities has produced noticeable improvements for a substantial group of users. Nevertheless, the combined neutral and negative responses remain large. The result illustrates the distinction between devolving a function and achieving uniformly effective delivery. Service improvement depends on staffing, supplies, management, infrastructure, and referral capacity, all of which can vary across facilities and sub-counties.

Quality of Maternal Healthcare

Regarding quality, 38.29% of respondents agreed or strongly agreed that maternal healthcare had improved since devolution, 32.56% disagreed or strongly disagreed, and 29.17% were neutral. The finding suggests modest improvement in users' experience of care but also points to uneven quality. Functional devolution gives the county greater responsibility for tailoring services to local priorities, yet quality still relies on skilled healthcare workers, essential

commodities, facility readiness, respectful care, and timely referral. Abimbola et al. (2019) similarly show that the effects of decentralization depend on institutional, socio-economic, and geographic context, meaning that local authority produces better outcomes only when the surrounding system can support effective implementation.

Antenatal and Postnatal Care Utilisation

The study also examined whether more women were attending antenatal and postnatal care services following devolution. A total of 39.84% agreed or strongly agreed, 34.90% disagreed or strongly disagreed, and 25.26% were neutral. The positive plurality suggests that devolved maternal and child health functions, community outreach, and county-led primary healthcare have supported utilisation in some areas. However, the sizeable negative response indicates that service availability does not automatically translate into attendance for women facing distance, transport, cultural, livelihood, or staffing barriers. Andersen's (1995) model helps explain this result: a devolved service may become an enabling resource, but individual and contextual barriers can continue to influence actual utilisation.

Overall Perceived Contribution of Functional Devolution

On the overall statement that functional devolution had improved access to maternal healthcare, 43.49% of respondents agreed or strongly agreed, 27.08% were neutral, and 29.42% disagreed or strongly disagreed. This was the most favourable overall response pattern among the functional-devolution items. The result supports the proposition that bringing service-delivery responsibility closer to communities can improve maternal healthcare access. At the same time, almost three in ten respondents did not perceive an improvement and more than one in four were neutral. The evidence therefore supports a qualified conclusion: functional devolution has created meaningful opportunities for improved service delivery, but the benefits are uneven and have not fully overcome the structural disadvantages affecting remote and pastoralist communities.

Correlation and Regression Findings

The correlation analysis reported a positive but weak relationship between functional devolution and maternal healthcare access ($r = 0.089$). Although the association was small, functional devolution had the strongest positive bivariate correlation with maternal healthcare access among the four devolution dimensions. The weak magnitude indicates that access is shaped by multiple factors and that service-delivery devolution alone cannot explain women's experiences of maternal healthcare.

Table 4: Correlation Analysis

Variables	Maternal Healthcare Access	Functional Devolution
Maternal Healthcare Access	1.000	
Functional Devolution	0.089	1.000

Source: Field Data (2026).

In the thesis multiple-regression model, functional devolution recorded a positive and statistically significant coefficient ($\beta = 0.077$, $p = 0.015$) after fiscal, governance, and administrative devolution were controlled. The reported coefficient was the largest among the four devolution dimensions. On the basis of the reported p-value, the null hypothesis that functional devolution has no statistically significant influence on maternal healthcare access was rejected. The result indicates that improvements in the effective delivery of devolved maternal healthcare functions were associated with improved access, even after accounting for the other dimensions of devolution.

Table 5: Functional Devolution in the Thesis Multiple-Regression Model

Predictor	Reported Coefficient (β)	Reported p-value
Functional Devolution	0.077	0.015

Dependent variable: Maternal Healthcare Access Index. Source: Field Data (2026).

Discussion of the Main Finding

The positive regression result is consistent with Decentralization Theory. When service-delivery authority is moved closer to communities, county governments have greater scope to organize primary healthcare, maternal and child health services, community outreach, and referral arrangements around local needs. In Marsabit, this local discretion is particularly important because service delivery must respond to dispersed populations and long travel distances. The finding therefore supports the theoretical expectation that the location of responsibility can matter for access when local institutions use that responsibility to strengthen frontline services.

The finding is also consistent with Wahome (2019), who reported improved access to maternal health services under devolution in Nyandarua County through greater availability of maternal services and expansion of primary healthcare infrastructure. It further aligns with Kilonzo et al. (2017), who found that maternal healthcare users in Western Kenya associated improved access with devolution, while also demonstrating that transport, national health initiatives, and county-level resource decisions contributed to the observed gains. Abimbola et al. (2019) likewise show that decentralization outcomes depend strongly on institutional and geographic context. Together, these studies explain why the positive effect identified in Marsabit should be interpreted as conditional rather than automatic.

The weak bivariate correlation and the mixed descriptive responses reinforce that caution. Functional devolution does not remove the physical and institutional conditions that determine whether services can actually be used. In Marsabit, the thesis findings repeatedly identify long distances, transport limitations, workforce shortages, limited facility capacity, and unequal service reach as continuing constraints. Thus, the significance of functional devolution should not be interpreted as evidence that access problems have been solved. Rather, the result indicates that service-delivery devolution is a useful pathway whose benefits depend on the strength of county implementation.

The result also has an equity implication. Women in locations closer to facilities may experience improvements sooner than women in remote or mobile pastoralist communities. Without deliberate outreach, mobile services, functioning ambulances, strong referral links, and an adequate rural health workforce, functional devolution may improve average access while leaving substantial spatial inequalities intact. This concern is consistent with broader decentralization literature showing that local autonomy can produce unequal outcomes when sub-national units differ in capacity and resource endowments (Abimbola et al., 2019).

From a maternal-health perspective, the most relevant contribution of functional devolution is therefore not the transfer of responsibility itself but the ability of county institutions to convert that responsibility into dependable, reachable, and good-quality services. The findings on facility services, quality, and ANC/PNC attendance indicate that this conversion has begun in Marsabit County but remains incomplete. Policy attention should consequently shift from the formal architecture of devolution toward the practical service systems through which pregnant and postpartum women experience care.

9. CONCLUSIONS

The study concludes that functional devolution has positively influenced access to maternal healthcare services in Marsabit County. The detailed descriptive findings show that a substantial proportion of women perceived improvements in facility-based maternal services, quality of care, antenatal and postnatal attendance, and the overall contribution of devolved service-delivery functions. The thesis regression model also reports a positive and statistically significant association between functional devolution and maternal healthcare access.

The improvement is nevertheless uneven. Negative and neutral responses remained substantial across the functional-devolution indicators, showing that many women have not experienced the same gains. Marsabit's geographical scale, dispersed settlements, transport limitations, healthcare-worker shortages, and uneven facility capacity continue to restrict the reach and consistency of maternal healthcare. Functional devolution should therefore be understood as an enabling institutional arrangement rather than a sufficient condition for equitable maternal healthcare access. Its success depends on the county's capacity to strengthen primary healthcare, outreach, referral, staffing, and quality systems in the places where women face the greatest barriers.

10. RECOMMENDATIONS

1. The County Government of Marsabit should strengthen primary healthcare facilities in underserved areas and ensure that devolved maternal health functions are supported by adequate staffing, essential supplies, and basic service-readiness infrastructure.
2. Mobile clinics and community outreach should be expanded for remote and pastoralist settlements so that antenatal, postnatal, health-promotion, and referral services reach women who cannot easily travel to fixed facilities.
3. Ambulance and referral systems should be strengthened, with clear linkages between community units, dispensaries, health centres, and Level Four hospitals to reduce delays in obtaining skilled maternal care.

4. County health planning should use location-specific service data to identify communities with persistently low access and direct functional investments to those areas rather than relying only on county-wide averages.
5. Future research should focus specifically on women in remote pastoralist communities and examine how geographical, cultural, and socio-economic conditions shape the benefits they derive from healthcare devolution.

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