STRATEGIC CHALLENGES IN THE IMPLEMENTATION OF UNIVERSAL HEALTH CARE COVERAGE IN THE KIBERA INFORMAL SETTLEMENT SLUM, NAIROBI CITY COUNTY

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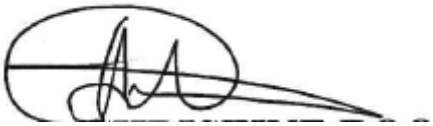
APRIL,2021

DECLARATION

This research project is my original work and has never been submitted for the award of a degree in any other learning institution.

Signature  ……Date ……14/7/2021……

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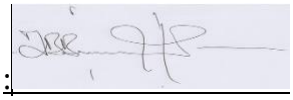
SUPERVISOR'S DECLARATION

This research project has been submitted for presentation with my authority as the university supervisor

Signature- :  Date-16th November 2021

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DEDICATION

This study is dedicated to my family.

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LIST OF ABBREVIATIONS AND ACRONYMS

HRH	Human Resources for Health
ICT	Information Communication Technology
MDGs	Millennium Development Goals
MoH	Ministry of Health
ORA	Optimal Resource Allocation
RBV	Resource Based View
SPSS	Statistical Package for Social Sciences
UHC	Universal Health Care
UN	United Nations
WHO	World Health Organization

ABSTRACT

A critical responsibility of strategic management theory and research is the improvement of institutional results. Practices around strategic management thus, are important to the management of public, private, and non-governmental organizations since they have a contribution to the sustenance of the environment. Government and its agencies the world over continue to implement traditions around strategic management with the sole aim of boosting the results of service delivery. This study revolves around two theories; 1) Resource Based View (RBV) theory and 2) Optimal Resource Allocation (ORA) theory. The main aim of this study was to investigate the strategic challenges in UHC implementation in the informal settlement in Kibera slums, Nairobi City County. Specifically, the study sought; to analyze the effect of ICT on implementation of universal health care coverage; to analyze how resource allocation influence on UHC implementation; to analyze the role of stakeholders' engagement on implementation of universal health care coverage in the informal settlement in Kibera slums, Nairobi City County. The outcomes of this study, specifically the recommendations may enable private hospitals managers and stakeholders to comprehend how they can effectively manage the implementation of UHC. This study employed descriptive study design with employees in the public health institutions in Kibera slums targeted. Questionnaires were used in data collection. To run descriptive and inferential statistics, Social Packages for Social Sciences (SPSS,version 23.0) was used for quantitative data analysis. The study reported that resource allocation ($r=0.380$, $p<0.00$); stakeholders' engagement ($r=0.756$, $p<0.00$); information communication technology ($r=0.639$, $p<0.00$); influence implementation of universal health care coverage in the informal settlement in Kibera slums, Nairobi City County. This study concluded that stakeholders play a crucial role UHC in health institutions and this has led to the achievement of the extensive and much needed support in the organization's strategies implementation. Resource allocation is among the factors that affect implementation of UHC. Information Communication Technology improves delivery of services in. The study recommends that health institutions in Kibera slums should allocate substantial amount of financial resources in the budget for investment in ICT. Equity in resource distribution should be observed to enable workable UHC implementation. In order to ensure that strategic objectives, goals and targets are met leaders in the hospitals implementing UHC should motivate employees to ease UHC implementation.

CHAPTER ONE: INTRODUCTION

1.1 Background of the Study

Strategy implementation encompasses objectives achievement through motivation of staff and organization of a firm's resources. Firms have been faced with dynamic environmental conditions. Nowadays, global competitive environment has become largely unpredictable, dynamic and complex. In order to deal with unpredictable change, focus has mainly been directed to strategy implementation (Thompson, Strickland& Gamble, 2007). Organizations have adopted modular forms rather than hierarchical structures in order to create organizational flexibility in response to environmental turbulence (Balogun, 2003).However, organizations still face numerous strategy implementation challenges that include resource allocation, communication and leadership (Beer &Eisenstat, 2000).

The study's direction was based on Resource Based View (RBV) theory and Optimal Resource Allocation (ORA) theory. RBV view theory focuses on internal weakness and strengths of organizations resources, regarding how resources are deployed and allocated during strategy implementation. According to Freeman (2014), optimal resource allocation requires managers to be clear about apportionment of productive assets among different uses.

Despite the fact that there are previous studies on UHC in Kenyan rural areas (Mbugua *et al*., 1995; Collins *et al*, 1996) corresponding studies in urban slums are scanty. Therefore, there is lack of clarity as to the determinants of health care demand among households in the slums, given the fact that the current programs on health reforms targets improvement of urban health care. Mwabu *et al*., (1992) observed that about 69 % of study participants do not visit public health facilities irrespective of their proximity; instead, they visited alternative health facilities that are more expensive.

In spite of the fact that there has been extensive research on UHC in the rural areas of Kenya, such similar studies are missing in the urban slums. As such, there is lack of evidence as to the determinants of health care services demand among households in informal settlements such as Kibera (UN-HABITAT, 2005).

Some observational studies show that over 69 percent of the respondents preferred alternative health facilities to public health facilities even though these health facilities were closer to them than these other health facilities. These observational studies further revealed that the alternative health facilities visited were more costly in terms of money and time. What is even perplexing is the report that those who preferred public health facilities did not incur any problem in relation to drugs availability (Mwabu *et al*., 1993, Sahn *et al.*, 2003).

Strategy implementations seem to be elusive to many organizations since they face problems such as lack of communication, weak managerial roles during implementation, misunderstanding of the strategy uncontrollable environmental structures and poor organization structures (Beer &Eisenstat, 2002). Chebet (2005) concluded that leadership and organization structure by far influence implementation of strategies among petroleum firms in Kenya. Availability of resources and how they will be utilized during strategy implementation influences the desired outcomes. Amollo (2013) analyzed aspects influencing successful adoption of strategies in the parliamentary service commission (Kenya) and pointed that resource utilization and the longstanding administrative bureaucracy in profoundly influence strategy implantation at the commission.

1.1.1 Challenges of Strategy Implementation

Allen (2011) describes strategy implementation to be process whereby strategic intentions become real. This often involves asking questions about what really works and what does not work in order guarantee competitive advantage (Allen, 2011). Implementation of strategies involves a series of steps and investment in programs, understanding of how special programs are executed and how resources are also mobilized (John & Richard,2013).

Therefore, it is paramount to note that implementation efforts are dramatically limited by vague strategies (Hrebiniak, 2006). Successful and effective strategy implementation is dependent on sporadic variables outside and inside the organization. Whereas the analysis of the environment crafting of missions, cerebral and creative endeavor, implementation is about really doing the work that brings the strategy to life at it was intended (Allen, 2011).

A study by Johnson and Scholes (2012) concluded that formulation and execution of strategies by an organization will reinforce its competitive advantage. Organizations face numerous strategy implementation challenges that include lack of shareholders engagement poor resource allocation, poor communication and leadership, limited organization resource and strategy misunderstanding (Beer &Eisenstat,2000).

Implementation efforts can be significantly restricted by poor or unclear strategy. It is even more difficult to address the limitation of a poor strategy or bad strategic planning endeavors merely through proper execution. There are certain factors within and without organizations that determines effective and successful strategy implementation. Implementation of UHC programs require more than just the right pieces; it requires putting those pieces together correctly. Whereas the analysis of the environment the crafting of missions, and the formulation of strategies is a creative and cerebral endeavor, implementation is about really doing the work that brings the strategy to life as it was intended (Allen, 2011).

According to Johnson and Scholes (2012), enhancing the competitiveness of organizations operating in a competitive environment is hinged on the development and implementation of strategies to lay out plans to be taken in the future. According to Beer & Eisenstat (2000), organizations are grappling with implementations problems which include leadership gaps in implementation, poor communication, lack of stakeholder's involvement, limited understanding of the strategy, lack of commitment on the part of the implementors, unaligned organizational resources and certain uncontrollable environmental factors.

1.1.2 Implementation of Universal Health Care Strategy in Kenya

Universal health coverage has the affinity of transforming and saving life of millions. The structure allows everyone to access medical services despite of their economical standing (Karanja, 2014). The intention of Universal Healthcare is to ensure citizens have accessibility to medical services. According to (KPMG Africa,2014), this involves common goals like just processes and accessibility to medical care.

The Kenyan government continues to undertake numerous changes on the medical structure and continues to pay attention to the delivery of proper hospital services and minimal cash expenses (Owino, 2018). Existing state programs towards the Universal Healthcare Coverage continue to oversee the management of medical equipment across counties, free maternity health program and expanded NHIF. Pandey (2018) submits that the path to achieving UHC is characterized my many strategic challenges that countries have to grapple with.

Relationship between stakeholders, workers and the organization are enabled by participative management. It therefore addresses critical issues on governance in an organization (Hahim, 2014). The influence of corporate decisions by shareholders seen to be a paradox in the present economy (Rajabu, Marthandan & Yusoff, 2015).

Universal health coverage definition embodies certain related aims: 1) that there is equitable access to health by those who needs it without financial discrimination, 2) guaranteed health services with quality which is good enough to result into an improvement in health of the recipients and 3), financial risk protection thereby alleviating the risks of suffering financial hardships in the pursuit for health care. In addition, UHC has two fundamental goals which is to maximize health impact and eliminating or reducing impoverishment due to the cost implications of seeking health care (WHO, 2010). Moreover, UHC means that all people are able to access quality health services without financial catastrophe. UHC gained fresh momentum in 2015 with the adoption of the 2030 transformative agenda (SDGs). The eighth target of the third goal-Good Health and Wellbeing is explicit about achievement of UHC (United Nations, 2015).

Universal Health Coverage (UHC) has been implemented in several ways. It is a broad concept tailored to extend health care access to as many people. Implementation of UHC should be through certain tools including legislation, regulation and taxation. Under the universal health coverage, individuals are at liberty to enjoy health promotion services including prevention activities, rehabilitation and specialized medical care, while also ensuring that the user is not exposed to financial hardships (WHO, 2016). Health services, finance and population are the key components of UHC. It is a process that is subject to dynamism and continuum shifting in relation to demographic, technological and epidemiological trends in addition to people's expectation (Clark, 2014).

1.1.3 Informal Settlement Slums in Kenya

Informal settlement growth in Kenya can be traced back in the colonial period in 1899; Nairobi founded a station as a result of Mombasa –Uganda railway line. The railway line made the British to declare Nairobi as a capital in 1907. In 1915, several protective laws were passed to safeguard the white, in owning agricultural land (Jackson & Rosberg, 1986).

According to Huchzemeyer (2011) after Kenya assumed self-rule in the year1963, poor planning and poor governance, autocratic leadership that were adopted by the African elite resulted to the exclusion of the poor. Withdrawal of colonial restrictive law after the independence, unemployment and poor agricultural practices in the rural resulted to rural–urban migration.

The intensified rural–urban migration, happened at a time when there were no plans of accommodating newcomers to Nairobi. This resulted to mushrooming of substandard houses. In 1970's, the global concerns made the government of Kenya to come up with strategies of managing the slums. The government of Kenya has continually come up with varied development strategies and policies that guide slum settlements (UN-HABITAT, 2005).

Upon gaining independence in the year 1963, poor governance, authoritarian leadership and poor planning assumed by the African elite only led to further social exclusion and class separation (Huchzermeyer, 2011). According to K'Akumu & Olima (2007), the enactment of liberal laws after independence, unavailability of employment opportunities in the rural parts of the country and unproductive rural agriculture led to influx of people in urban areas. With this influx, coupled with rapid urbanization and lack of proper planning, housing situation became dire forcing people to construct substandard houses.

In the wave of global call to elimination of slums in cities in the late 1960s, the Kenyan government was prompted to look for ways to respond to the increasing number of substandard houses in the capital city. The government have over the years come up with different programs and approaches/policies and strategies to address these challenges and other upgrading programs (UN-HABITAT, 2008). The most dominant for of slum eradication in Kenya was forced eviction until early 2000, when the UN member states ratified the Millennium Development Goals focusing on slum upgrading(MDGs, 2000).

1.1.4 Kibera Informal Settlement in Nairobi

Kibera informal settlement in Nairobi covers approximately 2.25 square kilometers and it is 5 kilometers away from the city centre (UN Habitat, 2001). Kibera settlement was established in 1912 when the Nubian soldiers were allowed to settle there (Boderves,2005). The Nubian soldiers who originated from South Sudan were recruited for the purposes of suppressing British rule rebellion.

According to Kenyan population census in 2009, Kibera has a total of 140,070 residents. UN Habitat (2001) has an estimate represent different point in time there is no possibility of having a huge swing from the actual population (Nevwirth, 2005).Kibera compared to other slums is located next to affluent neighbors, has an association with characteristics of labor relationship. According to Bodewes (2005), the main sources of income is informal and formal employment. Syagga *et al.*, (2002) estimates that only 17 percent the residents are formally employed while the rest of the residents are informally employed. According to Research International (2005), the population of Kibera is mainly composed of tenants with few people living in their own homes. The tenants are the majority, forming about 90 % of the total population while those with own homes are about 5 percent.

This disproportionality in the population of the tenant's vs the population of the people who own rental houses denies Kibera informal settlement the tag of squatter settlement as one would suppose. On the flipside, the informal settlement is characterized by a rental enterprise in which the owners of the structures make vast use of these structures in precarious conditions (Neuwirth, 2005).

According to Syagga *et al.,* 2002), only around 17 percent of the residents of Kibera slums are in formal employment while the rest are in the informal sector. Those formally employed mainly work in factories and industries or offices in the capital. Still, a number of people are in the building construction industry and serving as domestic servants in the leafy suburbs of Nairobi.

1.2 Research Problem

According to Miller &Dess (1996), implementation of strategy involves transforming intentions in to actions; strategy implementation can also be defined as adoption, interpretation, communication and enacting strategic plans (Noble, 1999). According to Awino (2001) management and leadership of an organization are the sources of strategic challenges; it includes limited resources and resistance to change (Awino *et al.,* 2012).According to Aosa (1992), competitive environment poses challenges.

Irrespective of numerous resources and efforts that have been channeled to UHC implementation in the informal settlement in Kibera slums there is still failure. This means strategy implementation is a dominant challenge in UHC in Kibera slums. This is evidenced by failure of UHC in Kibera slums in meeting strategic objectives in their strategic plans.

Thus, strategy adoption continues to attract the interest of many investigators. In a study by Harrington (2006) in Canada, the focus was on assessing the moderating influence of engagement, managerial leadership, and institutional size on plan adoption. According to (Schaap, 2006), a study was undertaken to evaluate the contribution by the leadership in Nevada Gaming. Ogunmokum, Hopper and Mc Clyment (2014) wanted to determine the connection relation among institutional results and plan adoption. However, the analysis employed purposive sampling that demonstrates failure to reach conclusions. Candido and Sergio (2019) examined implementation obstacles and strategy implementation failure. However, their study relied on secondary data only.

Several studies on strategic implementation have been carried out in Kenya. Some of these studies include Awino *et al*., (2012) focused on challenges that face sugar industry in the implementation of differentiation strategy; Aosa (2012) focused on strategy implementation and formulation in private manufacturing companies in Kenya; Awino (2001) which studied private manufacturing companies in Kenya. Awino (2001) studied problems of strategy implementation in NHIF.As a buildup to these previous studies, this study sought to respond to the question, “what are the strategic challenges faced by universal health in Kibera slums?” This study therefore examined strategic challenges in the implementation of UHC in the informal settlement in Kibera slums, Nairobi City County.

1.3 Research Objectives

The main purpose of this study was to examine strategic challenges in the implementation of universal health care coverage in the informal settlement in Kibera slums.

1.3.1 Specific Objective

i) To analyze the effect of information communication technology on implementation of UHC in the informal settlement in Kibera slums, Nairobi City County.
ii) To analyze how resource allocation influence implementation of UHC in the informal settlement in Kibera slums, Nairobi City County.
iii) To analyze the role of stakeholders' engagement on implementation of UHC in the informal settlement in Kibera slums, Nairobi City County.

1.4 Value of the Study

As a result of this study on challenges in the implementation of UHC coverage in the informal settlement, policy makers, regulatory bodies and both County government of Nairobi and the National government will be able to play an oversight role as well as formulate appropriate policies that govern UHC implementation in the informal settlement.

The outcome of this study, specifically the recommendations will enable private hospitals managers and stakeholders to comprehend how they can effectively manage the implementation of universal healthcare coverage. This study would be very useful to Kenyan health sector as it would allow them to exactly understand the challenges which are always the first step to solving a problem.

Managers at all levels of the hospitals will benefit by finding direction on how to handle implementation of universal health care coverage. This study avails rich reference material to academicians, researchers and future scholars interested in carrying out future research in UHC implementation.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

Relevant studies are reviewed in this charpter in order to identify gaps for the study. It also examines theories on challenges of Universal Healthcare Coverage implementation explaining interrelationship of the study variables of the present studies. The theories discussed include resource-based view (RBV) and optimal resource attraction theory.

Empirical studies related to the study topic have also been reviewed concerning independent variables of the study. The empirical studies include information communication technology and UHC implementation; resource allocation and implementation of universal health care; and stakeholder engagement and UHC implementation. Finally, the chapter also presents variables incorporated in the study in terms of knowledge gaps.

2.2 Theoretical Foundation

Theories explain reasons of behavioral change. They help in describing and identification of problem existence as well as prediction of behavior.

2.2.1 Resource Based View (RBV)

Barney and Wernerfelt developed resource-based view (RBV)theory while analyzing heterogeneous firms, the theory explains how organizational performance is dependent on organizational resources. The resources are therefore a determinant of competitive advantage. Exploitation of available opportunities is therefore efficient as compared to acquisition of new skills.

RBV theory classifies resources into human capital assets, physical and organizational assets. Efficient allocation of these resources helps in greater organizational performance by ensuring sustainable supply chain. Hence the theory explains e-procurement and sustainable supply claims in hospitals. According Parida & Parida (2005), employing e-procurement practices such as e-sourcing hospitals with complex supply chain can effectively and efficiently utilize its resources. Just as Resources Based View (RBV) theory suggests, doing this improves company performance while ensuring supply chain sustainability.

As a result, RBV has been found to be very relevant in explaining e-procurement and supply chain sustainability in health facilities. It is also debated that due to RBV theory, health facilities are set to find the use of strategic policies more efficient due to the fact that it ensures that resources are distributed in an equitable manner and that there is effective utilization.

RBV theory explains that universal health care can only be implemented when requisite resources are available. In addition, resource-based theory enables the use of strategic policies efficiently, by ensuring that resources are distributed evenly and utilized effectively**.** Hence the theory explains allocation of resources in hospitals.

2.2.2 Optimal Resource Allocation Theory

ORA theory was promoted by Laska, *et al.,* (1973). It postulates that when available resources are not uniformly allocated, equitable distribution of services will be stifled. The proponents of the theory, in a bid to advance the theory, they contend that in order to accomplish certain tasks by the sources, resources are required and that the sources are fascinated that it does possess all the time, the capability to irregularly apportion its services to projects (Laska, *et al.,* 1972).

The theory, on the flipside, suggest that the source is required to come up with favorable plans to ensure optimal allocation of resources in a way that would enhance completion of task in time and prevent potential project collapse (Laska, *et al.,* 1972). Keshtkar, *et al.,*(2015) contends that it is paramount to have a reliable strategy to ensure optimal human resources allocation for health. This theory is consistent with a study on variable distribution of financial and human resources which supports that health care projects are adversely impacted in the absence of commensurable allocation of HRH-doctors, physicians, midwives and nurses.

Based on the theory, UHC can only be implemented when resources are adequate and are in tandem with the standards of operations. Based on this theory, hospitals can find optimal use of strategic policies efficiently because it enables equitable distribute of resources as well as optimal utilization. This theory supports this study by explaining the significance of optimal allocation of human and financial resources optimally.

2.3 Challenges of Strategy Implementation in Organizations

Management of change is the basis of a strategy. Strategy implementation is adversely affected by resistance to change. According to Hill and Jones (1999) strategic change is moving the organization from present to future state in order to gain competitive advantage. Individual behavior dictates the failure of strategy implementation (Mc Larly *et al.*,1987).

Organizational change may attract resistance and conflict. Employee in an organization occasionally resent projects, making strategy implementation elusive (Lyrich, 2000). This could be as a result of economic loss and uncertainties. Okumus (2000) observes that major strategic implementation barriers include poor planning, lower-level management resistance and lack of coordination and support.

Unless the management persuades the employees to accept changes, it may not be realistic for employees to accept these changes. Leadership is therefore central in driving the change process, by altering the perception of the employees, hence bringing personal influence. Revisiting personal contract is integral in strategy implementation process (Okumus,2001).

According to Freedman (2003, there are innumerable drawbacks to implementation such as isolation, failure to ensure stakeholder involvement among many others. Sterling (2003), on the other hand, attributes strategic failures to unanticipated shift in market, little or no support from the management, inability to achieve buy-in, misunderstanding, failure to focus and poorly conceived business model. In some occasions, strategies flop because they are simple ill conceived.

Okumu, (2003) reveals that change initiatives by corporates whether proactive or reactive alter employees dimensional contract terms. It may be unreasonable for management to expect staff to wholeheartedly support changes that alter the way things are done without resentment, unless the terms are defined and employees persuaded to accept them. It is also incumbent upon the leadership to drive the process of change far enough for the employee's perception to be altered, resulting into revised personal impacts. The change process required to achieve change goals must factor in the aspect of employees' contract revision as an integral part of the change. Similarly, employee's commitment must be redefined to new goals-goals that everyone understands. This is great transformational leadership.

2.3.1 Information Communication Technology and Implementation of UHC

Information communication technology medical system's formulation entails different players. It is the role of the state through relevant ministries to initiate and equally come up with plans guiding ICT's integration into the medical sector. Medical experts are important players in the process of integrating information communication systems for properly providing medical services to those in need, Houghton (2002). Their awareness on the manner information systems enhances the delivery of service with little changes and reforms in the manner they undertake daily processes (Kerry, 2007).

Based on Odekunle *et al.,* (2017), HER's adoption continues to be cited as a variables limiting HER adoption. In the Sub-Saharan Africa, EHR adoption has been linked to very high cost of implementation, training, hardware and software (Gabbay & Le May, 2004; Cather, 2006; Aknbi *et al.*, (2012). The cost of computerized machines in most developing countries hospitals are prohibitive (Kanyua, 2015).

In Ethiopia, Shiferaw and Zolfo (2012) established that implementation of telemedicine is not dependent on technological factors, but also on process of capacity building. Samuel and Alfred (2010) suggest that external and internal factors affect implementation of e-health in Zimbabwe. Njeru, Muraguri and Abayo (2019) concluded that technology is a critical element in explaining UHC implementation in Kenya.

Mugo (2014) summarized the determinants of electronic health in developing countries and evaluated the most recent studies to determine the extent to which eHealth has been integrated in the larger health care structure by low- and middle-income countries. Studies have shown various determinants of eHealth adoption that can help low-resource settings to leapfrog over advanced one in providing accessible and quality health care. Nonetheless, more studies need to be done to ascertain the effect of the aforementioned determinants, to find out other determinants of eHealth adoption and to show how developing countries cooperation on eHealth strategies that can profoundly impact the journey towards it.

In a bid to examine the factors influencing e-health implementation by health care providers in Zimbabwean public hospitals, Samuel and Alfred (2018) conducted a study guided by qualitative research in conjunction with series of case studies. The authors collected qualitative data and reported that e-health implementation in public hospitals in Zimbabwe is subject to both internal and external factors. According to the study, internal factors consist of unavailability of basic medical facilities and other demographic factors among others. Health policies, funding and bureaucracies are the external factors.

Njeru, Muraguri, and Abayo (2019) examined aspects impacting UHC's adoption in the county of Makueni. The aanalysis intended to evaluate the effect by technology towards the adoption of Universal Healthcare across the Kenyan counties. The study settled for a descriptive study model targeting 291 participants consisting of consultant doctors, 23 medical officers, 199 nurses and 67 clinical officers operating in the county and Sub-County medical facilities across the county. Based on the study's key deductions, the conclusion was that technology greatly helped the realization of UHC across medical institutions in the county of Makueni.

2.3.2 Resource Allocation and Implementation of Universal Health Care

Ahimedor *et al.* (2014) over that implementation of UHC is influenced by uneven distribution of human resources. Milicevic, Vasic and Edwards (2015) revealed that implementation of UHC is influenced by human resource distribution bottlenecks in Serbia. According to Bordignon and Turati (2009) reported that health infrastructure and human resource financing influence UHC implementation in Italy.

Harris, Ko and Waller (2017) explored methods that can be adopted in allocating resources in healthcare setting. The model highlighted activities and opportunities that can be adopted in consumer engagement. Gitonga and Keiyora (2017) studied elements influencing health care projects implementation in Meru County. Descriptive study design was adopted with about 700 respondents as the target population. A sample size of 249 was used and this was distributed among Meru County Health Staff (15), medical personnel at the public hospitals in Meru County (224) and Health Civil societies managers (10). The study found that collaboration of communities, human and financial resources distribution, and adoption influence health care projects implementation in Meru County, Kenya.

Wang, Tuma, Rosemberg and Ulisubisya (2018) argued that mechanism of funds allocation should give the poor a priority in order to improve health outcomes (Sanongo, Fantage & Yaya, 2019). A systematic review was conducted and guided by Cochrane Handbook. The study reviewed previous research and those that mentioned studying the influence of universal health coverage on access to health care equitably, facilitating factors and impediments to access to care for vulnerable populations. The study concluded that even though UHC seems to accelerate demand for health services, physical inaccessibility, lack of awareness, prenatal services, previous experiences, lack of gender-based autonomy and fear of C-section deterred the much needs health access.

2.3.3 Stakeholders' Engagement and Implementation of Universal Health Care

The study by Hoang, Hill, and Nguyen (2018) analyzed universal health coverage in Vietnam with an objective to gain clear understanding of stakeholders influence in accelerating UHIC to achieve healthcare equity. The study finding shows the different levels of support stakeholders provide in the HI formulation and implementation beginning from 1989 when HI was first introduced to 2013 when the grand plan for UHIC was launched. A study in Zambia by Kapiriri (2018) on stakeholders' involvement in health research priority setting in low-resource setting fills the gap by establishing and exploring the roles and legitimacy of various stakeholders in health research in Zambia. The study used an interview guide and transcribed and analyzed the audio with the help of NVIVO 10. The key theme was identifying the different dimensions of stakeholder's involvement. About 28 policy makers and practitioners participated in the study with reported participants in health research priority setting being research users, researchers, donors and community. Even though there is some commitment to broad stakeholders' involvement, there is limited public or patient's involvement.

Nanyonjo and Okot (2013) avers that challenges that influence implementation of UHC include doctors who are fewer than nurses in Uganda. Mwamuye and Nyamu (2014) observed that stakeholder participate in central in the implementation of UHC projects. Oketch (2010) argues that uneven distribution of human resource adversely affects implementation of UHC.

Oketch and Lelegwe (2015) also analyzed UHC and equity on health care in Kenya, relying heavily on secondary sources on the subject even though there was primary data was also collected.

Primary data was collected through key informant interviews with various stakeholders involved in the UHC such as policy makers, researchers, and implementers. The study key findings include UHC commitment with limited health care financing, health care system dysfunctionality and little opportunities for training. The finding also reported governance concerns at NHIF, low capitation, corruption, low payout ratios, inconsistent approval of facilities, improper benefit packages among others (Okech & Lelegwe, 2015).

2.4 Empirical Studies and Research Gaps

It is clear from the literature review that numerous studies have been done outside Kenya, particularly concerning factors influencing UHC implementation. It is also warranted to point out that a lot of studies in his area have been carried out in Vietnam and West Africa (Shiferaw and Zolfo, 2012; Ahimedor et *al.,* 2014; Milicevic, Vasic and Edwards, 2015). Challenges that face implementation of UHC are numerous. The study sets to examine the strategic challenges in the UHC implementation in Kibera slums, Nairobi City County. Since strategic challenges in the implementation of universal health care coverage is under researched, he recommended future studies should focus various counties (Njeru, Muraguri & Abayo, 2019). A study by Mugo (2014) summarized determinants of electronic health in developing countries, which does not represent informal settlement like Kibera.

Conceptually, recent studies about the strategic challenges to UHC implementation in Kenya have focused on referral hospitals and not Sub County Hospitals. There is still unresolved debate on the interaction between stakeholder's involvement, ICT, resource allocation and implementation of universal healthcare that this study seeks to address.

Methodologically, studies such as Shiferaw and Zolfo (2012); Odekunle *et al.,* (2017) and Hoang, Hill and Nguyen (2018) adopted purposive sampling in their studies. However, the study, used purposive sampling method which cannot be used to make inferences. As such this study therefore adopted stratified sampling to enable better representation of the target population.

It is evident that strategic challenges on UHC implementation studies are of concern to managers and policymakers seek to understand challenges of UHC implementation. Globalization and

competition for productive human resources has made managers to seek understanding of strategic challenges in UHC implementation which this study endeavors to establish.

Table 2.1: A summary of past research on Strategic Challenges in the Implementation of Universal Health Care Coverage

Author and year	**Research topic**	**Variables**	**Findings**	**Methodology**	**Gaps**
Shiferaw & Zoflo (2012)	Role of ICT towards UHC in Ethiopia universal health coverage in Ethiopia.	**Independent variables** Information communication technology	Technological factors are not the sole determinants of Telemedicine implementation.	**Nil**	The study was biased to information technology but not resource allocation and stakeholder engagement.
Mugo (2014)	Determinants of e-Health in low-resource settings.	**Independent variables** Information communication technology **Dependent Variable** Implementation of universal health coverage	Study reveals that various e-health adoption determinants which will help developing countries.	**Nil**	The study solely focused on secondary data. No primary data was collected
Oketch & Lelegwe (2015)	UHC and equity on health care in Kenta	**Independent variables** Stakeholder commitment **Dependent Variable** Equity on health care	Stakeholder commitment towards UHC; influence implementation of UHC	Secondary data analysis	The study was biased to Stakeholder commitment but not resource allocation and information technology

Harriss, Ko & Walter (2017)	Effective allocation of resources as a way of achieving sustainability in health care.	**Independent variables** Resource allocation **Dependent Variable** Sustainability of health care	Research findings revealed that resource allocation have an impact on Sustainability of health care.	Thematic analysis	The study solely focused on secondary data with no evidence of primary data.
Samuel &Alfred (2018)	Features impacting the adoption of e-health by medical doctors in the public hospitals in Zimbabwe.	**Independent variables** ICT landscape, e-health technologies, ICT skills **Dependent Variable** Implementation of e-health	The study revealed that e-health implementation by is influenced by certain factors-both intrinsic and extrinsic	**Nil**	The study solely focused on secondary data with no evidence of primary data.
Sanango, Fantage & Yaya (2019)	UHC and facilitation of health equity in Africa	**Independent variables** Team Building **Dependent Variable** Employee Performance	The study established that the participants had diverse notions concerning what activities constitute team building and what team building really is.	Thematic analysis	The study solely focused on secondary data with no evidence of primary data.

Source: Researcher, 2021

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

The third chapter offers the methodology, design employed to enable generation of background information concerning the present study criterion and predictors variables. This chapter further describes data collection techniques that was adopted in the data collection process. Furthermore, it discusses administration of data collection instruments to the study respondents which include, superintendents, and doctors, Nurses, Administrators, Department heads and Sub County Health Officers.

It therefore presents the study blueprint; the study design adopted. This chapter also discusses the sampling and data analysis procedure utilized in this study including both inferential and descriptive analyses.

3.2 Research Design

Based on (Mugenda & Mugenda, 2003), the decision of an appropriate descriptive research model is based on the reason that it enables the realization of the manner conditions affect a phenomenon. A research design offers an extensive profile of the manner a study was undertaken and entails how data is collected, tools used in collection and how data analysis is done (Cooper & Schindler (2006).

Descriptive design method has the capacity of enabling background information collection as well as that the researcher has little chance of motivating the respondents in order to influence research participants' response. The strength of the study's design is the affinity, to explore, describe, as well as analyze the respondents' relationships included in this study (Sekaran, 1992). This study adopted Mugenda and Mugenda (2003) as it enables researcher to establish the nature of prevailing condition with little or no manipulation of subjects.

To explain strategic challenges in the implementation of UHC in Kibera slums, Nairobi City County, this study employed a descriptive study model in describing the relationships among resource allocation, information technology, stakeholder engagement and strategy implementation.

3.3 Pilot Study

According to Gudmundsdottir & Brock-Utne (2010) pre-testing is a feasible study for assessing the likelihood of undertaking the major analysis in relation to its execution and use. Most oftenly, a pilot study is regarded as a pretest conducted with the intention of having a plan on the manner of undertaking a study, (Thabane et al., 2010, p. 1). Thus, the role of pilot study is to determine possible threats that will be used in improving the study.

A feasibility study was conducted in Kibera slums, in the targeted public health institutions targeted under this study. A total of 31 respondent took part in the mini study. The reason for this exercise was to determine certain factors such as cost and time, which would affect the main study. These 31 respondents did not however participate in the actual study as they would introduce bias to the study.

3.4 Study Population

Cooper & Schindler (2006) reports that a population of study is a total sum of elements in which a principal investigator wishes to make inference. It is a whole group of objects, events or individuals exhibiting homogeneous characteristics that can be observed (Mugenda & Mugenda, 2003). Maxwell (2012) defines a target population as objects or a group that interests a researcher in order to deduce information as well as drawing conclusions.

The target population of the study comprises of public health centres that include Kibera DO Health Center, Kibera AMREF Health Centre, GSU Kibera Health Centre, Kibera South Health Center, Mbagathi District Hospital, Kenya Defense Forces Memorial Hospital and Kenyatta Teaching and Referral Hospital. The study settled on this target population because they directly deal with strategic implementation matters in a hospital set up.

3.5 Sample Design

Kothari (2004) argues that the process of sampling permitsselection of smaller numerical values of events,objects or individuals for analysis purposesso asto establish something that represents the selected study population. The study adopted both stratified and simple random sampling. The first stage of sampling was stratified sampling which was used to ensure representation from the

different respondents, superintendents, doctors, Nurses, Administrators, Departmental heads and Sub County Health Officers from all Sub-County health facilities in Kibera. Stratified sampling allows a researcher to select a representative portion of the study population to enable carrying out measurements and drawing conclusion concerning the entire population (Maxwell, 1996). The advantage of this method is that it saves time. Simple random sampling was adopted because of its ease of use and its accuracy in representation of the larger population.

3.6 Sample Size

This study targeted 298 health care workers in government health institutions in the informal settlement in Kibera slums. Out of these 298people, the study intended to have 95% a confidence level and a margin of error of 0.05. The sample size is thus, calculated using the

Yamane formula (Yamane, 1967). According to the formula;

$$n=\frac{N}{1+Ne2}$$

n= desired sample size

N= Target Population=298

e= the degree of accuracy expressed as a proportion=0.05

$$n=\frac{298}{1+298\ (0.06218)2}= 171$$

Sample Size=171 respondents

3.7 Data Collection

Collection of data was through self-administered questionnaires issued to study participants and collected once they were through. Each category of respondents received a questionnaire personalized to their group. In order to ensure reliability and validity of the questionnaires, a pre-testing was conducted to aid checking for completeness and removal of vague questions. Quantitative data were coded to aid in identification of the groups. This helped in checking for inconsistencies in the data collected.

Questionnaires were used since they are the most effective way of collecting data and it allows for collecting data devoid of biasness. It is also effective in regard to time and cost.

Upon receiving approval from the University of Nairobi, National Commission for Science, Technology and Innovations (NACOSTI) issued a license to go ahead with the study. A letter was sent to the sampled health institutions to make prior arrangement and bookings for the data collection exercise. For covering larger territories as well as suitable scheduling due to the busy nature of medical centers, the investigator had to recruit help from research assistants. There was the creation of positive relations with the study's participants for purposes of ensuring the study's intention was properly understood.

3.8 Data Analysis

In the determination of consistency as well as completion, there the use of standardized processes during data entry. There was questionnaire coding preceding entry of data. Inconsistencies were verified using the numbers.

The data collected was analysed using SPSS (version 23). In section A, of the questionnaire descriptive analysis was done and frequencies in their absolute and percentage forms. Mean and standard deviation was used to measure central tendency and dispersion. The study used frequency distribution tables to present the findings. In section B of the questionnaire inferential analysis entailed both correlation and regression analysis to establish the magnitude of relationship between criterion and predictor variables.
The equation below was used:

$$\mathbf{Y = C + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \beta_4 X_4 + \varepsilon}$$

Y= Supply Chain performance

C= Constant term

$\boldsymbol{\beta_1 - \beta_5}$= Co-efficient

$\mathbf{X_1}$= Resource allocation

$\mathbf{X_2}$= Information Communication technology

$\mathbf{X_3}$= Stakeholder Engagement

ε = Error term

CHAPTER FOUR: RESULTS AND DISCUSSION

4.1 Introduction

The fourth chapter provides the study's determinations and discussion. Further, the chapter captures the characteristics of the participants as well as opinions concerning strategic challenges in the adoption of universal health care coverage in the informal settlement in Kibera slums, Nairobi County. The study aimed at analyzing the effect of information communication technology on UHC implementation; to analyze how resource allocation influence adoption of universal health care coverage; to analyze the role of stakeholders' engagement on implementation of universal health care coverage in Kibera slums, Nairobi County. The researcher used tables to present the responses from the study participants.

4.2 Response Rate

A total of 298 employees of government health institutions in the informal settlement in Kibera slums were targeted. A total of 124 participants responded to the questions out of 171 questionnaires administered (72.51% return rate).The filled and returned questionnaires were as follows Kibera DO Health Center (17),Kibera AMREF Health Centre(13),GSU Kibera Health Centre (18), Kibera DO Health Centre(14), Kibera South Health Center (19), Mbagathi District Hospital (11), Kenya Defense Forces Memorial Hospital (13) and Kenyatta Teaching and Referral Hospital (19). According to Nachmias and Nachmias (2004), researchers face an imminent challenge of low questionnaire return rate, barely above 50%. For this reason, it is satisfactory if a response rate is slightly above 50%.

4.3 Demographic Characteristics of the Respondents

In this section, the intention was to analyze the demographic features of the participant's like sex, schooling level, age, employment span and designation in all the Sub-County health facilities in Kibera.

4.3.1 Gender Distribution of the Respondents

Findings on the participants' gender are tabled below in table 4.1.

Table 4. 1: Gender of the Respondents

Gender	Frequency	Percentage (%)
Male	72	58.1
Female	52	41.9
Total	**124**	**100**

Source: Research Data (2021)

Based on table 4.2, the determination by was that the male respondents were 58.1% while the female counterparts were 41.9% implying that the Sub-County health facilities in Kibera are gender sensitive even though the male counterparts are dominant.

4.3.2 Age Bracket of the Respondents

Findings on the participants age are detailed below in Table 4.2.

Table 4. 2: Age Bracket of the Respondents

Age Brackets	Frequency	Percentage (%)
Below 30	12	9.7
30-34 years	12	9.7
35-39 years	24	19.4
40-44 years	50	40.3
Above 45 years	26	21
Total	**124**	**100**

Source; Research Data (2021)

Most of the respondents were aged between 40-44 years were 40.3%. The group of 45 years and above was 21.0%, while those below 30 years of age was 9.7%. The age bracket between 35 and 39 years were 19.4%. Thus, a conclusion could be reached that most of the top leadership positions in the Sub-County health facilities in Kibera fell above 30 years of age.

4.3.3 Working Experience in the Company

The study's participants had to indicate the duration they had been employed at the health institution. The results are detailed below in table 4.3.

Table 4. 3: Working Experience

Experience brackets	Frequency	Percentage (%)
Below 5 years	12	9.7
6-10 years	36	29.0
11-15 years	50	40.3
16-20 years	13	10.5
21 years and above	13	10.5
Total	**124**	**100.0**

Source: Research Data (2021)

Based on the results in the table 4.3, 40.3% of the study participants have worked in their health facilities between 11 and 15 years, 29% have worked for their health facilities between 6 and 10 years while 10.5% have worked for their respective companies between16-20years, same as 21years and above. This serves to mean that the participants are well conversant with strategic challenges in UHC implementation, owing to the number of years spent in health institution, therefore, they supplied the study with crucial insights

Education Level

Table 4. 4: Education Level

Education Qualification	Frequency	Percentage (%)
Diploma	48	38.7
Undergraduate	37	29.8
Masters	26	21.0
PhD	13	10.5
Total	**124**	**100.0**

Source: Research Data (2021)

The determination here was that 29.8% of the participants had university degree, 38.7% had diplomas, and 21% had a second degree while 10.5% of the participants had doctoral degree. The conclusion thus is that the respondents passed the literacy test and could tackle the study's questionnaires.

4.3.4 Organization Formation

The study participants had to state the time their organizations were formed as in the table 4.5.

Table 4.5: Organization Formation Period

Period	Frequency	Percentage (%)
10 years ago	24	19.4
More than 15 years ago	100	80.6
Total	**124**	**100**

Source: Research Data (2021)

The study found that 80.6% of organizations were formed more than 15 year ago while19.4% were formed 10 years ago. This implies that the organization have existed long enough, therefore the study generated invaluable information on challenges facing implementation of implementation of universal health care coverage.

4.4 Descriptive Results

Here, the descriptive analysis on the results on the dependent (Implementation of UHC) and independent variables (Information Communication Technology, resource allocation and stakeholders' engagement) are presented.

4.4.1 Implementation of Universal Healthcare

The study participants had to indicate individual agreement levels with the statements on the adoption of Universal Healthcare as highlighted in table 4.6.

Table 4. 6: Descriptive Statistics for Implementation of Universal Healthcare

Statement	n	Mean	Std. Deviation
Management ensures completion of projects in our organization.	124	3.17	1.72
Lead time always influence procurement process in institution	124	3.13	1.57
Having a right source allows the availability of standard products	124	2.46	1.36
There's the availability of finances for the payment to suppliers in the institution	124	2.38	1.41
Every year the established strategic plan is usually adopted in the institution	124	2.84	1.39
Valid N (list wise)	124		

Source:Reseach Data (2021)

The study found that most of those scoring a mean score=3.17 and a SD= 1.72 affirmed that the management ensures completion of projects in their organization followed by those who concured that lead time always influenced procurement process in their organization at a mean score=3.13 and a SD=1.57. Further, the participants affirmed that every year the established strategic plan is usually adopted in the institution at a mean score=2.84 and a SD=1.39. Having a right source allows the availability of standard products at a mean score=2.38 and a SD=1.41, and There's the availability of finances for the payment to suppliers in the institution at a mean score=2.38 and a SD=1.41.

4.4.2 The Influence of ICT on Implementation of UHC

The study participants were asked to indicate how they agree with the statements in the table 4.7 on the influence of information communication technology on implementation of universal health care.

Table 4. 7: Influence of Information Communication Technology on Implementation of Universal Health Care

Statement	N	Mean	Standard deviation
Inadequate adoption of ICT influences our strategy adoption	121	2.47	1.51
Through communication, the workforce show awareness on job demands responsibilities and processes.	121	2.57	1.41
Uncertainty when management communicates disrupts work and employees feel sidelined	121	2.80	2.24
ICT keeps employees informed on the new plans and progress made in implementing changes.	121	2.50	1.41
Failure to communicate with all staff during strategy implementation breeds ground for rumors and panic in the workplace.	121	3.02	1.41
ICT enable keep one up to date on what is going on.	119	1.61	.48

Source:Reseach Data (2021)

Information Communication Technology has been recognized as one of the elements that Professoroundly influence UHC implementation.based on the findings in table 4.8, most scoring the highest mean (M=3.02, SD=1.41) affirmed that management is able to provide direction and control during strategy implementation. Failure to communicate with all staff during strategy implementation breeds ground for rumors and panic in the workplace. This was closely followed by uncertainty when management communicates disrupts work and makes employees to feel as not part and parcel of decision-making processes. (M=2.80, SD=2.24). Futhermore, participants afirmed that Through communication, the workforce show awareness on job demands responsibilities and processes (M=2.57, SD=1.41), and ICT keeps employees informed on the new plans and progress made in implementing changes (M=2.50,SD= 1.41). Inadequate adoption of ICT influences our strategy implementation (M=2.47,SD=1.51).

The present study agrees with Houghton (2002) that medical experts are important players in the process of integrating information communication systems for properly providing medical services to those in need, Houghton (2002). Their awareness on the manner information systems enhances the delivery of service with little changes and reforms in the manner they undertake daily processes (Kerry, 2007). Njeru, Muraguri and Abayo (2019) concluded that ICT is critical in UHC implementation in Kenya.

This study findings are consistent with Chang (2014) who confirms that ICT has a significant contribution in complementing a more resilient and homogenized procurement systems in organizations. The homogenized procurement systems result to centralized data procurement database creating a conducive setting for proper digitization of procurement activities. According to Chopra (2013), electronic and standard procurements are the forms of procurement structures, with the two being extensively applied as well as being integrated into a accounting software product. Baily (2017) reports that by implementing the Enterprise Resource Planning (ERP) system, organizations can easily automate their procurement function through effective ICT.

4.4.3 The Influence of Resource Allocation on Implementation of UHC

The study's participants had to indicate personal agreement levels with the statements in the table 4.8. The findings are detailed in table 4.8 below.

Table 4. 8: Influence of Resource Allocation on Implementation of Universal Health Care

Statement	N	Mean	Standard deviation
We face resource allocation challenges towards strategy implementation		3.00	.84
In my opinion resources are adequately allocated for strategy implementation		2.01	.25
Top leadership has provided financial and non-financial resources for plan adoption.		1.13	.33
The institution possesses the desired monetary ability to adopt strategies		1.86	.71
There is motivation by the leadership to its workforce towards enhancing results and improving strategies adoption		2.17	.72
There is proper management of utilities by the leadership efficiently		1.42	.51
The institution uses optimally the allocated utilities to attain successful strategy plan		1.58	.73
The institution's human resource department is made up of qualified staff		2.35	1.44

Source:Reseach Data (2021)

There is some recognition on resource allocation having the ability to impact UHC implementation. Based on the results on table 4.8, most of the participants scoring highest (M=3.00, SD=0.84) affirmed they face resource allocation challenges towards strategy implementation. This was followed by the institution's human resource department is made up of qualified staff (M=2.35, SD=1.44). Futher, more resopndents agreed that the There is motivation by the leadership to its workforce towards enhancing results and improving strategies adoption with (M=2.17, SD=0.72).

The results agree with Wang, Tuma, Rosemberg and Ulisubisya (2018) argued that mechanism of funds allocation should give the poor a priority in order to improve health outcomes. Sanongo, Fantage and Yaya (2019) adopted PRISMA for a systematic review of UHC implementation. It was established that non–financial barriers contribute to the effectiveness of UHC.

This finding agrees with the position that the human resource department is a major factor impacting the adoption of strategies, Kirui (2013); As such, organizations are obligated to effectively leverage the capabilities of their staff. The management should coordinate and integrate their activities. There is further argument that for whenever an institution possesses a better plan as well as the monetary utilities desired, there is the desire for successful adoption. When it comes to strategy adoption, recruitment of poorly qualified staff for plan adoption negatively influencing strategy adoption.

Further, the study's deductions affirm the position around immediate funding tools present to an institution towards the mobilization of monetary utilities consist of; profits, loans from banks, funding from donors and business, Bryson (2014). It is possible for an institution to employ a single or numerous forms in meeting their fund targets for purposes of influencing the adoption of plans. Also, the institution must account for present plans as well as the desire for the funding request to be regarded along the allocation process.

4.4.4 Influence of Stakeholders Engagement on Implementation of UHC

The respondents were asked to show their agreement levels on the influence of stakeholders' engagement on UHC implementation. The finding are indicated in the table 4.8.

Table 4. 9: Influence of Stakeholders Engagement on Implementation of Universal Health Care

Statement	N	Mean	Standard deviation
The state as well as the the public continue to support our business operations		2.33	1.37
The institutions get funding and support from different players		2.56	1.46
External players complement the institution's goals despite the presence of varied interests		2.84	1.49
Organizational interests become superior compared to external players interests		2.21	1.38
There exists loyal funding partners and other players in the institution's operations.		3.95	1.25

Source:Reseach Data (2021)

Stakeholder engagement has been identified as one of the elements that impact implementation of UHC. In a bid to prove the posistion, the participants had to rate their responses on a likert scale of 1-5 where: 5= Strongly Agree; 1=Strongly Disagree. Table 4.8 above indicate that the majority who scored the highest (M=3.95, SD=1.25) agreed that there are reliable donors and other stakeholders to the operations of our organization. This was followed by stakeholder's support organization Interests despite diversified interests (M=2.84, SD=1.49). Furthermore, resopndents agreed that the organization receives support from various stakeholders with(M=2.56, SD=1.46). This finding agrees with Mwamuye and Nyamu (2014) observe that stakeholders participate in central in the implementation of UHC projects. Oketch (2010) argues that uneven distribution of human resource adversely affects implementation of UHC.

Nanyonjo and Okot (2013) avers that challenges that influence implementation of UHC include doctors who are fewer than nurses in Uganda.

Oketch and Lelegwe (2015) also analyzed UHC and equity on health care in Kenya, relying heavily on secondary sources on the subject even though there was primary data was also collected. Original data was collected through key informant interviews with various stakeholders involved in the UHC such as policy makers, researchers and implementers. The study key findings include UHC commitment with limited health care financing, health care system dysfunctionality and little opportunities for training. The finding also reported governance concerns at NHIF, low capitation, corruption, low payout ratios, inconsistent approval of facilities, improper benefit packages among others (Okech & Lelegwe, 2015).

4.5 Hypothesis Testing

In this section, regression findings, variance analysis are presented.

4.5.1 Relationship between Independent Variables

This part presents the link between implementation of UHC and stakeholder engagement, resource allocation, and information communication technology.

Table 4. 10: Relationship Between Independent Variables

Correlations

		Implementation of UHC	Information Communication Technology	Resource allocation	Stakeholders' engagement
Implementation of UHC	Pearson Correlation	1			
	N	120			
Information Communication Technology	Pearson Correlation	.639**	1		
Resource allocation	Pearson Correlation	.380**	.364**	1	
	N	111	108	114	
Stakeholders' engagement	Pearson Correlation	.756**	.698**	.440**	1
	N	120	115	114	123

Source: Research Data (2021)

Results on table 4.10 shows positive correlation between ICT and implementation of UHC in Kibera Sub County, significant at 63.9 %. Allocation of resources of resources and UHC implementation in Kibera slums has a positive correlation at a significant 0.05 level and a strength of 38.5%. The findings continue to signify that stakeholder engagement and implementation of universal healthcare in Kibera Sub County has positive correlation between at 75.6% strong.

4.5.2 Relationship Between Dependent and Independent Variables

Table 4. 11: Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.770[a]	.594	.582	.810

a. Predictors: (Constant), Stakeholder Engagement, Resource Allocation, ICT

b. Dependent Variable: Implementation of Universal Healthcare.

Source: Research Data (2021)

Table 4.11 shows that R^2 to be 0.594 suggesting that 59.4% of implementation of universal healthcare in Kibera Sub County is explained by stakeholder engagement, allocation of resources, and ICT leaving 41.6% unexplained. Therefore, studies should be carried by future researchers to determine other factors (41.6%) that affect UHC implementation other than (stakeholder engagement, allocation of resource, and information communication technology) influencing implementation of universal healthcare in Kibera Sub County.

These results are also in tandem with Kirui (2013) who stated that, stakeholder engagement, resource allocation, and ICT offer the opportunity for a competitive edge and allocation of resources to activities to chart the organizations future growth path.

Table 4. 12: Relationship Between Independent Variables

ANOVA[a]

Model		Squares of sums	Df			Significance
1	Regression	96.849	3	32.283	49.171	.000[b]
	Residual	66.311	101	.657		
	Total	163.160	104			

a. Implementation of UHC (Dependent Variable)

b. Stakeholders' engagement, resource allocation, information communication technology-Predictors: (Constant),

Source: Research Data (2021)

Regression model was highly significant in predicting how stakeholder engagement, allocation of resources and ICT influence implementation of UHC in Kibera Sub-County ($p<0.05$).

Table 4.23 Relationship Between Dependent and Independent Variables

Coefficients

Model		B	Std. Error	Standardized Coefficients Beta	t	Sig.
1	(Constant)	.062	.622		.100	.921
	Information technology	.272	.108	.226	2.523	.013
	Resource allocation	.144	.349	.029	.414	.680
	Stakeholder engagement	.660	.105	.582	6.287	.000

a. Dependent Variable: Procurement Strategy Implementation

Source: Research Data (2021)

Stakeholder engagement has the highest positive influence on implementation of universal healthcare, followed by ICT, and resource allocation. The results suggest that ICT and stakeholder engagement were statistically significantly related to implementation of universal health care(p-value<0.05).

The study findings agree with the study by Handfield (2009) which showed that information communication technology, when integrated with procurement functions, enables many public training institutions to improve procurement effectiveness. According to Sanjeeve (2009), automated systems in, absence of e-procurement methods, unsupportive ICT infrastructure and the lack of skills in ICT impede the implementation of ICT base procurement methods. Tanzi (2009) on the other hands reported that resource allocation, stakeholder engagement and ICT play a significant role in adoption of effective strategy implementation practices.

CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This segment discusses the summary of principal findings, conclusion and recommendations is. Furthermore, the section presents the implication of the study on policy and practice.

5.2 Summary

The study examined strategic challenges in the implementation of UHC in the informal settlement in Kibera slums, Nairobi City County. The study assessed to extent information communication technology influence UHC implementation; the extent to which resource allocation affects implementation of universal health care coverage; and analyzes the extent to which ICT influence UHC implementation in Kibera slums, Nairobi City County. Below is a summary of the findings:

The results affirm that, more than half of the participants submitted that allocation of allocation influence implementation of universal health care coverage. Further, statistically there is a strong positive relationship between resource allocation and implementation of universal health care coverage ($r=0.380$, $p<0.00$). In addition to, UHC implementation are influenced by resource allocation (Mintzberg & Waters, 1985).

The process of resource allocation determines which intended initiative gets funding and is able to pass through or denied certain resources (Mintzberg & Waters, 1985). According to Bower and Joseph (1986) opines that irrespective of the strategy sources, it must flow through the resource allocation process-the filter. More than often, company's actual strategy flows through a system of new products, processes, services and acquisition

The study showed that stakeholders engagement influence implementation of UHC ($r=0.756$, $p<0.00$). Hoang, Hill and Nguyen (2018) revealed that implementation of UHC depends on stakeholder's engagement. In Zambia, a study carried out by Kapiri (2018) revealed that stakeholder's engagement produces legitimate results in implementation of UHC. Okech and Lengewe (2015) reported that continuous medical training, stock quality concerns, adequacy of health workers, health infrastructure are the main variables that stakeholders should grapple with to ensure a successful UHC implementation.

As discussed in the results section, ICT influence implementation of UHC ($r=0.639$, $p<0.00$). The hypothesis was therefore rejected since the majority of the respondents seemed to connect with ICT and the strategic issues management steps: prioritizing, analyzing and evaluating. This finding agrees with Houghton (2002) that medical experts are important players in the process of integrating information communication systems for properly providing medical services to those in need (Houghton, 2002). Their awareness on the manner information systems enhance the delivery of service with little changes and reforms in the manner they undertake daily processes (Kerry, 2007).

5.3 Conclusion

This research concludes that decision making in allocation of resource only serves critical function in UHC implementation, realign resources with the priorities of the institution and distribute resources among projects that are likely to advance the organizations priorities. Some other criteria include putting the mission of an organization central, leadership qualities, how effective and efficient allocated resources will be used and the anticipated program/initiative/project impact.

This study reports that health institutions do acknowledge the significance of stakeholders in strategy implementation. The study appreciates that they help health institutions broaden support for activities and policies; they foster strategic partnership development, help in problem solving, avert unwarranted conflict during strategy implementations and provide an opportunity to make proper decisions. Furthermore, the role of stakeholders in UHC strategy implementation in the health facilities is underscored as it has resulted into much needed support and commitment in the UHC implementation in health facilities. It has resulted into problem solving in a collaborative manner during the execution phase.

This study also shows that process of ICT integration starts after strategies are incorporated into projects. It is possible, in the long run to analyze each project and evaluate those that are related to ICT, which are in essence inputs to ICT infrastructure. In this regard, BSC is considered as an

integral concept since it appears to help in monitoring and measurement of the whole process through results of evaluation. Similarly, integration process is marked by ICT investment supported by some business strategies stemming from ESP.

The study concluded that ICT Investment costs influence implementation of UHC in Kibera Sub County. In every company, ICT is central in buttressing business process with IT so as to gain a competitive edge; only that ICT and business area must move in the same direction.

5.4 Recommendations

The hospitals should ensure monitoring and overseeing stakeholders' engagement in order to better performance outcomes. It is recommended that innovation should be done regarding systems of communication this will encourage information users flexibility in adoption of changes that facilitated strategic plans execution. Equity in resource distribution should be observed to enable workable UHC implementation. In order to ensure that strategic objectives, goals and targets are met leaders in the hospitals implementing UHC should motivate employees to ease UHC implementation.

Since ICT provides the opportunity for organization improvement, health institutions should thus allocate enough capital for investment in ICT. Even though ICT doesn't immediately reward in monetary terms, health institutions need to invest in ICT infrastructure to better implementation of UHC overtime.

5.5 Suggestion for Further Studies

The study focused on strategic challenges in the implementation of universal health care coverage in Kibera slums, Nairobi. It has explored the impact of resource allocation, stakeholder's engagement and integration of ICT. Therefore, suggests that more research on exogenous factors that include industry type and organizational environment this will expound on the influence of external factors. This suggestion is guided by the fact that an organization is influenced by both external and internal environments.

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APPENDICES

Appendix I: Research Questionnaire

Please place a tick next to the appropriate answer (as per your view). This is just for academic purposes and your views will not be used against you or deny you any services.

SECTION A: GENERAL INFORMATION

1. Gender Male [ ] Female [ ]

2. Age Bracket

a) Below 30 years [ ]

b) 30 – 34 years [ ]

c) 35 – 39 years [ ]

d) 40 – 44 years [ ]

e) 45 years and above [ ]

3. Your working experience

5 years and below [ ]

6- 10 years [ ]

11-15 years [ ]

16- 20 years [ ]

21 years and over [ ]

4. Highest level of education

Diploma [ ]

Undergraduate [ ]

Masters [ ]

PHD [ ]

5. When was your organization formed?

About 5 years ago [ ] About10 years ago [ ] more than 15 years ago [ ]

SECTION B: INFORMATION COMMUNICATION TECHNOLOGY

6. To what extent do you agree with the following statements? Key: 5 strongly agree, 4 agree, 3 undecided, 2 disagree, 1 strongly disagree (please put an X as appropriate).

Information Communication Technology	1	2	3	4	5
Inadequate adoption of ICT influences our strategy adoption					
Through communication, the workforce show awareness on job demands responsibilities and processes.					
Uncertainty when management communicates disrupts work and employees feel sidelined					
ICT keeps employees informed on the new plans and progress made in implementing changes.					
Failure to communicate with all staff during strategy implementation breeds ground for rumors and panic in the workplace.					
ICT enable keep one up to date on what is going on.					

RESOURCE ALLOCATION

7. To what extent do you agree with the following statement. Key: 5 strongly agrees, 4 agree, 3 undecided, 2 disagree, 1 strongly disagree (please put an X as appropriate).

Resource allocation	1	2	3	4	5
We face resource allocation challenges towards strategy implementation					
In my opinion resources are adequately allocated for strategy implementation					
Top leadership has provided financial and non-financial resources for plan adoption.					
The institution possesses the desired monetary ability to adopt strategies					
There is motivation by the leadership to its workforce towards enhancing results and improving strategies adoption					
There is proper management of utilities by the leadership efficiently					
The institution uses optimally the allocated utilities to attain successful strategy plan					
The institution's human resource department is made up of qualified staff					

STAKEHOLDERS ENGAGEMENT

8. To what extent do you agree with the following statements? Key: 5 strongly agrees, 4 agree, 3 undecided, 2 disagree, 1 strongly disagree (please put an X as appropriate).

Stakeholders Engagement	1	2	3	4	5
The state as well as the the public continue to support our business operations					
The institutions gets funding and support from different players					
External players complement the institution's goals despite the presence of varied interests					
Organizational interests become superior compared to external players interests					
There exists loyal funding partners and other players in the institution's operations.					

IMPLEMENTATION OF UNIVERSAL HEALTHCARE

9. To what extent do you agree with the following statements on Procurement Strategy Implementation? Key:1 strongly disagree, 2 disagree, 3 undecided,4 agree,5 strongly agrees, (please put an X as appropriate).

Implementation of Universal Health Care	1	2	3	4	5
The management ensures completion of projects in our organization.					
Lead time always influence procurement process in institution					
Having a right source allows the availability of standard products					
There's the availability of finances for the payment to suppliers in the institution					
Every year the established strategic plan is usually adopted in the institution					

Thank you

Appendix II: List of health facilities in Nairobi City County included in the study

1. Kibera DO Health Center
2. Kibera AMREF Health Centre
3. GSU Kibera Health Centre
4. Kibera South Health Center
5. Mbagathi District Hospital
6. Kenya Defense Forces Memorial Hospital
7. Kenyatta Teaching and Referral Hospital

Source: Kenya Pharmtech Community (2020)

Appendix III: Cadres of health professionals who participated in the study

1. Medical superintendents
2. Medical doctors
3. Nursing Officers
4. Administrators
5. Heads of Departments
6. Sub County Health Officer.

Source: Researcher, 2021

Appendix IV: Consent Form for the study participants

TITLE: STRATEGIC CHALLENGES IN THE IMPLEMENTATION OF UNIVERSAL HEALTH CARE COVERAGE IN THE KIBERA INFORMAL SETTLEMENT SLUM, NAIROBI CITY COUNTY

I ……. Doctor/Nurse/Head of Department/administrator at …… in…… Kibera slum do hereby freely consent/ do not consent to participate in this study.

Mr/Ms……..... has explicitly explained to me nearly everything about the study and what I am required to do. I have understood that participating in this study is voluntary and there is no coercion. I am also informed about the purpose of this study and its intended contributions.

Signature of participant

……..

Date……

Signature of researcher……...

Name of researcher/research assistant……

Date……

Appendix V: University Approval

UNIVERSITY OF NAIROBI
COLLEGE OF HUMANITIES AND SOCIAL SCIENCES
SCHOOL OF BUSINESS

Telephone: 020-8095398
Telegrams: "Varsity", Nairobi
Telex: 22095 Varsities
Our Ref: **D61/10594/2018**

Tel: 020 8095398
Nairobi, Kenya
9th February, 2021

TO WHOM IT MAY CONCERN

The bearer of this letter, **Christine N. Boore** of Registration Number **D61/10594/2018** is a Master of Business Administration (MBA) student of the University of Nairobi.

She is required to submit as part of her coursework assessment a research project report. We would like the student to do her project on **strategic challenges in the implementation of universal health care coverage in the Kibera informal settlement slum, Nairobi County.** We would, therefore, appreciate if you assist her by allowing her to collect data within your organization for the research.

The results of the report will be used solely for academic purposes and a copy of the same will be availed to the interviewed organization on request.

Thank you.

PHILIP NGIGI
FOR: DEAN, SCHOOL OF BUSINESS

UNIVERSITY OF NAIROBI
SCHOOL OF BUSINESS
09 JAN 2021
P.O. Box 30197 - 00100, NAIROBI

Appendix VI: Approval from Nairobi Metropolitan Services

NAIROBI METROPOLITAN SERVICES

REPUBLIC OF KENYA

REF: EOP/NMS/HS/116

DATE: 16TH MARCH 2021

CHRISTINE NYAROKA BOORE
UNIVERSITY OF NAIROBI
NAIROBI

Dear Ms Christine,

RE: RESEARCH AUTHORIZATION

This is to inform you that the Nairobi Metropolitan Services - Health Directorate's Research Technical Working Group (RTWG) reviewed the documents on the study titled "Strategic Challenges in the Implementation of Universal Health Care Average in Kibera Informal Settlements / Slums Nairobi County".

I am pleased to inform you that you have been authorized to undertake the study in Kibera Informal Settlements. The researcher will be required to adhere to the ethical code of conduct for health research in accordance to the Science Technology and Innovation Act, 2013 and the approval procedure and protocol for research for Nairobi.

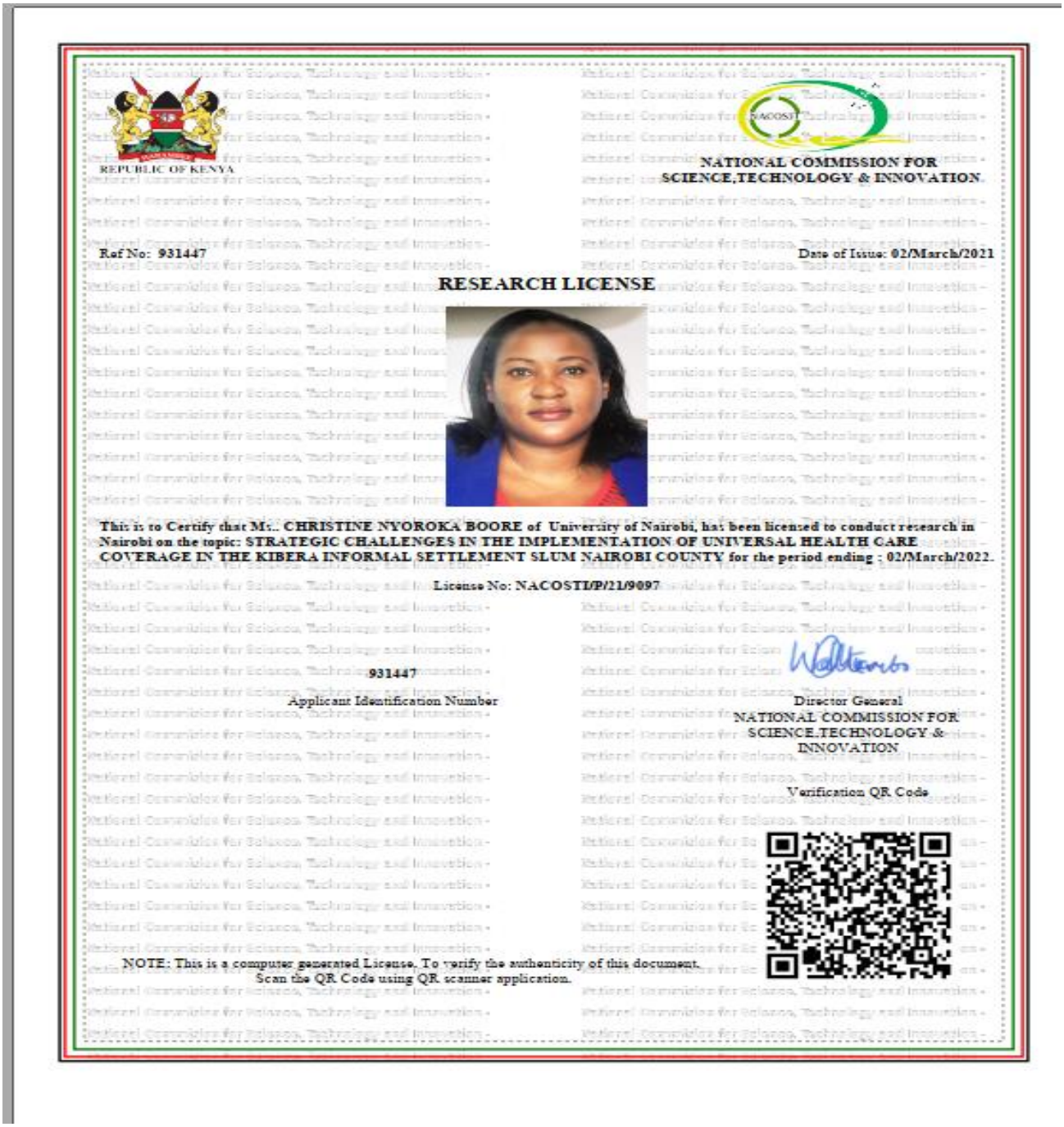
On completion of the study, you will submit one hard copy and one copy in PDF of the research findings to the RTWG. By copy of this letter, the SCMOH – Langata and Medical Superintendent – Mbagathi Hospital are to accord you the necessary assistance to carry out this research study.

Yours sincerely,

DR. OUMA OLUGA
FOR: DIRECTOR HEALTH SERVICES

Cc: SCMOH – Langata
Medical Superintendent – Mbagathi Hospital

Appendix VII: Approval from NACOSTI



REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Ref No: 931447

Date of Issue: 02/March/2021

RESEARCH LICENSE

This is to Certify that Ms.. CHRISTINE NYOROKA BOORE of University of Nairobi, has been licensed to conduct research in Nairobi on the topic: STRATEGIC CHALLENGES IN THE IMPLEMENTATION OF UNIVERSAL HEALTH CARE COVERAGE IN THE KIBERA INFORMAL SETTLEMENT SLUM NAIROBI COUNTY for the period ending : 02/March/2022.

License No: NACOSTI/P/21/9097

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Applicant Identification Number

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