INFLUENCE OF DEVOLVED GOVERNANCE AND PERFORMACE OF THE HEALTH SECTOR IN KENYA

FERDINAND GITHETHUKI MUCHOMBA

INFLUENCE OF DEVOLVED GOVERNANCE AND PERFORMACE OF THE HEALTH SECTOR IN KENYA

Muchomba, F., Jomo Kenyatta University of Agriculture & Technology (JKUAT), Kenya

Karanja, N., Jomo Kenyatta University of Agriculture & Technology (JKUAT), Kenya

ABSTRACT

Devolution, as other types of decentralization, profoundly changes governance relations in the health system. Devolution is meant to affect performance of the health system by transferring responsibilities and authority to locally elected governments. This study aimed to establish the effect of devolved governance on the performance of the health sector in Kenya. The guiding objectives included: To establish the influence of devolved procurement on the performance of the health sector; to determine the effect of devolved leadership on the performance of the health sector; to evaluate the effect of devolved resources on the performance of the health sector; and to establish the effect of devolved policy and regulatory framework on the performance of the health sector in Kenya. The study adopted the descriptive survey research design. The target population was 572 patients and health care providers from Nairobi and Mombasa County. Stratified sampling method was adopted at the rate of 10% to come up with a sample size of 57 respondents. Primary data was collected using questionnaires from all the respondents. Secondary data was sourced from health sector reports in Kenya from the year 2010 to 2014. The collected data was then analyzed through frequencies and percentages to enable the research come up with conclusions and recommendations for the study. The researcher employed the assistance of some computer tools, including the Statistical Programmes for Social Sciences (SPSS) and excel version 16 to analyze the data quantitatively. The analyzed data was presented in the form of graphs tables and charts.

The Study established that devolution process has not been fully implemented and its effect has not been fully experienced in the health sector. The sector performance was averagely rated in the study and its contribution to GDP reduced by 0.5 percent by the end of the year 2013. The devolved procurement process, organizational leadership, resources allocation and availability as well as policy and regulatory framework had a significant influence on the performance of the level four hospitals and the overall health sector. It was recommended that the health sector players should improve in financing of critical health investment areas, particularly those relating to improving quality of care. Key

***Key Words**: Devolved Government, Performance, Health Sector*

INTRODUCTION

1.1 Background Information

This study sought to establish the influence of devolved governance and the performance of the health sector in Kenya. Decentralization of health system structure and management has been and continues to be a key issue for many countries in the achievement of health for all, and development of primary health care. According to WHO (1990), decentralization can be defined in general terms as the transfer of authority, or dispersal of power, in public planning , management and decision making from national to sub national levels. "Decentralization is therefore, not only an important theme in health management but also a confused one", (Luoma et al, 2010). According to El-Saharty (2009), globally, there has been a trend in the devolution of authority in healthcare. One can say that authority that was often sitting with one central Ministry or Department of Health has devolved over time. Ethiopia for example has moved from centrally-organised authority to a situation where block grants are redistributed from regional governments to districts. The districts, in turn, can set their own priorities and are free to further allocate this budget to health facilities, (El-Saharty, 2009).

1.1.1   Devolved Governance

Devolved governance refers to restructuring or re-organization of authority that there is a system of co-responsibility between institutions of governance at the central, regional and local levels according to the principle of subsidiary. The devolution thematic area deals with all matters relating to the operationalization of the constitutional provisions on devolved government as provided for in Chapter Eleven of the Constitution, (Barker, Mulaki, Mwai, and Dutta, 2014). This includes the development of new policies legislation and administrative procedures and, in some cases, the review of existing policies, legislation and administrative procedures required to implement the devolved system of government, (Noorein, Asbjorn and Wells, 2010). The thematic area monitors the status and progress made in the development of legislation, policies and administrative procedures required to implement devolution. A list of legislation required for implementing devolution and the time frames within which the legislation must be passed is given in the Fifth Schedule to the Constitution.

Since independence in 1963, centralisation has been at the core of Kenyan governance, with power concentrated in the capital. As a result, Kenya has been marked by spatial inequalities during this period of time. It is against this backdrop that healthcare devolution is taking place, (MOH, 2013a). Discussion about devolving powers to the regional level is a big debate in Kenya today. In general, it is believed that local governments are more transparent than national governments. This is due to the proximity of local governments to their communities, (English et al., 2011). One of the aims of devolution is to create more intense community involvement in order to adjust service delivery models to the communities' specific needs. As such, the local government must have the authority to involve communities. Indeed, there is a great deal of scepticism about it. Despite this scepticism, most counties will use devolution as the latest panacea for the woes of their health care systems.

1.1.2   Health Sector

The health sector is made up of the people, institutions and resources, arranged together in accordance with established policies, whose primary purpose is to promote, restore and maintain health. It includes government ministries and departments, hospitals and other health services, health insurance schemes, voluntary and private organizations in health, as well as the pharmaceutical industry and drug wholesale companies, (Nzinga, Lairumbi and Mike, 2013). In many developing countries, private not-for-profit health care providers constitute an important part of the health sector, sometimes owning up to half of a country's hospitals. The health sector has been undergoing tremendous transformation globally. Health sector reform is a process that seeks major changes in national health policies, programmes and practices through changes in health sector priorities, laws, regulations, organizational structure and financing arrangements, such as user fees. The central goals are most often to improve access, equity, quality, efficiency and/or sustainability, (WB and CMI, 2012).

The Health sector has the overall goal of providing equitable and affordable health care to Kenyans at the highest affordable standards. The Health Sector comprises of Ministries of Medical Services, Public Health and Sanitation, Research and Development sub-Sectors, namely Kenya Medical Research Institute (KEMRI). The goal of Kenya's Vision 2030 for the Health Sector is to "provide equitable and affordable health care at the highest affordable standards to her citizens", (Atieno, Nancy and Spitzer, 2014). Good health is a prerequisite for enhanced economic growth, poverty reduction and a precursor to realization of the Vision's Social Goals. Further, the Constitution under the Bill of Rights states that access to healthcare

is a right to every Kenyan. It is against this background that the Health Sector is re-positioning itself to fulfil the expectations of Kenyans through various strategic interventions through improved health systems such as infrastructure and service delivery, (MOH, 2013b).

Following the general elections in March 2013, each county has the task of establishing a "blueprint for change" for its health system, (Barker, 2014). In the new Constitution of Kenya, 2010, fourth schedule in the article 185 ,186 and 187 , it establishes the distribution of functions between the National and the County governments where the National government handles National referral health facilities and Health policy, while County governments handle County health services, including, in particular, county health facilities and pharmacies; ambulance services; promotion of primary health care; licensing and control of undertakings that sell food to the public. Legal notice no. 137 of 2013 indicates all the health services transferred to the counties after the Counties made formal application (Mwatsuma, Mwamuye and Nyamu, 2014).

1.1.3   Performance of Health Sector

Performance measurement has considerable potential in health service management in enabling national priorities for health reform to be translated into organisational and individual objectives, to provide a focus on results, and to enhance accountability, (Baines, 2009). Devolution is proposed within a framework that provides adequate and accurate information to inform decisions and enables decision-makers, managers, and staff to be held accountable. For effective devolution in health, performance measurement systems are required that enable health boards and providers to demonstrate

that they are fulfilling devolved functions and for the department to monitor the performance of the system against agreed objectives, (Omondi,et al., 2012). The Comptroller and Auditor General (Amendment) Act, 1993 requires the Comptroller and Auditor General to audit the accounts of health boards, to include a review of whether the health board applied expenditure for the purpose for which it was intended, if transactions conformed to the correct authority, and if income and expenditure are supported by substantiating documentation. The Act also provides for the review of whether and to what extent resources were used, acquired or disposed of economically and efficiently and if disposals effected 'the most favourable terms reasonably obtainable'. It gives the Comptroller and Auditor General the right to access documents and information, to examine systems, procedures and practices, and to make comparisons as considered appropriate, (MOH, 2014).

Successive governments in Kenya have sought to address the problems of health system by adopting a variety of ways. As long ago as 1994, the Government of Kenya (GOK) approved the Kenya Health Policy Framework (KHPF) as a blueprint for developing and managing health services. According to (Kpmg, 2013), central to the creation of a health care system is the devolved authorities' ability to use these governance tools to rationalize, integrate and coordinate previously autonomous and sometimes competing services. Such rationalization can occur vertically (between institutional and community-based services) and horizontally (among institutional service) such as hospital mergers or among community-based services. Kenya Health Policy 2012 – 2030 provides guidance for the achievement of the highest standard of health. It aims to achieve this by "supporting provision of equitable, affordable and quality health and related services at the highest attainable standards to all Kenyans" by focusing on primary care. Devolution of healthcare to the counties provides an enabling environment for this approach as the county governments are responsible for the provision of primary care. Bringing primary care services closer to the people allows for ownership and participation, (MOH, 2014).

Like most countries in Africa, the shortage of healthcare workers is not unique to Kenya. Indeed, Kenya is one of the countries identified by the WHO as having a "critical shortage" of healthcare workers. The WHO has set a minimum threshold of 23 doctors, nurses and midwives per population of 10 000 as necessary for the delivery of essential child and maternal health services. Kenya's most recent ratio stands at 13 per 10 000, (WHO, 2010). This shortage is markedly worse in the rural areas where, as noted in a recent study by Transparency International, under-staffing levels of between 50 and 80 percent were documented at provincial and rural health facilities. As a signatory to the 2001 Abuja Declaration, Kenya committed to allocating at least 15 percent of its national budget to health, (WHO, 2010). Not only is Kenya spending a relatively low amount as a percentage of GDP on healthcare, but the allocation of funds to public facilities has been uneven. According to a 2011 Healthy Action report, secondary and tertiary facilities have historically been allocated 70 percent of the health budget. The same report notes that allocation of funds to primary care facilities has been "poor" – this despite the significant role these facilities play as the first point of contact in the provision of healthcare

services, (Bashaasha, Najjingo and Nkonya, 2011).

Resource allocation formulas can help countries to redress inequities in access to healthcare by systematically and objectively incorporating needs-based criteria into allocation decisions. However imperfect the underlying data or their weighting may be, such efforts can help nations make progress toward achieving equitable access to healthcare, (Briscombe, Suneeta, and Margaret, 2010). Other African nations that face the same health challenges as Kenya have implemented effective approaches to ensure the equitable allocation of resources, including the introduction of needs-based criteria into their budgetary processes. Most of these nations face inequalities of access to healthcare, poor data collection and availability, and severe budgetary constraints similar to those of Kenya, (Briscomb, 2010).

Another notable weakness in many health resource allocation formulas is their failure to address equity in human resource and drug allocations. Often these two resources prove more difficult to quantify in monetary terms because their costs are difficult to calculate or estimate, (Briscomb, 2010). Decentralization implies an increase in sub-national responsibilities for planning, implementing, and monitoring health services, yet sub-national entities currently lack the capacity to shoulder these responsibilities. Sub-national authorities also lack corresponding authority to secure resources and hold national-level policymakers accountable for promised funding and representation. The WHO has conducted some training on the preparation of budgets, but broader efforts are needed to build capacity to collect and use data, plan collaboratively, and

manage resource allocation processes and formulas, (Atieno, Nancy and Spitzer, 2014).

At the heart of an assessment of how best to deliver services efficiently and effectively is the issue of how to serve the public interest and generate 'public value', (English et al, 2011). The concept of public value has been advanced as a way of thinking about and evaluating the goals and performance of public policy and as providing a yardstick for assessing activities produced or supported by government. 'Public value provides a broader measure than is conventionally used within the new public management literature, covering outcomes, the means used to deliver them as well as trust and legitimacy, (Bashaasha, 2011). It addresses issues such as equity, ethos and accountability

1.2 Statement of the Problem

Devolved government invariably involves a shift of power and control, and thus challenges accountability and performance management frameworks built around more traditional hierarchical authority structures. According to Kpmg (2013), a key challenge is to find new ways to support accountability, performance and public confidence while allowing for innovation and locally designed solutions to meet citizens' needs. In the devolved government, the Kenya Health Policy 2012 – 2030 provides guidance to the health sector in terms of identifying and outlining the requisite activities in achieving the government's health goals. The policy is aligned to Kenya's Vision 2030 (Kenya's national development agenda), the Constitution of Kenya and global health commitments such as the Millennium Development Goals, (MDGs). Kenya devolved its healthcare system since the time the county government came in power in March 4th 2013, however, very little has been done to establish

the implications it has had in Kenya, (Atieno, Nancy and Spitzer, 2014).

Health staff unrest has been witnessed since the advent of county governance; affecting service delivery thus posing health risks to thousands of county residents and scaring away potential investors. Both the national and county government together with the various development stakeholders have paid little attention to such a situation despite the fact that if it remains unchecked could jeopardize service delivery, (Mwatsuma, Mwamuye, and Nyamu, 2014). Further, the case of stock outs on essential drugs has promoted health risks in the hospitals as well as affecting the economic status of households as they seek drugs from private pharmacies. This has a negative social effect especially to the poor who depend on subsidized government supplies. Poor treatment for emergencies as well as unserviced equipment, vehicles and facilities pose a challenge in the effective delivery of health services in the hospitals in Kenya. The problem of underfunding and poor control of resources, embezzlement and pilferage at the hospitals have significantly influence the above problems in Kenya, (Kpmg, 2013).

Dealing with rapid, complex, and often discontinuous change requires leadership. Ministry of Health and Medical services (2010) suggests that for county governments to have successful health care system the leaders must understand the nature and implications of change, have the ability to develop effective strategies that account for change, and the will as well as the ability to actively manage the momentum of the devolution. It is against this backdrop that this study is conceived so as to fill the knowledge gap**.**

1.3 Objectives of the study
1.3.1 General Objective

The general objective of the study was to establish the influence of devolved governance on the performance of health sector in Kenya.

Specific Objectives

The guiding objectives of the study included:

i) To establish the influence of devolved procurement on the performance of health sector Kenya;
ii) To determine the influence of devolved organizational leadership on performance of health sector in Kenya;
iii) To evaluate the effect of devolved resources on the performance of health sector in Kenya
iv) To establish the effect of devolved policy and regulatory frameworks on the performance of health sector in Kenya

1.4 Research Questions

This study sought to answer the following questions:

i) What is the influence of devolved procurement on the performance of health sector Kenya?
ii) How much is the influence of devolved organizational leadership on the performance of health sector in Kenya?
iii) To what extent do devolved resources influence the performance of health sector in Kenya?
iv) To what extent does devolved policy and regulatory framework influence performance of health sector in Kenya?

1.5 Justification of the Study

The study aimed at establishing the implications devolution has brought about in Kenya with a

special emphasis of Nairobi and Mombasa County, so as to be able to compare and recommend best practices for adoption by other counties in Kenya and other countries devolving healthcare. The study also aimed at providing information on areas for further research since devolution is a new concept in Kenya and despite other countries having devolved healthcare, every country has its own unique challenges and opportunities. Both the county governments and national government can make use of the findings to come up with strategic interventions to enhance service delivery to citizens. Sector players in the health sector would also find this study crucial as it presented the current scenario of devolution in the health sector and its impact on the internal and external customers as well as strategic planning in the sector. Other researchers in future would benefit from the study as it would be a reference point.

1.6 Scope of the Study

The study was confined to the four objectives. Further, the study was undertaken at Nairobi and Mombasa County. The study was conducted on the public who were customers/patients at the level four hospitals. For this study, the respondents composed of patients the study areas since they are more readily available and interact with a lot of residents in their areas. The hospital attendants were also targeted.

1.7 Limitations to the Study

Some respondents were not available during data collection, while others were not willing to participate. Further, the literacy levels of some of the respondents impeded on the accuracy of the information provided. However, the researcher inducted all targeted respondents

on the significance and confidentiality of the information provided. Also, the respondents were assisted to comprehend the questions although not led to form any opinion.

LITERATURE REVIEW

2.1 Introduction

This chapter presents the reviews of previous researchers on the health sector, its performances as well as the factors influencing the performance levels. It entails the overview, the theoretical review, the critical review and gaps to the study. The conceptual framework, critical analysis and the study gaps justifying the conduct of this study will also be presented.

2.2 Theoretical Review

2.2.1 The Health Sector in Kenya

A 2010 review of the health situation in Kenya, performed by the Ministry of Medical Services and the Ministry of Public Health and Sanitation, reveals that improvements in health status have been marginal in the past few decades and certain indicators have worsened. The review notes that, "geographical and gender differences in age-specific health indicators persist." According to Republic of Kenya (2010), approximately 78 percent of Kenyans live in rural areas, yet a disproportionate share of healthcare facilities are located in urban areas. Those in rural areas often have to travel long distances, often on foot, to seek care. According to the World Bank, the index of access to health services (measuring the share of new-borns delivered at a health facility) in Kenya, speaks volumes to this disparity. For example, over eight in ten children born in Kirinyaga County, which is located in the central part of the country, are delivered in a health facility. In Wajir, which is

located in one of the most remote and marginalised regions of the country, one child in twenty is born in a health facility, (World Bank, 2010).

Atieno, Nancy and Spitzer (2014) inform that the health sector has achieved considerable outcomes as per its mandate: reduction of Under Five Mortality from 115 per 1,000 live births in 2003 to 74 per 1,000 live births in 2008/9 and Infant Mortality from 77 per 1000 live births to 52 per 1000 live births in the same period. The sector has also seen increased immunization coverage for under 1 year olds from 71% in 2008 to 77% in 2011. However, the sector still experiences some challenges especially regarding the high disease burden. Maternal Mortality Ratio has deteriorated from 414 in 2003 to 488 deaths per 100,000 live births in 2008-09; Births attended by skilled health personnel declined from 51 percent in 2007 to 43 percent in 2010/11, despite considerable funding flowing to the programmes. Even with the increasing allocation to the sector, Public Per Capita spending currently stands at $19.2 and in general, Per capita health spending still remains low at $42 compared to the WHO recommendation of $54 per capita, (Atieno, 2014).

Further, Atieno (2014) assert that recurrent allocations and expenditures generally dominate overall Medical Services sub-sector. In the Preventive and Promotive health programme, actual recurrent expenditures totalled Kshs 12.4 billion in 2011/12, up from Kshs 6.1 billion in 2009/10. Compensation to employees (personnel emoluments) accounted for 36% of the total expenditure during 2011/12 FY which is a decrease from 41% in 2009/10 FY. However, in absolute terms, the Ministry's

health spending on personnel emoluments has increased, but there is still a shortage of health workers. Expenditure on goods and services, grants, transfers and subsidies and acquisition of non-financial assets accounted for 48 percent, 11 percent and 5 percent respectively in 2011/12 financial year. In the Research and Development programme, the institute receives a one line budget which is used both for operations and capital expenditure. Personal emoluments utilised 13%, Acquisition of Non-Non-Financial Assets 82 % and Use of Goods and Services 5% of the budget in 2011/12.

Ministry of medical services (2010) documents that in the Constitution health service delivery is a two tier system whereby the National Government will focus on Health policy, National Referral Hospitals, Capacity Building and Technical Assistance to Counties. On the other hand the County Health services will focus on County Health Facilities and Pharmacies, Ambulance Services; Promotion of primary Health Care; licensing and control selling of food in public places; veterinary services, cemeteries, funeral parlours and crematorium; referral removal; refuse dumps and solid waste. This scenario will need concerted effort in restructuring organizational arrangement in relation to human resource management, infrastructure development and maintenance, health financing, donor funding and partnerships.

The Health Sector was allocated Kshs.93 billion in FY 2013/2014. During the medium-term planning period, the sector emphasis will be on strengthening of health systems particularly focusing on high impact interventions and priority investment areas. To accelerate this process, the Sector will focus on progressive improvement of governance frameworks,

health infrastructure, human resource for health, social health protection and access to quality and affordable medicines and medical supplies across the country. This will ensure achievement of the necessary standards and norms required for effective and comprehensive health service delivery, (Atieno, 2014).

According to Sihanya (2013) Kenya has an average of 19 doctors and 173 nurses per 100,000 population, compared to WHO recommended minimum staffing levels of 36 and 356 doctors and nurses respectively. Regarding the optimal staff establishment, the sector would require 72,234 staff. Currently the sector has an approved staff establishment of 59,667 but only about 49,096 positions are filled, leaving 10,371 positions vacant. The Research and Development (R&D) sub-sector has developed a critical mass of human resource to conduct health research. Currently the number of research personnel (in post) stands at 204. Poor working conditions remain a major challenge. These have resulted in brain drain which is adversely affecting research and development capacity in the sector. In the recent past, the health sector has witnessed industrial unrest by the health professionals agitating for increased remuneration which has serious budgetary implications within the sector. The shortages of Human Resource and industrial unrest have had negative impact on the Sectors capacity to deliver services, (Tangcharoensathien et al, 2011).

2.2.2 Devolved Governance in the Health Sector in Kenya

Nzinga (2009) accord that in the devolved system, healthcare is organized in a four-tiered system: Community health services. This level is comprised of all community-based demand creation activities, that is, the identification of cases that need to be managed at higher levels of care, as defined by the health sector; Primary care services:- This level is comprised of all dispensaries, health centres and maternity homes for both public and private providers; County referral services- These are hospitals operating in, and managed by a given county and are comprised of the former level four and district hospitals in the county and include public and private facilities; National referral services- This level is comprised of facilities that provide highly specialized services and includes all tertiary referral facilities. The counties are responsible for three levels of care: community health services, primary care services and county referral services. The national government has responsibility for national referral services

The fourth schedule (article 185 (2), 186 (1) and 187 (2)) establishes the distribution of functions between the national government and the county governments where the government handles National referral health facilities and Health policy, while county government handles County health services, including, county health facilities and pharmacies; ambulance services; promotion of primary health care; licensing and control of undertakings that sell food to the public; However county governments were supposed to apply for the functions, (Chuma, 2009). In a special issue1795 of the Kenya Gazette Supplement No. 116 Legislative Supplement No. 51) legal notice no. 137 health services were transferred to the counties. County health services including, County health facilities and pharmacies and county health facilities including county and sub county hospitals, rural health centres, dispensaries, rural health training and demonstration Centre's, rehabilitation and maintenance of county health facilities including maintenance

of vehicles, medical equipment and machinery. The success of devolution of health care will require strategic approach in order to realize the benefit of new governance dispensation, (Sihanya, 2013).

Sihanya (2013) posits that devolution can make the actions of local officials more transparent and provide a check on corruption, appointments based on family ties or other connections and other poor practices. However, this assumes that there is an active local political system, news outlets which are themselves not part of these webs of influence and that people will be prepared to blow the whistle where they see problems and that they will be listened to. External audit and review and the opportunity for issues of this sort to be escalated may be required. Devolving responsibilities does not only impact on those organisations or regions where responsibilities are devolved to, it also impacts on the organisation – typically a Ministry of Health – that is devolving its authority. Good governance should clearly spell out what (policies) the Ministry of Health would still be responsible for in a devolved health system. Examples of these are quality regulations and education and training of doctors. The role of a Ministry is therefore likely to be one of 'stewardship' and 'guidance' instead of 'own and control' in a devolved system.

As with all policies there is always a danger that the change may produce some unexpected and unwelcome results, (Marchal, 2009). Experience in some countries like Ghana and elsewhere suggests some potential concerns: Training- This is often organised nationally and new techniques are cascaded down the system. Some training still needs to be nationally organised; Career structures can suffer- Small administrative areas have fewer layers and,

while this is an advantage in terms of efficiency, it reduces the opportunities for talented people to rise up through promotion; Planning the workforce becomes more difficult- Workforce planning and the production of new staff – particularly where only small numbers are required – can become difficult as the system may be fragmented. Information can be difficult to acquire; Conflict with vertical programmes- Programmes such as HIV, TB and health promotion are often organised on a vertical basis, sometimes funded by external donors, (Ministry of Medical Services Republic of Kenya, 2008).

In some situations, these donors are nervous about using the devolved structures and have developed confidence in their own vertical programmes. There is a potential for unhelpful overlaps and conflict between the vertical programmes and the newly-devolved structures. The complete devolution of budgets also means that it is difficult to run large national programmes and less money can be earmarked; the loss of expertise and economies of scale- The fragmentation of procurement can increase costs and the risks of corruption. There are a number of supporting functions such as financial management, human resource management etc. which may be more economical to operate at a level above counties to reduce costs and make use of scarce expertise, (Milward, 2010).

The growth in devolved government is part of a broader diversification of public sector delivery modes. The concept of what constitutes the 'public service' has been evolving somewhat by stealth, with a greater focus on an 'enabling' rather than a 'doing' role. As a result, traditional barriers between sectors have become blurred, (Pavignani and Colombo, 2009).

2.2.3 Devolved Procurement and the Performance of the Health Sector

The following, according to C.I.P.S (2010) are some of the potential sources of risks in the in the supply chain: sources of risks from buyers; Clarity of definition of requirements, Presentation and approach to market, internal relationships and barriers to use particular suppliers. Other Sources of risks are from Suppliers, Production process capacity & supply chains, Competing demands from different buyers, Commercial and financial capability. Risks from existing buyer supplier Relationships; includes Contractual allocation of risks, Cultural fit and associated skill sets on both sides to manage the relationship Performance management arrangements. According to the findings of Bloom (2011)), there are five different sources of supply chain risks. These are based on, technological risks, political risks, market risks, turbulence risks, financial risks and organizational and societal risks. These risks affect the performance of the supply to varied levels depending with the existing circumstances.

Development of cross-functional teams aligns organizations with process oriented structure, which is much needed to realize a smooth flow of resources in a supply chain. As suggested by Bennett, Corluka, Doherty, and Tangcharoensathien (2012b), such teams promote improved supply chain effectiveness. They minimize or eliminate functional and departmental boundaries and overcome the drawbacks of specialization, which according to (Pavignani and Colombo 2009), can distribute the knowledge of all value adding activities such that no one, including upper level managers, has complete control over the process. Such teams helped in the formation of modern supply chains by promoting greater integration of organizations with their suppliers and customers.

A tenet of the Constitution of Kenya, 2010 (COK, 2010), is the right to healthcare for every individual. To this end, the government is working towards achieving universal health coverage (UHC) for its citizens. As the government implements approaches to increase demand, it will be imperative to ensure that the supply side is able to adequately respond. According to the Kenya Medical Supplies Agency (KEMSA) procurement Review Report (2008) there was no comprehensive consolidated annual procurement plan prepared by procurement unit for some tenders and contracts. Concerns were also raised over the inadequate pre-procurement planning that at times contributed to non-payment of suppliers. Clear procurement documentation, including objectives, scope, deliverables, timing, progress, and payment reporting must be established. All these are risks elements which will affect the performance of the supply chain function within the organization and therefore the need for a risk management strategy.

2.2.4 Devolved Organizational Leadership and the Performance of the Health Sector

In China, the government's capacity to shape the sector is further undermined by the role of the Communist Party. Hospital managers are often prominent party officials, or are closely connected to those who are prominent, which affords them opportunities to shape government priorities. When the government adopts measures controlling hospitals' behaviour in response to popular angst, the managers' party affiliations help to dilute their content and implementation (Chen 2011). The weakening of government control over providers has influenced the performance of the health sector. Another effect resulted from the gradual demise of health insurance during the 1980s. While previous health insurance programmes were a mechanism for mobilizing

resources from the population rather than modern insurance pools with active purchasing functions, they did provide some supervision and control over providers. Once they had disappeared amidst transition to market economy, virtually no mechanisms remained to monitor providers and hold them accountable, (Tam 2008, 2010).

District/ Level four hospitals in low-income African settings often have between 60 and 300 inpatient beds and similar numbers of total staff, (KPMG, 2013). These numbers, although small by developed-country hospital standards, are typically organized as multiple service delivery units. These reflect the nature of care (outpatient and inpatient) and service type (for example, adult surgical or paediatric wards). Traditionally, the focus in low-income settings among those expected to lead such units has been on technical competence, yet it is increasingly recognized that leadership, supervision, information dissemination and communication are major mediators and moderators of the quality and effectiveness of health care.

O'Neil (2008) accords that within the hospital setting, the senior management is made up of a hospital management team that holds administrative power. This comprises persons in charge of administration, nursing, pharmacy and allied health services and is typically led by the medical superintendent. Those in charge of different clinical service units or departments are invariably clinicians and nurses who operate without any specific departmental administrators. Bennett (2012b) allude that they are expected to plan and advocate for resources, although they are unlikely to have direct control over a specific departmental budget. Such individuals also supervise teams of front-line workers, either medical or nursing, and contribute directly to service delivery.

Fulop and Day (2010) allude that the lead clinician may have a higher degree in an appropriate medical specialty or, especially in smaller rural hospitals, may still have a general medical qualification. Specialist doctors in leadership roles may have as few as 5 years' total work experience (including their 3 years training), although some will have many more. General medical practitioners in smaller hospitals may have only 1 year of work experience before taking charge of a department. The nurses leading departments tend to have more work experience although very few at this level have any higher training in a specific clinical specialty (for example paediatric or surgical nursing).

Previous work in Kenyan public hospitals has revealed leadership gaps and poor communication between senior administration and lower cadres as an impediment to achieving better practice, (Birken and Weiner, 2012). Management training for senior health professionals has been recognized as a priority and is now being provided. Clinical leaders in both settings often have a significant professional identity with considerable autonomy within their work and organizational setting. Such autonomy increasingly results in calls for greater accountability, with leaders having to accept greater levels of responsibility for management. Prompting clinicians to accept management roles is the fear of losing authority and of being treated as simply technicians. Arguably, this results in the emergence of the hybrid clinical manager across many settings. This is likely to be particularly true as Kenya undergoes both major administrative changes resulting from greater devolution (Atieno, 2014) and because, like other low-income settings, major changes are needed to improve service delivery now and to promote continuous organizational learning and improvement. To

achieve this, better support for health professionals who are also leaders is required in addition to that focusing on the role played by senior managers in Kenya. Such training should emphasize the development of personal attributes that facilitate this role and may increase job satisfaction and performance

2.2.5 Devolved Resources and the Performance of the Health Sector

A study by (Muula, 2007) showed that shortages of essential drugs including vital anti-malarials or antibiotics pervade all levels of care as had been documented previously in Malawi, even in the vicinity of the capital. This excludes anti-retroviral drugs, which followed, up until this study, a different and independent mode of procurement and delivery. The reasons for inadequacies in drug procurement, storage and delivery were manifold. They documented deficiencies of finances, physical infrastructure (warehousing), staffing and drug quantification. Kutzin, Cashin and Jakab (2010) assert that possibly a structural challenge to reform is that procurement process embedded in central government structures. This means that it is highly dependent on direct funding from the Ministry of Finance and has a lack of discretion over recruitment of staff (including their qualification) and inadequate means of responsibility to perform duties independent of central government.

Vaillancourt (2009) accords that the devolution of purchasing power to Counties is providing more discretion to districts but this measure will remain unsuccessful until the procurement process has the means to manage drugs adequately at national level, including quantification of need and keeping an adequate buffer stock. Many donors and others have therefore called for procurement process to be changed into a (semi-) independent trust. Discussions regarding the institutional change are under way, but many complain about the long process and express doubt that procurement process can ever become independent of political interference, (Pavignani and Colombo 2009).

Kenya's most recent human resources for health HRH strategic plan (National Human Resources for Health Strategic Plan, 2009 – 2012) was formulated prior to devolution. It therefore logically follows that a revised HRH policy that is aligned to the new form of government should be implemented, this was the participants' first proposal on policy.One of the unintended consequences of the devolution of healthcare workers, as documented in the KPMG Devolution report is that "career structures can suffer, "that is, smaller administrative areas with fewer layers can reduce opportunities for talented people to progress up the career ladder. Support educational institutions, including Health Education Centres, and other entities in their efforts to create or update training, providing targeted continuing education opportunities for existing health professionals to support health care delivery efforts.

Patrick (2013) asserts that the county government needs to shift the emphasis of health care to the people themselves and their needs, reinforcing and strengthening their own capacity to shape their lives. Health care needs to be delivered close to the people; thus, should rely on maximum use of both lay and professional health care practitioners and includes the following eight essential components: education for the identification and prevention , control of prevailing health challenges, proper food supplies and nutrition; adequate supply of safe water and basic sanitation, maternal and child care, including family planning, immunization against the major infectious diseases, prevention and

control of locally endemic diseases, appropriate treatment of common diseases using appropriate technology, promotion of mental, emotional and spiritual health, provision of essential drugs. Harmonization of available resources to ensure that the limited resources available are utilized optimally, (Patrick, 2013). Human resources development is an important part of rebuilding the health sector post-conflict but has received relatively little attention in the literature and may be overlooked by decision-makers and donors (O'Hanlon and Budosan 2011).

2.2.6 Devolved Policy and Regulatory Framework and the Performance of the Health Sector.

Globally, providers increasingly realise that delivering top quality care gives them the competitive edge they need in order to safeguard their growth – or more simply, their existence, (Bolton andHaulihan, 2007). Operational costs have to be brought down, while the safety, effectiveness, patient-centeredness, and timeliness of care have to be improved. Kenyan providers are no different. Indeed, the Joint Commission International (JCI) which provides healthcare accreditation to hospitals globally, and is a mark of quality, has made it to the Kenyan market. As is observed in the Ghanaian devolution process, different role players impact on the (performance of) the local health systems. Since there is no overarching strategy, policies, or regulations, many stakeholders have a limited understanding of government's plans and process objectives in terms of decentralisation, deconcentration and devolution of responsibilities to sub-national levels, (Bennett , 2012).

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, (Noorein and Pam, 2010), such as the introduction of performance management and advocacy for the "empowerment" of managers. Mbua and Ole Sarisar (2013) assert that devolving responsibilities does not only impact on those organisations or regions where responsibilities are devolved to, it also impacts on the organisation – typically a Ministry of Health – that is devolving its authority. Good governance should clearly spell out what (policies) the Ministry of Health would still be responsible for in a devolved health system. Examples of these are quality regulations and education and training of doctors. The role of a Ministry is therefore likely to be one of 'stewardship' and 'guidance' instead of 'own and control' in a devolved system.

Chuma J, Okungu V, Molyneux C., (2010) posit that the Kenya Health Policy 2012 - 2013 is the guiding policy document for the health sector. It outlines the orientations and objectives that are imperative in attaining the government's health goal of "Better Health in a Responsive Manner." In addition to providing the health sector strategy, Kenya Health Policy 2012 – 2030 also provides an implementation framework. Implementation will be through five-year medium-term strategic plans and will employ a multi-sectoral approach at both government levels and involve clients/consumers, non-state actors and state actors – including semi-autonomous government agencies.

2.3. Empirical Review

In May, 2011, the Pan American Health Organization (the regional office for the Americas of WHO) undertook a survey of national AIDS programmes in 12 countries to characterise stock-outs or episodes where there was a risk of stock-out affecting antiretroviral

HIV supplies in Latin America. Results of a Pan American Health Organization survey of stock-out episodes in Latin America. Stock-outs occur when there are insufficient HIV drugs and supplies, resulting in interruption to treatment programmes. Risk-of-stock-out episodes happen when emergency measures have to be implemented to avoid supply interruption. From January, 2010, to April, 2011, 67% of countries surveyed reported antiretroviral stock-outs, all reported antiretroviral risk-of-stock-outs, and 50% reported stock-outs of HIV laboratory supplies. Of the 90 stock-out events, the products most severely affected were coformulated zidovudine plus lamivudine (13%), coformulatedabacavir plus lamivudine (9%), abacavir (8%), lamivudine (6%), saquinavir (6%), tenofovir (6%), lopinavir (4%), raltegravir (4%), and fosamprenavir calcium (4%).

Stock-out events occurred most frequently from November, 2010, to February, 2011, and lasted on average for 40 days each. The most common causes were delays in the bidding process (29%) or acquisition (13%), distribution problems (10%), or difficulties with drug production (9%). Response measures that were implemented included emergency purchases (46%), changing providers (15%), or changing regimens (11%). There were 89 episodes when risk-of-stock-out was imminent in the same period. Reasons included delays in delivery from the manufacturer (31%) or in acquisition (26%), forecasting problems (10%), and delays in the bidding process (10%). 51% of episodes needed emergency purchases and in 14% of cases loans were requested from other countries.

A recent survey by Gao (2011) found that insurance coverage has done little to improve access. Disturbingly, the survey found that 30% of NCMS enrolees did not seek health care due to fear of the costs involved. Similarly, Jung and Liu (2011) found that the incidence of catastrophic health expenditures is actually higher for the insured compared to the non-insured, possibly because the latter avoid hospitalization altogether. Kping (2013) study in Thailand reported that devolution of health centres occurred only when there was good governance, demonstrating that it was capable of managing the health centre. It was also a requirement that, at least half of the health centers' staff involved were willing to transfer to LAO employment. LAO became responsible for primary health service delivery through health centres. The planning made it mandatory for day-to-day operational responsibility of the LAO , including financial and human resource management, The Ministry of Health continued to be responsible for technical policy, supervision, training and regulation of health professionals. The involvement of the majority of the staff in decision making made health devolution workable.

Bernard Bashaasha, et al, (2011a) study in Uganda showed that there has been no improvement in health services with many health status indicators either stagnating or worsening. In general, decentralization of education and health services has not resulted in greater participation of the ordinary people and accountability of service providers to the community. Lack of community participation, inadequate financial and human resources, a narrow local tax base, a weak civil society, underscored the need to ameliorate them if devolution was to attain the anticipated results.. The case study from Uganda cautions against the tendency to romanticize devolution as the new-found solution for past and current institutional and socio-economic distortions and argues that devolution itself can make state

institutions more responsive to the needs of the communities, but only if it allows local people to hold public servants accountable and ensures their participation in the development process

Briscombe, Suneeta, and Margaret (2010) study conducted in Kenya on improving resource allocation in Kenya's Public Health Sector established that decentralization has been a stated policy objective for Kenya since 1994; however, the allocation of health sector financial resources remains highly centralized and opaque, relying primarily on previous years' budget allocations rather than on health needs indicators. Equitable or fair resource allocation can only be accomplished by considering variation in needs across geographic and economic groups. The Health Policy Initiative's research revealed that the allocation of health sector funds in Kenya has not accounted for differences in health achievement, access, and provision costs across the regions, provinces, and districts

2.4 Conceptual Framework

Independent variables   Dependent Variable
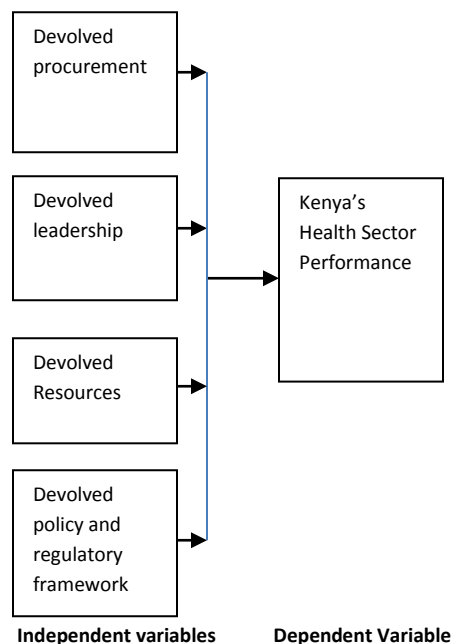
Fig 2.1 Conceptual Framework

The conceptual framework provides the relationship between the study variables. Establishing the performance of the health sector in Kenya is the primary goal of this study. As such it is the dependent variable. The influencing factors include devolved procurement, devolved leadership, devolved resources as well as devolved policy and regulatory framework. These form the independent variables of the study. The significance of their level of influence to the health sectors performance will be measured during the study.

2.5 Critical Review

In all health systems, users are usually the weakest pillar in the governance structure. Individually, they are powerless not only relative to governments but also providers. Collectively, they have some potential to affect the behaviour of both the government and providers, but find it hard to mobilize due to practical limitations of organizing. On the face of it, the government is in an exceptionally strong position to steer the sector because it owns and operates over 90% of hospitals, and hence has the legal authority to demand total compliance with its directives. Yet, the government finds it difficult to affect their behaviour due to the organizational limitations. The health bureaucracy's capacity to demand information and enforce accountability is as weak as the providers' capacity to resist such demands is strong.

Health sector governance and participation at local level are important elements for devolution because the influence held by various stakeholders over decision making process could express priorities as a mean of

holding higher quality care. Ethiopia had a rather impressive structure of citizen participation from the facility to the district level; however their viability was not clear. Also from the case of Uganda devolution can only succeed only if it allows local people to hold public servants accountable and ensures their participation in the development process. What is seen in other countries is that devolution creates opportunities to generate additional income, usually by charging co-payments from patients using facilities. As such, devolution is also used to limit the burden on government's budget spent on healthcare. The downside of this is that it might further constrain access to healthcare for the poorer groups of the population.

2.6 Study Gaps

Although adequate funding is crucial for any health system to be effective, it is not only funding that impact on health outcomes and service delivery. In all of the examples above, having the right governance and accountability structures as well as managerial capacity are believed to have a stronger impact on performance and outcomes than funding does. Further study is crucial to enlighten on the significant factors influencing the performance of the health sector under devolved governance system. It is clear that managerial capacity is a prerequisite for devolution to achieve its goals. It is often assumed that local capacity required managing a local health system and/or health facility is available, but in practice this turns out differently.

It is clear that Kenyan referral hospitals fall under the responsibility of the Ministry of Health. Yet, it is less clear how patient referral mechanisms will impact on this and what (financial) incentives enforce these

mechanisms. For example – is it profitable for hospitals, falling under the counties' responsibility, to treat as many patients as possible or will their budgets put pressure on them to refer patients to national referral hospitals in order to save costs and prevent losses? What mechanisms are put in place to prevent fraud and corruption? Will county offices be subject to annual national audits? Will the national department offer support in terms of setting up professional procurement departments at the county level? Have decisions been made in terms of the above on what thresholds approval from national departments is required? These aspects, if not addressed, pose potential risks to the success of devolution. This study sought to establish the reality of this phenomenon under the devolved system of government.

RESEARCH METHODOLOGY

3.1   Introduction

This chapter describes the methodology that will be used in conducting the study. This includes: The research design; target population, sampling design and procedures; research instruments for data collection; the research process; validity and reliability of the research instruments as well as data processing and analysis techniques.

3.2   Research Design

Silverman (2011) defines the research design as the master plan that will be used in the study in order to answer the research questions. This was a descriptive survey, concerned with finding out the effects of devolved governance on the performance of the health sector. A descriptive study is one in which information is collected without changing the environment (i.e., nothing is manipulated). Sometimes these are referred to as "co relational" or

"observational" studies. Descriptive studies are usually the best methods for collecting information that will demonstrate relationships and describe the world as it exists. These types of studies are often done before an experiment to know what specific things to manipulate and include in an experiment. Silverman (2011) suggests that descriptive studies can answer questions such as "what is" or "what was." Experiments can typically answer "why" or "how", According to Sekaran and Bougie (2010) survey is a method that studies large population (universe) by selecting and studying the samples from the population to discover the relative incidence, distribution and interrelations of sociological and psychological variables. The survey was applied to gather information from respondents from different geographical locations. The respondents provided their own views and observations of the devolved systems in their local hospitals, a factor that enriched the study.

3.3   Target Population

The study was undertaken on level four hospitals in Nairobi County and Mombasa County. The study engaged key informants in the study areas, composing of patients before and after the implementation of devolution, accessed through the hospital registry. The target accessible was patients attending clinics for the last five years (2010-2014). These patients had experience on the services provided by the hospital before and after devolution. Further, health providers were targeted. As such 572 were targeted, (composing of 372 patients and 200 staff) for this study and distributed as stipulated below.

Table 3.1 Target Population

County	Population	
	Patients	Staff
Mombasa	84	87

Nairobi	288	113
Total	**372**	**200**

3.4   Sampling Procedures and Sample Size

Stratified sampling was used in the research. It is a method of sampling that involves the division of a population into smaller groups known as strata. In stratified random sampling, the strata are formed based on members' shared attributes or characteristics. A random sample from each stratum is taken in a number proportional to the stratum's size when compared to the population. These subsets of the strata are then pooled to form a random sample, **(**Silverman, 2011). The study used a 10 percent sampling frame from each stratum in the population. Hence, from a total of 572 Target populations, a sample of 57 respondents was taken, composing 37 patients and 20 hospital attendants.

Table 3.2 Sampling Size

County	Population		Sample Size	
	Patients	Staff	Patients	Staff
Mombasa	84	87	8	9
Nairobi	288	113	29	11
Total	**372**	**200**	**37**	**20**

3.5   Data Collection Methods

The instruments for primary data collection were questionnaires which were administered by the researcher with help from local field enumerators to enable coverage of the sampled respondents. The secondary data was obtained through reading previous health sector annual performance reports, journals and relevant books. A community profile questionnaire was administered to a key informant (typically the patient) in the community, to collect information about features relevant to the use and experience of health facilities, such as the distance from government and other health

care facilities. Key informant questionnaires also sought to establish the implementation of devolution in the County.

The questionnaires were simply structured for ease of administration and also to obtain the necessary information for the study with ease. The researcher sought authority from the relevant regulatory in order to be in tandem with ethical considerations of research. A general section, administered to the respondents, covered socio-economic status, demographics, and views about key public services. Further sections covered views and experience about several public services. The section on health services asked about access to this service, and about self-reported knowledge of how to complain about the service (without asking what the method of complaining was). It further asked about the experience of the service on the last occasion when it was used by the patient or by any family member, where possible getting this information directly from the family member concerned (or the carer in the case of a child): presence of a doctor; explanation about the condition; availability of medicines in the facility; and satisfaction with the service received.

3.6 Pilot Study

Before using the questionnaires for generating data for the study, a pilot study was conducted in selected patients in Kiambu County. The purpose of pre-testing the research instrument was to verify whether the questionnaire were clear to the respondents, establish whether the questionnaire would effectively address the data needed for the study, assess and identify any problems respondents would encounter in completing the questionnaire that may not have been foreseen when constructing the questionnaire. This was used to test the correctness of the data collection tools.

3.6.1 Reliability

According to Sekaran and Bougie (2010), reliability is a measure of the degree to which are search instrument yields consistent results or data after repeated trials. An instrument is reliable when it can measure a variable accurately and consistently, and obtain the same results under the same conditions over time. Cronbach's Alpha method was used: it is mathematically equivalent to the average of all possible split-half estimates. In this case, the researcher will calculate all split-half estimates from the same sample. Because it measured the entire sample on each of the items, all to be done was to have the computer analysis do the random subsets of items and compute the resulting correlations.

3.6.2 Validity

Validity on the other hand refers to the degree to which results obtained from the analysis of the data actually represent the phenomenon under study, (Franklin, 2012). It is the degree to which a research tool measures what it purports to be measuring. This is to help the researcher in identifying items in the research instrument that may not elicit the relevant information. Modification of such items was made to ensure the research tools elicit the anticipated data. Formative Validity was applied. When applied to outcomes assessment it is used to assess how well a measure is able to provide information to help improve the program under study.

3.7 Data Processing and Analysis

Data collected was quantitative. Franklin (2012) defines data analysis as the process of systematically searching and arranging

completed research instruments after field work, with the aim of increasing understanding and hence enabling one to present them to others. Statistical data analysis was used to organize, summarize and present the data in a way that it could be meaningful and communicated. The coding involved arranging the data to show occurrence of the different responses to the matrix questions. Tallies were calculated against each question and their frequencies recorded. The frequencies and percentages were presented in terms of graphs and tables, in the course of discussing the findings. Secondary data was analysed through the assessment of significant change in performances annually. The Quantitative data was analyzed using descriptive statistics i.e. frequencies, percentages, mean and standard deviation. It is from this that there searcher will be able to draw inferences, conclusions and recommendations.

DATA ANALYSIS AND PRESENTATION

4.1 Introduction

This chapter presents the analysis of the findings of the study. The data is presented in the form of graphs, tables and charts.

4.2 Data Analysis

4.2.1 Response Rate

The response rate was commendable since fifty five out of the fifty seven questionnaires administered were returned fully answered. Two patients did not return the instruments. This showed a response rate of 96%, and thus making the data reliable for inference.

Table 4.1 Response Rate

| County	Population	
	Frequency	Percentage
Returned	55	96
Unreturned	2	4
Total	**57**	**100**

4.2.2 Gender distribution of respondents

The gender distribution of the respondents was 51% female and 49% male. As such there was an equitable distribution of the respondents and this reduced the effects of biased responses based on gender, an important ethical consideration in social sciences.
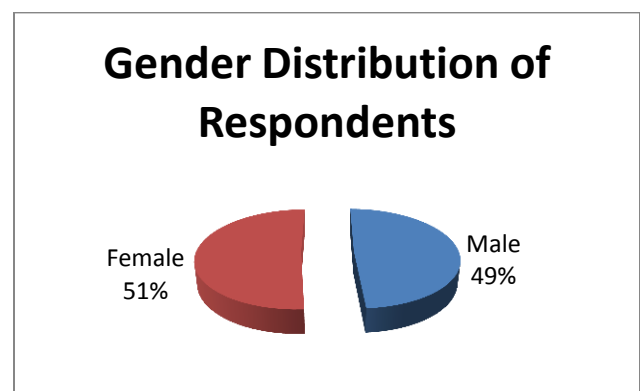
Figure 4.1 Gender Distribution of Respondents

### 4.2.3 Age Distribution of Respondents

The age of the respondents was distributed as 41-50 years 36.3%, 31-40 years 32.7%, 18-30 years 20%, 51-60 years 9% and above 60 years 2%. Thus respondents were mainly young adults who could objectively contribute to the study.

Respondents' Age Distribution
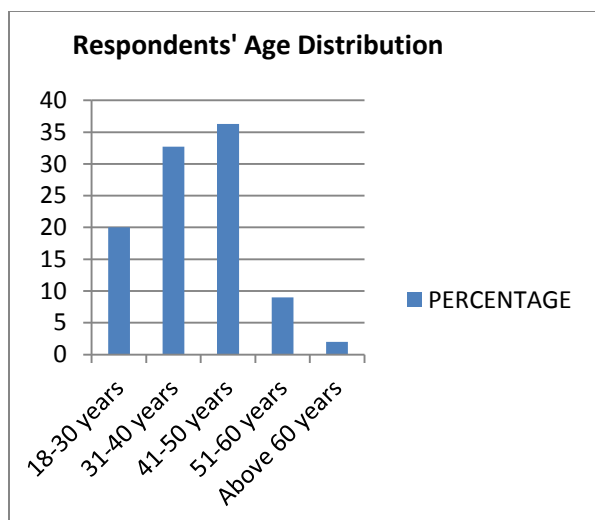
Figure 4.2 Age distribution of the respondents

### 4.2.4 Respondents level of education

The education levels of the respondents were cited to be tertiary by 43.6% of the respondents, university and KCSE by 25.5 % respectively and post graduate by 5.4% of the respondents. This should commendable academic standing that enabled the respondents to comprehend and provide reliable information for the study.

Respondents' level of Education
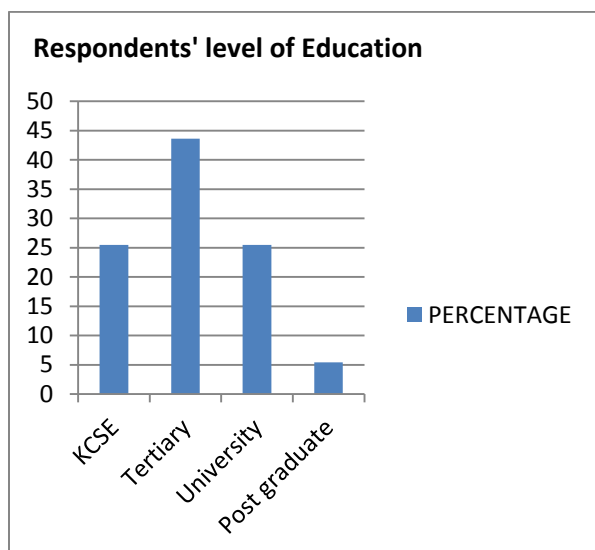
Figure 4.3 Respondents level of education

4.2.5 Experience in the health sector

The experience in the health sector was sought from the hospital attendants. Accordingly, 50% had 10-15 years' experience, 25% 5-10 years' experience, 10% below 5 years and 15-20 years respectively and 5% over 20 years. Thus the respondents from the hospital had experience in the health sector and could thus provide credible information befitting the study.

Experience in the Health Sector
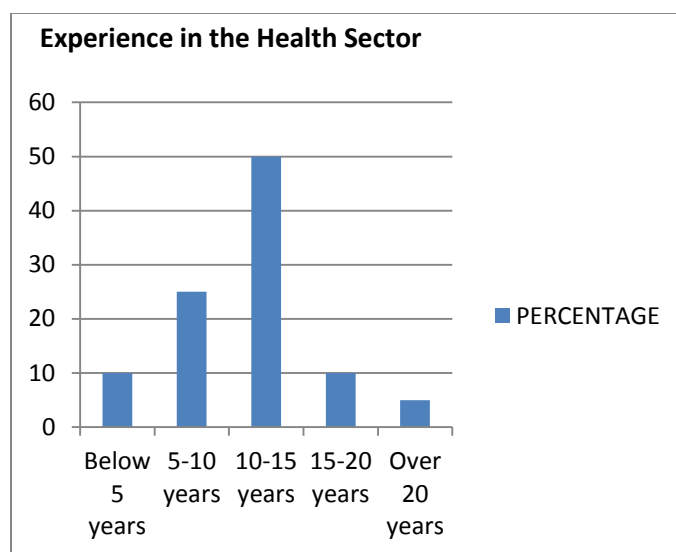
Figure 4.4 Experience in the health sector

4.2.6 Rating of the performance of the level four hospitals in respondent's area

The rating of the performance of the level four hospitals in respondents' area was average by 61.8%, low by 27.2%, high by 9% and very low by 2%. As such, the level four hospitals did not have high performance, a factor influencing the performance level of the overall health sector in Kenya.

Level Four Hospitals Performance Rating
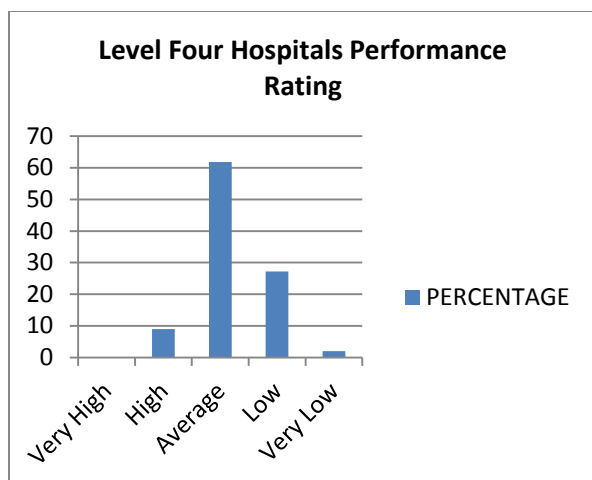
Figure 4.5 Rating of the performance of the level four hospitals in respondent's area

4.2.7 Rating of the respondent's satisfaction level of quality services delivered in the level four hospitals

The satisfaction level of the respondents on the quality of service delivery in the level four hospitals was rated average by 56.4% of the respondents, low by 36.4% and very low by 7.2% of the respondents. Thus, the hospitals were not providing services to meet the needs of the patients, a factor influencing low performance rating by the public.

Rating of Satisfaction of Quality of Services at Hospitals
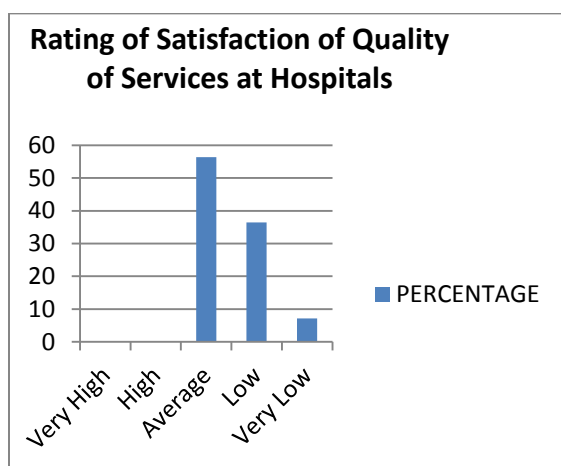
Figure 4.6 Rating of the respondent's satisfaction level of quality services delivered in the level four hospitals

4.2.8. Whether Health services have improved since the implementation of devolved governance

The study sought to establish whether health services had improved since the implementation of devolved governance. Accordingly, 73% of the respondents disagreed, 9% strongly disagreeing while 13% agreed and 5% strongly agreed. As such, there has not been a significant improvement of the health services after devolution.
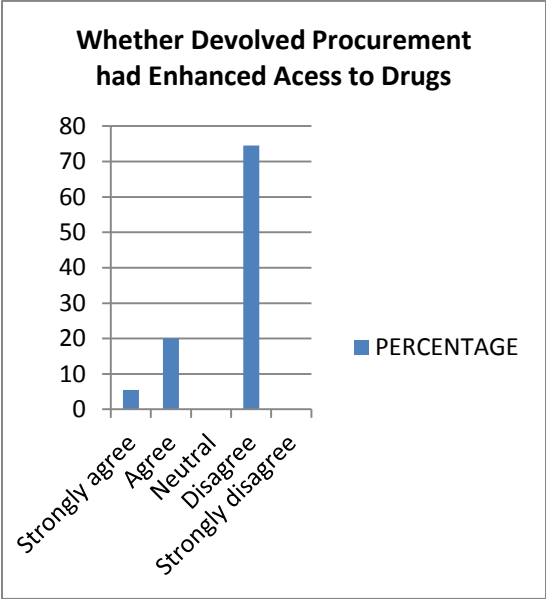
Whether Health services had improved after devolution
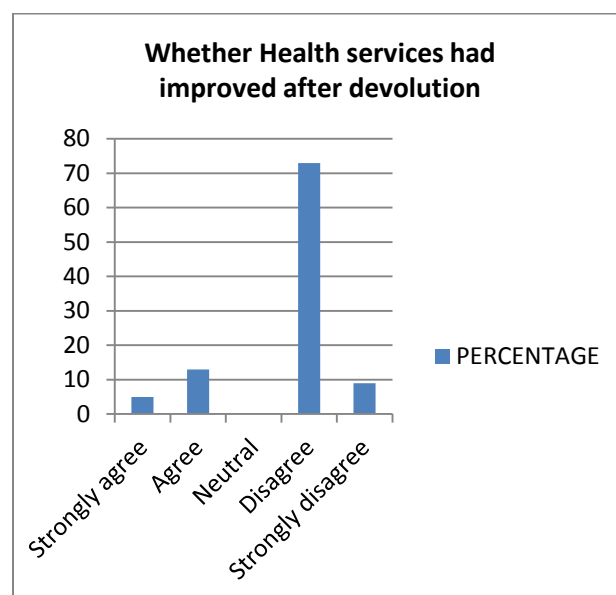
Figure 4.7 Whether Health services have improved since the implementation of devolved governance

SECTION B: DEVOLVED PROCUREMENT AND HEALTH SECTOR PERFORMANCE

4.2.9 Whether devolution of the procurement process has enhanced access to drugs, equipment and facilities at the level four hospitals
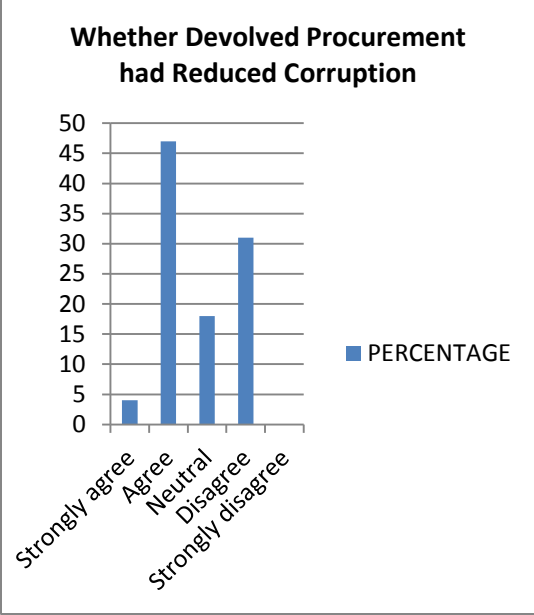
As to whether devolution of the procurement process has enhanced access to drugs, equipment and facilities at the level four hospitals, 74.5% of the respondents disagreed, 20% agreed and 5.5 % strongly agreed. Thus access to drugs had not improved after implementation of devolved procurement.

Whether Devolved Procurement had Reduced Corruption

Whether Devolved Procurement had Enhanced Acess to Drugs

Figure 4.9 Whether devolved procurement process has reduced the instances of corruption at the level four hospitals

Figure 4.8 Whether devolution of the procurement process has enhanced access to drugs, equipment and facilities at the level four hospitals

4.2.10 Whether devolved procurement process has reduced the instances of corruption at the level four hospitals

In response to whether devolved procurement process has reduced the instances of corruption at the level four hospitals, 47% of the respondents agreed, 31% disagreed, 18% were neutral while 4% strongly agreed. As such there was some significant improvement in curbing corruption in the procurement process, through devolution at the level four hospitals.
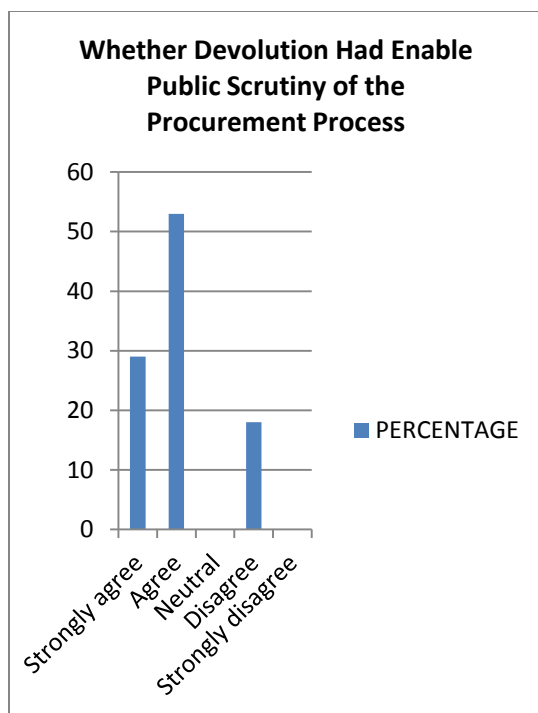
4.2.11 Whether devolution has enabled public scrutiny of the procurement process at the level four hospitals

Response as to whether devolution has enabled public scrutiny of the procurement process at the level four hospitals was provided. Accordingly, 53% agreed, 29% strongly agreed while 18% of the respondents disagreed. This showed that devolution has empowered the community to monitor the procurement process at the level four hospitals, a factor enhancing the health sector performance.

Whether Devolution Had Enable Public Scrutiny of the Procurement Process

Figure 4.10 Whether devolution has enabled public scrutiny of the procurement process at the level four hospitals

SECTION C: DEVOLVED LEADERSHIP AND THE PERFORMANCE OF THE HEALTH SECTOR.

4.2.12 Extent to which the new management under devolution has enabled quicker decision making by the level four hospital leaders

The extent to which the new management under devolution has enabled quicker decision making by the level four hospital leaders was cited to be much by 56% of the respondents, very much by 35% and moderate by 9%. Thus, quicker decision making has been enabled through devolution, an important factor for strategic change at the hospitals.

Devolution and Quicker Decision Making at the Hospitals
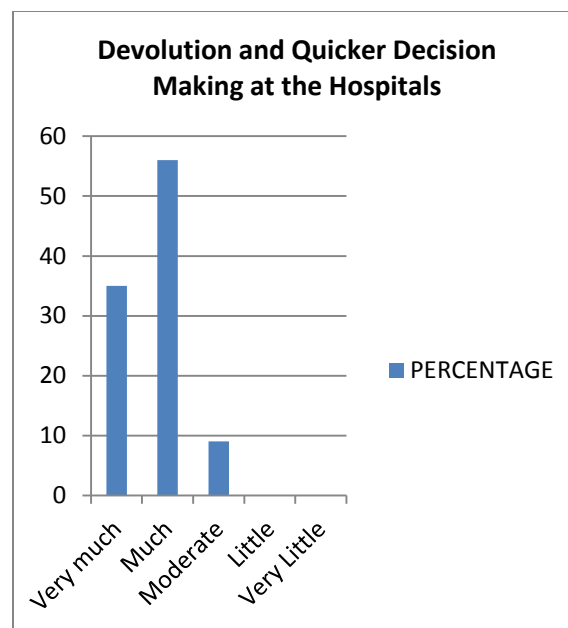
Figure 4.11 Extent to which the new management under devolution has enabled quicker decision making by the level four hospital leaders

4.2.13 Rating of the influence of devolved leadership on hospital development planning

The influence of devolved leadership on hospital development planning was rated as very high by 73% and high by 27% of the respondents. As such, devolved leadership had a significant and positive influence on hospital development planning.

Devolved Leadership Influence on Hospital Development Planning
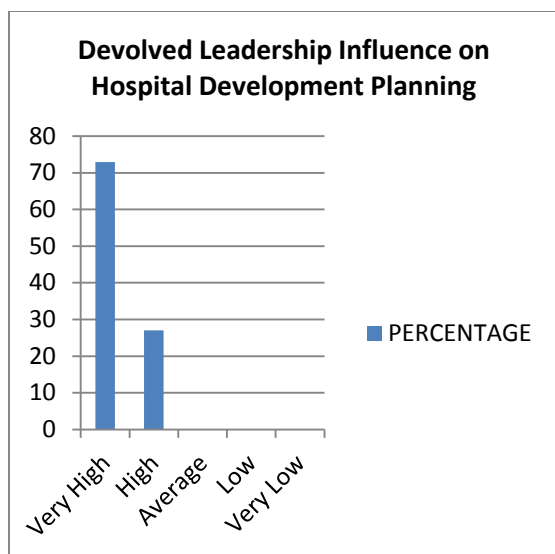
Figure 4.12 Rating of the influence of devolved leadership on hospital development planning

4.2.14 Rating of the public accessibility to leadership under devolution in the level four hospitals

Public accessibility to leadership under devolution was cited to be very high by 55%, high by 29% and average by 16%. Thus devolution has significantly enhanced public accessibility to the level four hospital leaders, a factor that enhances communication and improvement of services for better performance.


Rating of Public Accessibility to Hospital Leaders under Devolution
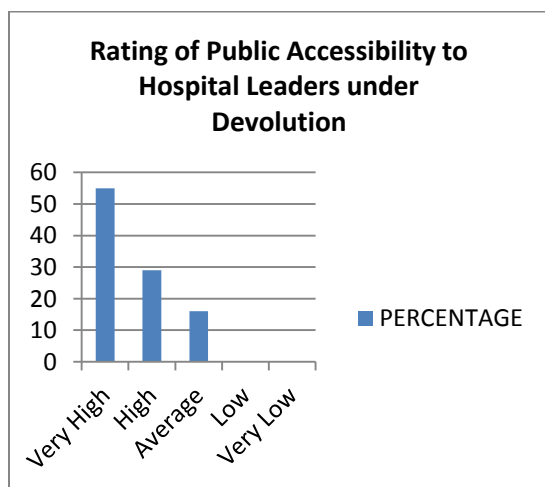
Figure 4.13 Rating of the public accessibility to leadership under devolution in the level four hospitals

SECTION D: DEVOLVED RESOURCES AND THE PERFORMANCE OF THE HEALTH SECTOR

4.2.15 Rating of the access to medical drugs and facilities at the level four hospitals in respondent's area

Access to medical drugs and facilities at the level four hospitals was cited as insufficient by 51% of the respondents, fairly sufficient by 29%, sufficient by 13% and highly insufficient by 7% of the respondents. As such, there was generally low access to drugs and facilities at the hospitals, a factor depicting low performance levels in the health sector.

Rating of Access to Drugs and Facilities at the LevelFour Hospitals
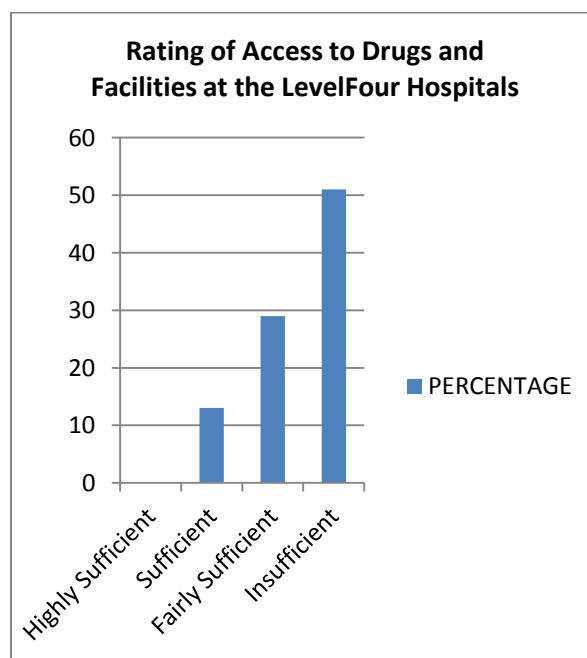
Figure 4.14 Rating of the access to medical drugs and facilities at the level four hospitals in respondent's area

4.2.16 Whether devolved governance enabled the satisfaction of the human resource at the level four hospitals

In response as to whether devolved governance enabled human resource satisfaction at the level four hospitals, 96% of the respondents were of the contrary opinion, while 2% affirmed. Thus devolution has not enhanced the satisfaction levels of the human resource, a factor influencing their output and the overall performance of the health sector.
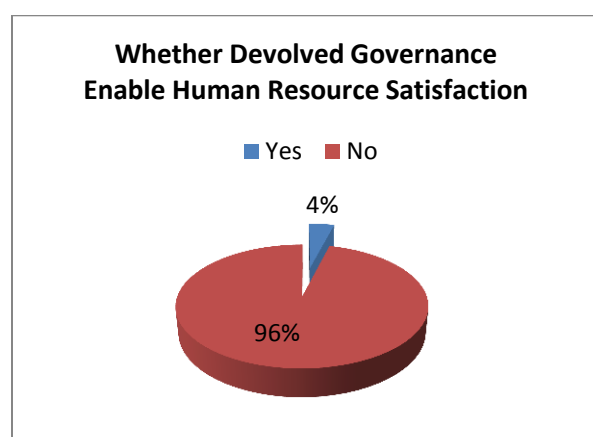
Figure 4.15 Whether devolved governance enabled the satisfaction of the human resource at the level four hospitals

4.2.17 Rating of the influence of devolved resources on rehabilitation and improvement of the level four hospitals

The influence of devolved resources on rehabilitation and improvement of the level four hospitals was rated as high by 40% of the respondents, average by 38% very high by 13% and low by 9%. As such, devolved resources had a significant influence on infrastructure development at the hospital which facilitated better service delivery and performance of the hospitals.
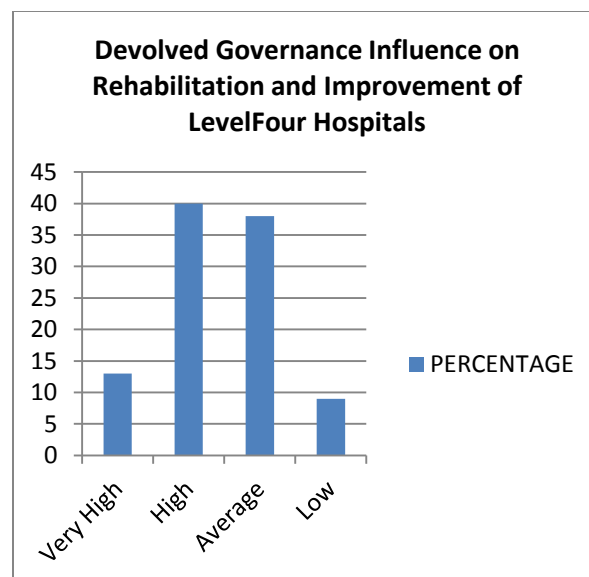
Figure 4.16 Rating of the influence of devolved resources on rehabilitation and improvement of the level four hospitals

## 4.2.18 Rating of the performance level of staff in the level four hospitals today

The performance level of the staff at the level four hospitals was rated low by 55% of the respondents, average by 22% and high by 14%. This showed generally low performance levels and this has a poor influence on the performance of the health sector.

Rating of the Hospital Staff Performance
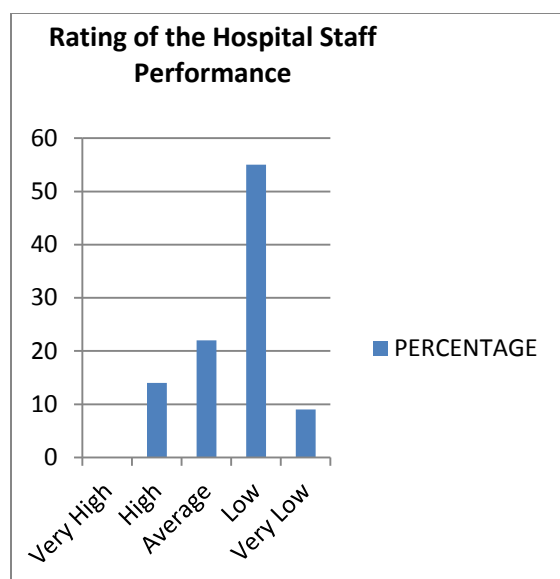
Figure 4.17 Rating of the performance level of staff in the level four hospitals today

4.2.19 Whether the devolution of resources enabled effective allocation of adequate facilities at the hospitals

According to 67% of the respondents, the devolution of resources enabled effective allocation of adequate facilities at the hospitals. However, 33% cited that it did not, and as such devolution had some influence on resources allocation at the level four hospitals.

Whether Devolution of Resources enhanced Allocation of Adequate Resources
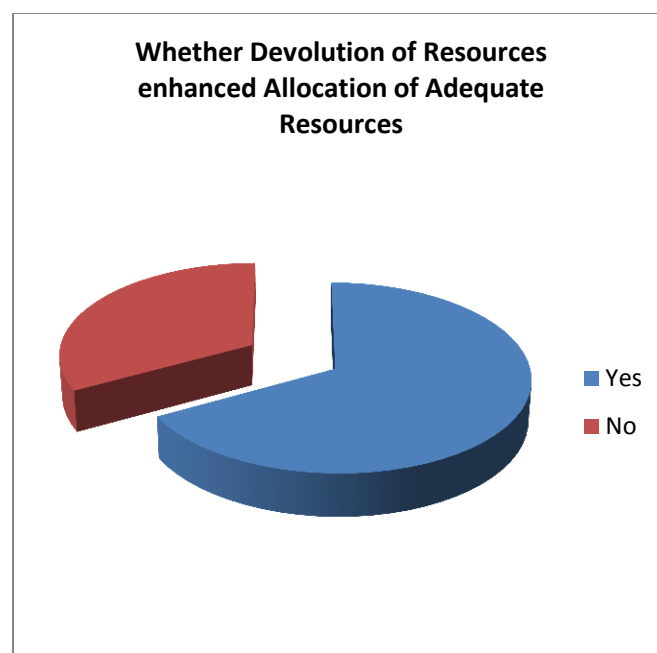
Figure 4.18 Whether the devolution of resources enabled effective allocation of adequate facilities at the hospitals

4.2.20 Extent to which capacity building of hospital managers will influence the health sector performance

Capacity building of hospital managers' influence on the health sector performance was cited to be very high by 76% of the respondents and high by 24%. As such capacity building for the managers of the hospitals was recognized as crucial for hospital and overall health sector performance.

Capacity Building for Hospital Managers Influence on Health Sector Performance
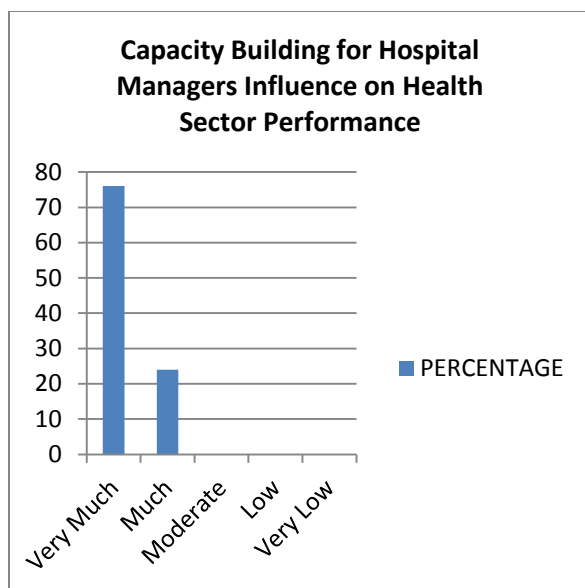
Figure 4.19 Extent to which capacity building of hospital managers will influence the health sector performance

SECTION E: DEVOLVED POLICY AND REGULATORY FRAMEWORK

4.2.21 Rating of the National Health Policies in enabling patients' satisfaction on services delivered at the hospital

The capacity of the National health policies in enabling patients' satisfaction at the level four hospitals was rated high by 36% of the respondents, average by 26% and very high by 20%. Thus the health policies and regulations were well formulated to enable effective and efficient service delivery to the satisfaction of patients at the level four hospitals.

National Health Policies Capacity to Enable Patients Satisfaction
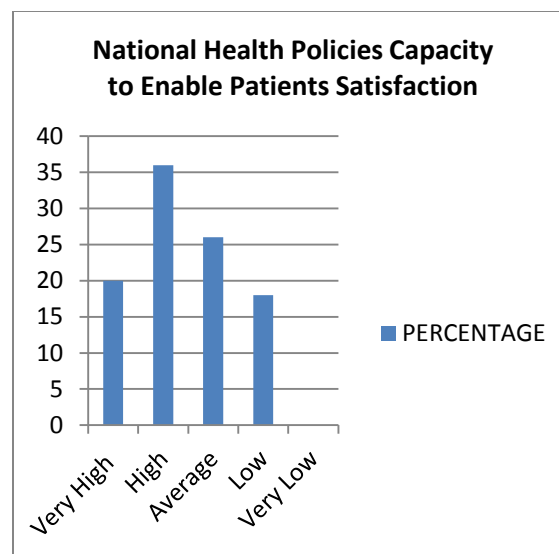
Figure 4.20 Rating of the National Health Policies in enabling patients' satisfaction on services delivered at the hospital

4.2.22 Whether there any strategic measures undertaken by the level for hospitals to effectively implement the health sector policies

According to 55% of the respondents, there were no strategic measures undertaken by the level four hospitals to effectively implement the health sector policies. However, 45% said that they were there, and this showed low strategic planning by the hospital administration to ensure sector policies are followed for better performance.

Whether the Hospitals had Strategic Measures for Sector Policies Implementation

- Yes
- No
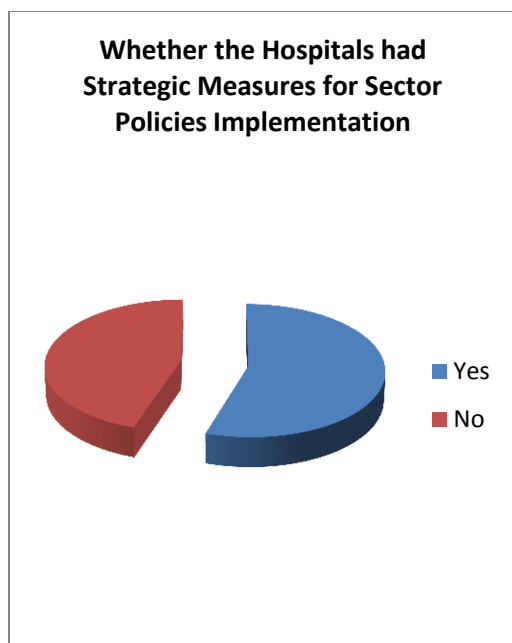
Figure 4.21 Whether there any strategic measures undertaken by the level for hospitals to effectively implement the health sector policies

4.2.23 Whether respondents had ever been involved during the formulation of policies and regulations in the level four hospitals

As to whether respondents had ever been involved during the formulation of policies and regulations in the level four hospitals, 80% cited that they had not while 20% had, showing low inclusivity during the policy formulation process. This influences the strategic planning to the needs of patients at the hospitals.

Whether Respondents had been Involved During Policy Formulation

- Yes
- No
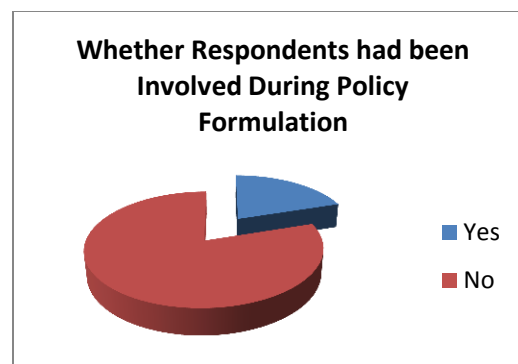
Figure4.22 whether respondents had ever been involved during the formulation of policies and regulations in the level four hospitals

4.2.24 Extent to which public participation will enhance the performance of the level four hospitals

The extent to which public participation would enhance the performance of the level four hospitals was cited to be high by 55%, very high by 40% and average by 5% of the respondents. Thus, public participation was viewed to be crucial for level four hospital performance as irt enabled ownership of strategic plans and feedback from community on needs assessment for better performance.

Public Participation Influence on Hospital Performance.
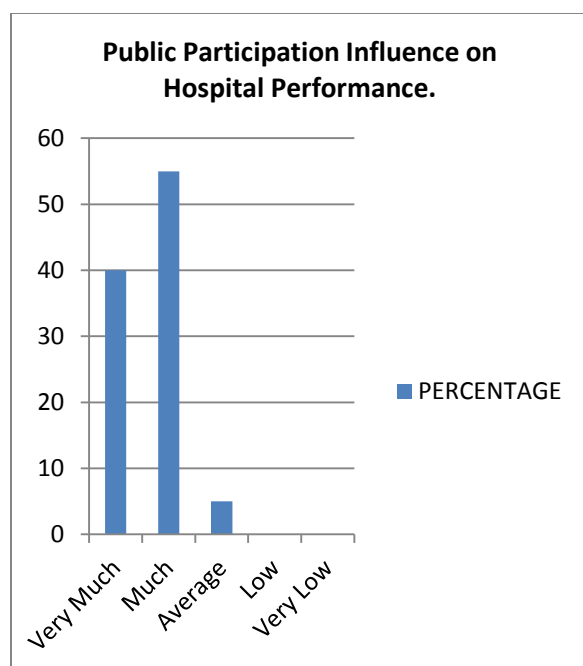
Figure 4.22 Extent to which public participation will enhance the performance of the level four hospitals

SECTION F: SECONDARY DATA ANALYSIS

The contribution of the health industry to the overall GDP is shown below.

Contribution of health to GDP (Kshs)

	2010	2011	2012	2013
OVERALL GDP at market prices	2,570,334	3,047,392	3,403,534	3,797,988
Total Health industry	64,738	74,237	81,850	72,914
Private actors contribution	34,920	38,805	42,153	45,112
Government contribution	29,818	35,432	39,697	27,803

Source: Economic Survey 2014

The contribution of the health industry to the overall GDP has remained low, and showed a reduction to 1.9% from 2.4%. The trends in the annual production accounts for health in the country also show a reduction in the health output (expenditure), with the per capita health spending suggestive of a reduction from KES 3,046 (US$ 35.84) to KES 2,722 (US$ 32). The Service Availability and Readiness Assessment Mapping (SARAM) exercise provided the health sector with a comprehensive baseline regarding availability of services, and investments at the beginning of the reporting period. Further, Looking at the health workforce, useable information is difficult to come by, particularly as a result of the transition of the health workforce management to counties during the period. However, it can be inferred that the disruptions in personnel emoluments for health workers noted during the year reduced their productivity.

The effects on health services arising from reduced productivity would be most marked in the counties that witnessed severe disruptions in services and less so in those counties that managed to maintain personnel emoluments for their staff. Additionally, this effect should be blunted by the –as of now anecdotal evidence of –increased availability of lower level cadres recruited by counties to make functional their lower level facilities. It is however imperative that both levels of government must put in order mechanisms of monitoring and reporting on the health workforce delivering health services both at the county and at the National level.

Finally looking at leadership and governance, we see the general trend in most of the counties being that of calling for quick results in health outcomes. To facilitate these, the health management teams in counties were largely left intact, with changes primarily at the political and administrative levels where CECs and Chief

Officers were appointed. These provide the required political and administrative oversight of health activities as required in the constitution. As a result, it has been seen at least two trends in management structures emerging in the counties depending on how the technical health functions are managed

1. A single, versus multiple Directors (public health, clinical / medical)
2. A single large county management team, versus a small county management team complemented by multiple sub county teams

It is expected that improvements in access, quality of care, and demand for services resulting from the various investments made in the sector. From this perspective, it is noted the sector primarily focused on improvements in access to services as opposed to quality of care, or demand for services. Such access improvements are most noted with physical access (more reported facilities / staff / commodities) and financial access (free maternity services, and free primary care services), though there is no clear evidence of improved socio-cultural access. The effects of this are quite varied across counties. Quality of care initiatives are mostly still at the drawing board, with very limited roll out across implementing units effected. The community based, and advocacy efforts to improve demand and use of available services were being scaled up in selected counties –with no clear evidence these were having significant impact by the end of the reporting period

SUMMARY OF FINDINGS, DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the summary of the findings from data collected during the study. Further, it entails the discussions on the findings, conclusions and implications for policy and recommendations for further research.

5.2 Summary of Findings

The performance of the level four hospitals in respondents' area was rated average by 61.8%, low by 27.2%, high by 9% and very low by 2%, while **the satisfaction level** of the respondents on **the quality of service delivery** in the level four hospitals was rated average by 56.4% of the respondents, low by 36.4% and very low by 7.2% of the respondents. As such, **the level four hospitals did not have high performance**. The study also sought to establish **whether health services had improved since the implementation of devolved governance**. Accordingly, 73% of the respondents disagreed, 9% strongly disagreeing while 13% agreed and 5% strongly agreed. As to **whether devolution of the procurement process has enhanced access to drugs**, **equipment and facilities** at the level four hospitals, 74.5% of the respondents disagreed, 20% agreed and 5.5 % strongly agreed.

In response to whether **devolved procurement process has reduced the instances of corruption** at the level four hospitals, 47% of the respondents agreed, 31% disagreed, 18% were neutral while 4% strongly agreed. Response as to **whether devolution has enabled public scrutiny of the procurement process** at the level four hospitals was provided. Accordingly, 53% agreed, 29% strongly agreed while 18% of the respondents disagreed.

The extent to which the new management under devolution has enabled quicker decision making by the level four hospital leaders was cited to be much by 56% of the respondents, very much by 35% and moderate by 9%. **Thus, quicker decision making has been enabled through devolution**, **an important factor for strategic change at the hospitals**. The influence of devolved leadership on hospital development planning was rated as very high by 73% and high by 27% of the respondents.

Public accessibility to leadership under devolution was cited to be very high by 55%, high by 29% and average by 16%. Access to medical drugs and facilities at the level four hospitals was cited as insufficient by 51% of the respondents, fairly sufficient by 29%, sufficient by 13% and highly insufficient by 7% of the respondents. In response as to **whether devolved governance enabled human resource satisfaction** at the level four hospitals, 96% of the respondents were of the contrary opinion, while 2% affirmed. **The influence of devolved resources on rehabilitation and improvement** of the level four hospitals was rated as high by 40% of the respondents, average by 38% very high by 13% and low by 9%. **The performance level of the staff** at the level four hospitals was rated low by 55% of the respondents, average by 22% and high by 14%. According to 67% of the respondents, **the devolution of resources enabled effective allocation of adequate facilities** at the hospitals. However, 33% cited that it did not agree. Capacity building of hospital managers' influence on the health sector performance was cited to be very high by 76% of the respondents and high by 24%.

The capacity of the National health policies in enabling patients' satisfaction at the level four hospitals was rated high by 36% of the

respondents, average by 26% and very high by 20%. **According to 55% of the respondents, there were no strategic measures undertaken by the level four hospitals to effectively implement the health sector policies.** However, 45% said that they were there. As to **whether respondents had ever been involved during the formulation of policies and regulations in the level four hospitals,** 80% cited that they had not while 20% had, showing low inclusivity during the policy formulation process. **The extent to which public participation would enhance the performance** of the level four hospitals was cited to be high by 55%, very high by 40% and average by 5% of the respondents.

The health sector performance report 2014 documents that the contribution of the health industry to the overall GDP has remained low, and showed a reduction to 1.9% from 2.4%. The trends in the annual production accounts for health in the country also show a reduction in the health output (expenditure), with the per capita health spending suggestive of a reduction from KES 3,046 (US$ 35.84) to KES 2,722 (US$ 32). Useable information was difficult to come by, particularly as a result of the transition of the health workforce management to counties during the period. However, it could be inferred that the disruptions in personnel emoluments for health workers noted during the year reduced their productivity. Looking at leadership and governance, the general trend in most of the counties was that of calling for quick results in health outcomes. To facilitate these, the health management teams in counties were largely left intact, with changes primarily at the political and administrative levels where CECs and Chief Officers were appointed. The report noted that the sector primarily focused on improvements in access to services as opposed to quality of care, or

demand for services. Quality of care initiatives are mostly still at the drawing board, with very limited roll out across implementing units effected Finally, the community based, and advocacy efforts to improve demand and use of available services were being scaled up in selected counties –with no clear evidence these were having significant impact by the end of the reporting period.

5.3 Discussions

Kenya Health Policy 2012 – 2030 provides guidance for the achievement of the highest standard of health. It aims to achieve this by "supporting provision of equitable, affordable and quality health and related services at the highest attainable standards to all Kenyans" by focusing on primary care. The performance of the level four hospitals in respondents' area was rated average by 61.8%, low by 27.2%, high by 9% and very low by 2%. This has an influence on the overall health sector performance. Actually the health sector performance report documents that the contribution of the health industry to the overall GDP has remained low, and showed a reduction to 1.9% from 2.4%. This performance influences the satisfaction levels of the patients and in this study, the satisfaction level of the respondents on the quality of service delivery in the level four hospitals was rated average by 56.4% of the respondents, low by 36.4% and very low by 7.2% of the respondents. Bashaasha (2011) posited the concept of public value has been advanced as a way of thinking about and evaluating the goals and performance of public policy and as providing a yardstick for assessing activities produced or supported by government. 'Public value provides a broader measure than is conventionally used within the new public management literature, covering outcomes, the means used to deliver them as well as trust and legitimacy. This thus needs to be entrench in the health sector policies in all the 47 counties.

The study also sought to establish whether health services had improved since the implementation of devolved governance and accordingly, 73% of the respondents disagreed. Devolution was expected to enhance health sector performance in all health care facilities. As suggested by Sihanya (2013), the success of devolution of health care will require strategic approach in order to realize the benefit of new governance dispensation. The study also found that devolved procurement process has reduced the instances of corruption at the level four hospitals since 51% of the respondents agreed to this. Sihanya (2013) posits that devolution can make the actions of local officials more transparent and provide a check on corruption, appointments based on family ties or other connections and other poor practices. Actually, devolution has enabled public scrutiny of the procurement process at the level four hospitals as agreed by 82% of the respondents, a factor that reduces corruption and resources mismanagement.

Access to medical drugs and facilities at the level four hospitals was cited as insufficient by 51% of the respondents, fairly sufficient by 29%, and as such patients were not satisfied at the hospitals. A tenet of the Constitution of Kenya, 2010 (COK, 2010), is the right to healthcare for every individual. To this end, the government is working towards achieving universal health coverage (UHC) for its citizens. As the government implements approaches to increase demand, it will be imperative to ensure that the supply side is able to adequately respond. According to the Kenya Medical

Supplies Agency (KEMSA) procurement Review Report (2008) there was no comprehensive consolidated annual procurement plan prepared by procurement unit for some tenders and contracts. Concerns were also raised over the inadequate pre-procurement planning that at times contributed to non-payment of suppliers. This influenced access to drugs at the hospitals.

In response as to whether devolved governance enabled human resource satisfaction at the level four hospitals, 96% of the respondents were of the contrary opinion. This finding concurs with those of Mwatsuma, Mwamuye, and Nyamu (2014) that health staff unrest had been witnessed since the advent of county governance; affecting service delivery thus posing health risks to thousands of county residents and scaring away potential investors. Both the national and county government together with the various development stakeholders have paid little attention to such a situation despite the fact that if it remains unchecked could jeopardize service delivery. However, public accessibility to leadership under devolution was cited to be y high by 84% of the respondents, a factor that enhances communication and feedback on health facilities issues. Health policy issues influenced the performance of the health sector. Their implementation process influenced successful service delivery and health care for all.

5.4 Conclusions

The health sector is crucial for nations. It reduces cases of diseases and deaths among the citizens, and provides affordable health care for all. Devolution process has not been fully implemented and its effect has not been fully experienced in the health sector. The sector performance was averagely rated in the study

and its contribution to GDP reduced by 0.5 percent by the end of the year 2013. The sector appears to have no significant increases in investments during the period under review. It was however characterized by accelerated implementation of the constitution, particularly devolution which changed the characteristics of determining and financing sector priorities. There were significant investments made across the different investment areas of the sector, though these were primarily focused in specific, visible areas relating to improving access to services (physical, financial access). There were minimal investments in other required output areas, particularly in quality of care. The devolved procurement process, organizational leadership, resources allocation and availability as well as policy and regulatory framework had a significant influence on the performance of the level four hospitals and the overall health sector. There are major efficiency gaps in the health sector, which if addressed can significantly increase available resources, and improve on the health outcomes for the people in Kenya. Further, Counties are utilizing health resources with levels of efficiency that are staggeringly different.

5.5 Recommendations for the Study

1.The level four hospitals should formulate internal policy and regulatory frameworks and plans for effective implementation. This will enable provision of quality health for all.

2. The Hospital administration should adopt e-procurement that is more efficient and reduces instances of corruption and enhance access to medical drugs and facilities.

3. The County governments should adopt effective remuneration systems that enhance staff motivation and better productivity.

4. The County governments should also avail development resources for the level four hospitals in order to enhance service delivery.

5. Improvement in financing of critical health investment areas, particularly those relating to improving quality of care is needed

6. The sector should focus more keenly on improving efficiency in the utilization of available resources, focusing on the counties with the lowest relative efficiency values

5.6 Recommendations for Further Research

Studies should be undertaken to establish the impact of devolution on the productivity of the staff in the health sector. Further study should be undertaken to establish the effect of privatization of hospitals on quality of service delivered.

REFERENCE

Atieno, P J, Nancy E.,& Spitzer, D., (2014) Kenyan Nurses Involvement in National Policy Development Processes Nursing Research and Practice Volume 2014 (2014), Article ID 236573, 10 pages

Bashaasha,B., Najjingo,M. M.i, & Nkonya, E., (2011). *Decentralization and Rural Service Delivery in Uganda. kampal*a: International Food Policy Research Institute.

Bennett S, Corluka A, Doherty J, Tangcharoensathien V, Patcharanarumol W, Jesani A, Kyabaggu J, Namaganda G, Hussain AMZ, Aikins A-G (2012a) Influencing policy change: the experience of health think tanks in low- and middle-income countries. *Health Policy Plan*, 27(3)**:194-203**

Bennett S, Corluka A, Doherty J, Tangcharoensathien V., (2012b) *Approaches to developing the capacity of health policy analysis institutes: a comparative case study.* Health Res Policy Syst 2012, 10**:7**

Birken S. , Lee S-Y., & Weiner B.,(2012) Uncovering middle managers' role in healthcare innovation implementation. *Implementation Sci*, **7**(1)**:28.**

Bloom, G., (2011) . *Building institutions for an effective health system: lessons from China's experience with rural health reform. Social Science and Medicine*;72:1302-9

Bolton, S C. & Haulihan, M. (2007) *Management, work and organizations*, Searching for the human in HRM, Palgrave Macmillan, New York

Briscombe, B., Suneeta S., and Margaret S., (2010). *Improving Resource Allocation in Kenya's Public Health Sector*. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.

Chen M(2011) . A study on corporate governance of public hospitals in China*. Chinese Journal of Hospital Administration;27:37-44*

Chuma J, Musimbi J, Okungu V, Goodman C, Molyneux C., (2009) Reducing user fees for primary health care in Kenya: Policy on paper or policy in practice? *Int J Equity Health* **8:**15.

Chuma J, Okungu V, Molyneux C., (2010) Barriers to prompt and effective malaria treatment among the poorest population in Kenya. Malar J*,* 9:144

El-Saharty, S., Sosena K., Olango, P. D., &Banafsheh S., (2009). Ethiopia: *Improving Health Service Delivery.* Washington DC 20433: The world bank.

Franklin, M.I. (2012). *Understanding Research*: Coping with the Quantitative-Qualitative Divide London and New York: Routledge.

Fulop L., & Day, G., (2010) From leader to leadership: clinician managers and where to next? *Aust Health Rev*, 34(3)**:**344.

Government of Kenya. (2010). *Kenya Health Situation Analysis, Trends and Distribution, 1994 – 2010 and Projections to 2030.* Ministry of Medical Services and Ministry of Public Health and Sanitation.

Kenya Health Policy, 2012 - 2030

Kpmg. (2013). *Devolution of healthcare services in Kenya*. South Africa: kpmg services. Patrick, I. M. (2013, September 20). University of kwazulu -Natal. Retrieved from University of kwazulu -Natal website:

Kutzin J, Cashin C, Jakab M,(2010) *Implementing health financing reform. Lessons from countries in transition.* World Health Organisation, on behalf of the European Observatory on Health Systems and Policies; 2010.

Marchal B, Cavalli A, & Kegels G(2009) *Global health actors claim to support health system strengthening—is this reality or rhetoric*? PLoS Med **,** 6 **(**4)**:**e1000059

Milward H. B, Provan K. G, Fish A, Isett K. R, Huang K., (2010) Governance *and collaboration: an evolutionary study of two mental health networks.* J Publ Adm Res Theor, 20(Suppl. 1)**:**i125-i41.

Ministry of medical services (2010) *Facts and figures on health and health related indicators.* Nairobi

Ministry of Medical Services Republic of Kenya (2008) *Ministry of Medical Services Strategic Plan 2008– 2012. Reversing the Trends: The Second National Health Sector Strategic Plan*. Nairobi

Muula A. S, Rudatsikira E, Siziya S., & Mataya R.H.,(2007) *Estimated financial and human resources requirements for the treatment of malaria in Malawi*. Malar J 6: 168.

Mwatsuma K., Mwamuye, 1., and Nyamu, H. M., (2014) Devolution of health care system in Kenya: A strategic approach and its implementation in Mombasa County, Kenya. *International Journal of Advanced Research*, Volume 2, Issue 4, 263-268

Noorein I.S, Pam W. A. O, (2010) Restructuring with the middle-management advantage. *Health Care Manag*, 29(4)**:**305-317.

Nzinga J, Mbindyo P, Mbaabu L, Warira, A., English M., (2009) Documenting the experiences of health workers expected to implement guidelines during an intervention study in Kenyan hospitals. *Implementation Sci*., 4(44)

O'Neil M (2008) Human resource leadership: the key to improved results in health. *Hum Resour Health*, 6(1)**:**10.

Patrick, I. M. (2013), september 20). University of kwazulu -Natal. Retrieved from University of kwazulu - Natal website:

Paul Mbua, P& Ole Sarisar, J., (2013). Challenges in the implementation of Performance contracting initiative in Kenya Public Policy and Administration Research Vol.3, No.2, pp 44

Republic of Kenya (2008) *Vision 2030: Sector Plan for Health 2008-2012.* Ministry of Medical Services and Ministry of Public Health and Sanitation

Republicof Kenya(2010) *Accessible, Affordable and Quality healthcare services in Kenya: Financing options for universal coverage.* Ministry of Medical Services and Ministry of Public Health and Sanitation, Nairobi

Sekaran, U., & Bougie, R., (2010). Research Methods for Business A Skill Building Approach (5th ed.). Chichester West Sussex UK John Wiley and Sons

Sihanya, B., (2013) *Presidentialism and Administrative Bureaucracy: 1963-2013,* Innovative Lawyering & Sihanya Mentoring, Nairobi & Siaya.

Silverman, D., (2011). *Qualitative Research: Issues of Theory, Method and Practice*, Third Edition. London, Thousand Oaks, New Delhi, Singapore: Sage Publications

Tam W., (2008) *. Failing to treat: why public hospitals in China do not work. The China Review 2008;8:103-30.*

Tam W.,(2010)   Privatising health care in China: problems and reforms*. Journal of Contemporary Asia;40:63-81.*

Tangcharoensathien V, Patcharanarumol W, Ir P, Aljunid SM, Mukti AG, Akkhavong K, Banzon E, Huong DB, Thabrany H, Mills A., (2011) Health-financing reforms in southeast Asia: challenges in achieving universal coverage. *Lancet*, **377**(9768)**:**863-873.

Taylor C. A., Taylor J.C., & Stoller J. K., (2008) Exploring leadership competencies in established and aspiring physician leaders: an interview-based study. *J Gen Intern Med*, 23(6)**:**748-754

Vaillancourt, D., (2009) Do Health Sector/Wide Approaches Achieve Results? Emerging Evidence and Lessons from Six Countries. Washington, D.C.: Independent Evaluation Group - The World Bank. 2009/4 2009/4.