A SURVEY OF THE PRACTICES AND FEATURES OF BOARDS OF DIRECTORS IN MISSION HOSPITALS IN KENYA

BY

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A MANAGEMENT PROJECT SUBMITTED IN PARTIAL FULFILMENT FOR THE AWARD OF THE DEGREE OF MASTER OF BUSINESS ADMINISTRATION OF THE UNIVERSITY OF NAIROBI

2003

DEDICATION

This work is dedicated to Jeremy my dear husband who supported me through it all and to my children Evans, Joy and Janet who sacrificed their time for me to complete my course.

ACKNOWLEDGEMENTS

Research work and thesis preparation are more than a notion - it is determination and hard work. Research and thesis writing is hardly a one person's show. It more often requires the input of others. It is a collaborative and consultative exercise. In all honest, this work would not have been possible without the input of a great team of individuals and institutions. The constraint of space, however, limits the mention of them all. Nevertheless, with the little space available I would wish to extend my sincere gratitude to my supervisor Prof Evans Aosa, who provided significant assistance both in class and in supervision. His advice was invaluable, his guidance meaningful and timely, and his patience encouraging. I am greatly indebted to him for distilling my raw ideas into a workable research.

I am indebted to Dr. Mwenda of CHAK and Mr Koskei of KES who offered immense insight concerning practical aspects of boards of directors in many Kenyan institutions. I offer special thanks to Mr. Kundu for his assistance in accessing data on hospital management. I am very grateful to the various hospital staffs who took time to update me on the latest developments in their respective hospitals and fill in the questionnaires amidst their busy schedules. I am also indebted to Bernard Wafukho and Jeremiah Omung'ala for their dedication, perseverance and hardwork in data collection.

I am greatly indebted to my employer the All Africa Conference of Churches (AACC) for the time off granted in order to finish my studies. I would also wish to thank my former employer, Maua Methodist hospital for extending time to allow me pursue this course. Without this input, this work could have at best remained a pipe dream.

Lastly special thanks to my husband and children for bearing with my long hours of absence. Their encouragement and love was a key driving force towards completion of this study. Special thanks also to my college-mates; Lilian, Njoro, Judy and Maggie who made enormous contribution towards the completion of this work possible, Mrs Mwenda who has been a pillar of strength and a shoulder to lean on when things became tough and to God for opening closed doors for me.

All in all I take responsibility for any errors and omissions.

TABLE OF CONTENTS

LOWER KABETE LIBRARY

Page

DECLARATION ---------- II
DEDICATION ---------- III
ACKNOWLEDGEMENTS ---------- IV
TABLE OF CONTENTS ---------- V
LIST OF TABLES ---------- VI
LIST OF FIGURES ---------- VII
LIST OF ACRONYMS ---------- VIII
ABSTRACT ---------- IX

CHAPTER ONE: INTRODUCTION ---------- 1

1.1 BACKGROUND OF STUDY ---------- 1
1.2 PROFILE OF MISSION HOSPITALS ---------- 3
1.3 RESEARCH PROBLEM ---------- 5
1.4 STUDY OBJECTIVE ---------- 5
1.5 SCOPE OF STUDY ---------- 5
1.6 IMPORTANCE OF THE STUDY ---------- 6

CHAPTER TWO: LITERATURE REVIEW ---------- 7

2.1 LITERATURE REVIEW ---------- 7
2.1.1 Corporate Governance ---------- 7
2.1.2 Boards of Directors ---------- 10

CHAPTER THREE: RESEARCH METHODOLOGY ---------- 14

3.1 INTRODUCTION ---------- 14
3.2 RESEARCH DESIGN ---------- 14
3.3 THE POPULATION ---------- 14
3.4 THE RESEARCH SAMPLE ---------- 14
3.5 DATA COLLECTION ---------- 15
3.6 DATA ANALYSIS ---------- 15

CHAPTER FOUR: RESULTS AND DISCUSSION ---------- 16

4.1 INTRODUCTION ---------- 16
4.2 PROFILE OF MISSION HOSPITALS ---------- 3
4.3 FINDINGS ---------- 16
4.4 DISCUSSIONS ---------- 17

CHAPTER FIVE: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS ---------- 37

5.1 SUMMARY ---------- 37
5.2 CONCLUSIONS ---------- 38
5.3 RECOMMENDATIONS ---------- 39
REFERENCES ---------- 40
APPENDICES ---------- 42
Appendix 1: The Research Questionnaire ---------- 42
Appendix 2: Mission Hospitals Operating In Kenya As At 31.12.2002 ---------- 47
Appendix 3: Research Sample List of Mission Hospitals ---------- 48

LIST OF TABLES

PAGE

TABLE. 1: CRITERIA OF HIRING TOP MANAGEMENT 26

TABLE. 2. POWER AND AUTHORITY VESTED IN BOARDS OF MISSION HOSPITALS. 31

TABLE. 3: SOURCES OF POWER AND AUTHORITY OF BOARDS OF MISSION HOSPITALS. 35

LIST OF FIGURES

Page

FIGURE: 1: CRITERIA FOR APPOINTING BOARD MEMBERS 18

FIGURE 2: NON-EXECUTIVE WOMEN DIRECTORS IN BOARDS OF MISSION HOSPITALS 19

FIGURE 3: WOMEN EXECUTIVE DIRECTORS' EXPERTISE 20

FIGURE 4 POSITIONS HELD BY WOMEN IN MISSION HOSPITALS 21

FIGURE 5: ROLE PLAYED BY BOARDS IN MISSION HOSPITALS 24

FIGURE 6 EXPERTISE CONTRIBUTED BY WOMEN NON-EXECUTIVE DIRECTORS 29

FIGURE 7: PERIOD SERVED BY BOARD MEMBERS IN MISSION HOSPITALS 33

FIGURE 8: TYPES OF BOARD COMMITTEES 34

LIST OF ACRONYMS

ACK	Anglican Church Of Kenya
ACMF	Africa Capital Markets Forum
AGC	Africa Gospel Churches
AGM	Annual General Meetings
AIC	African Inland Church
CEO	Chief Executive Officer
CMA	Capital Markets Authority
FBI	Faith Based Institutions
FBO	Faith Based Organisations
FCK	Friends Church of Kenya
ICGU	Institute of Corporate Governance of Uganda
MCK	Methodist Church Of Kenya
MOH	Medical Officer Health - Incharge
NGO	Non Governmental Organisations
OECD	Organisation for Economic Cooperation and Development
PCEA	Presbyterian Church Of East Africa
PSICG	Private Sector Initiative for Corporate Governance
RCEA	Reformed Church of East Africa
RCECG	Regional Centre for Excellence in Corporate Governance
SDA	Seventh Day Adventist
UK	United Kingdom

ABSTRACT

In today's turbulent environment the survival of organizations is dependent on the credibility and professionalism of its management. This means that, organizations that survive must be governed by people who know what the organizations are about, and have a clear vision and understanding of where they want to be in the years to come. This makes the issue of governance to be of critical importance in any type of organization. The concept of corporate governance is concerned with the way organizations are run. It primarily aims at influencing the means through which top management reach laid down company objectives. These means must be appropriate and rewarding to both the company and the immediate community or stakeholders

Many modern organisations have come to be characterized by a clear separation of ownership from control. Today, shareholders especially in large organizations have minimal influence over corporate affairs other than voting in the AGM. The boards of directors, which they elect, have come to fill this gap thereby being the link between the owners and management. Thus an organisation's chances of success depend heavily on both the quality of the board and senior management. Such boards, it is expected will practice the tenets of good corporate governance. This study seeks to carry out a survey of the practices and features of the board of directors in mission hospitals in Kenya.

The research design used in this study is the cross-sectional survey. It identifies the research population as those Christian mission hospitals affiliated to either CHAK or KCS in Kenya numbering 52 in total. It draws out a research sample by using stratified random sampling procedures to select the eventual number of 25 mission hospitals from two strata. The primary data was collected using a questionnaire administered by an interviewer. Secondary data was also utilised. Data was analysed using descriptive and inferential statistical methods.

The findings show that other bodies other than boards of directors have a profound influence on the appointment of board members and therefore direction of decision-making. The boards also lack a clear succession policy hence eroding the ability to attract good management. Women are marginalised as much as transparency is stifled. All these factors hinder good performance of board of directors in these institutions.

Even though the study had limitations such as time and financial resources among others, it proceeded to the end and recommends that empirical studies be carried out as well as formulation

of theoretical models for corporate governance as an element of mission hospitals' development in Kenya. Continuous research is necessary to chart out a proper path for corporate governance in hospitals. Apt management practises in mission hospitals need to be enhanced.

CHAPTER ONE: INTRODUCTION

1.1 BACKGROUND OF STUDY

The Global Corporate Governance Forum notes in its mission statement that: - "Corporate governance has become an issue of worldwide importance. The corporation has vital role to play in promotion of economic development and social progress. It is the engine of growth internationally, and increasingly responsible for providing employment, public and private services, goods and infrastructure. The efficiency and accountability of the corporation is now a matter of both private and public interest, and governance has thereby come to the head of the international agenda" (PSICG, 1999 P, 2)

In today's fast moving world, governments needs to rethink their role to meet the challenges posed by forces such as globalisation, decentralization, new technologies and the changing needs, expectations and influence of citizens. Good governance principles transform not only the relationship between governments, citizens and parliaments but also the effective functioning of government itself. Good, effective governance helps to strengthen democracy and human rights, promote economic prosperity and social cohesion, reduce poverty, enhance environmental protection and the sustainable use of resources, and deepen confidence in government and public administration (OECD 1999).

Over the years now and especially the late 80s and 90s many organisations have continued to evolve agents of management that ensure accountability. Such agents included shareholders, legislative codes, regulatory mechanism, social forces such as public opinions and the board. The key players identified would then be engaged in processes that seek to ensure accountability through influencing top management (Demb and Neubaure, 1992).

In Africa, the Africa Capital Markets Forum (ACMF) has been undertaking studies on the state of corporate governance on the continent. For instance the Kings Committee Report and Code of Practice for Corporate Governance in South Africa continues to enhance corporate governance in South Africa. A number of African countries have put in place national institutional mechanisms to promote good corporate governance (PSICG 2002).

In East Africa there have been conferences in the three countries to create awareness and promote regional cooperation in matters of corporate governance. The member countries were challenged to develop a framework and code of best practice to promote national corporate governance and

harmonise the same in the region. As a result, Uganda established the Institute of Corporate Governance of Uganda (ICGU). The Private Sector Initiative for Corporate Governance (PSICG) of Kenya in liaison with Uganda and Tanzania seeks to establish a Regional Centre for Excellence in Corporate Governance (RCECG). In Kenya, there have been various consultative corporate sector seminars among them one that resolved the formation of PSICG.

It has always been assumed that health institutions as other corporate entities will subscribe to the principles and practices of good corporate governance. The principles themselves as developed by PSICG are neither prescriptive nor mandatory. They are designed as a basis to assist individual organisations to formulate their own specific and detailed codes of best practice. They are also expected to excite and stimulate discussions on good corporate governance and result in further development of better practice and procedures. They are assumed to have succeeded if each entity will examine its own governance practice and makes relevant improvements (PSICG, 1999).

With this phenomenon, many modern organisations have come to be characterized by a clear separation of ownership from control. Consequently, shareholders especially in large organizations have minimal influence over corporate affairs other than voting in the AGM. The boards, which they elect, have come to fill this gap thereby being the link between the owners and management. An organisation's chances of success depend heavily on both the quality of the board and senior management. When faced with strong competition an organisation will be at risk if either its directors or senior management are not capable persons (Drucker 1974).

Before the turn of the last century institutions whose ownership and control were embodied in the same individuals dominated organisations. By 1932, ownership had become so dispersed that control had shifted from owners to managers (Berle and Means 1932). From that period onwards the emerging scenario demanded an accountable system of monitoring the management processes. The development of company ownership and management over time fuelled further the need for boards. The fact that a company became a distinct entity in society with its own personality and identity different from the owners required a separation of functions (Houlden, 1996).

Drucker (1974) notes that around the 70s, regardless of their legal position, all boards had one thing in common. They did not function! During this time, the decline of the board of directors became a universal phenomenon. It is clear that the steady decline of the board has surely been

due to the fact that top management, by and large, does not want a really effective board. An effective board demands top-management performance and removes top executives who do not perform adequately – this is its duty. An effective board, in other words, insists on being effective. And this, to most top managements, appears to be a restraint, a limitation, an interference with "management prerogatives," and altogether a threat (Drucker 1974).

The demand for enhanced corporate governance has seen the resurgence of boards of directors as agents of effectiveness. Boards are now perceived as representatives of shareholders. However contemporary writers, point out that this trend has changed over the years and currently the board represents an array of other stakeholders. It is in light of this representative position that the board acts as a governance organ. In this respect the board is concerned with its primary task to ensure responsible company behaviour and governance plus the achievement of common goals (Andrew 1987, Newman, et al, 1989).

1.2 PROFILE OF MISSION HOSPITALS

The health sector like any other sector in Kenya has been experiencing hard times in the last decade or so. This is mainly due to hard economic times facing the country and other forces such as changes in technology, liberalization, changing needs and expectations of patients, rising levels of poverty, poor infrastructure etc. All these changes have made it hard and very expensive to deliver health care in the country.

The government of Kenya caters for 60% of health care delivery while 40% is shared between the church owned health facilities and the private health units. The church owned health units are under the umbrella organizations of Christian Health Association of Kenya (CHAK) and Kenya Catholic Secretariat (KCS) whose role is to facilitate the role of the church in health care delivery in Kenya. The church health units comprise of 52 hospitals, 113 health centres and 480 dispensaries. This is a total of 645 health units, which are more than 50% of the non-government health facilities (CHAK, 2001).

Missionaries started most of these hospitals in early 20th century of which the majorities have been and still are being managed by these missionaries. The hospitals were started to provide health care to the poor and the under-served in the rural areas. Indeed over the years the contribution to health care by the church owned units has grown into wide network covering almost all the districts in the country.

These hospitals have been surviving on donor funds raised mainly by the missionaries. This has enabled them to give almost free medical care to their clients. However from the last decade or so the donor support has been on the decline making sustainability of these hospitals very difficult. On top of that the management of these hospitals is mainly based on the church structure style and practices. The historical development ensured structures and systems for spiritual development is usually well founded but that those for education and health lagged behind. Management structures in those hospitals mainly revolve around the spiritual leader, rather than professional management concepts.

Some of the hospitals have been closed down due to poor management e.g Kaimosi School of Nursing and Gao Methodist Hospital. Others like Maseno Mission Hospital are experiencing hardship dues to lack of proper management. Tumutumu PCEA Hospital was closed and later reopened under new management. Also a study done on 13 mission hospitals showed that, only 2 out of 13 had a business-oriented approach to management. That is they have a strategic plan and the structures and systems are formalized and open. 6 hospitals had traditional or classical church type, which lean more to the spiritual leader. In most cases these leaders have no time for the hospitals leaving the running to unqualified lay administrators. This has been responsible for weak health service administration and poor financial performance of the institutions. The rest of the hospitals have a quasi-traditional structure, characterized by very poor management structures and systems. The leadership was dogmatic, personalized and charismatic (CHAK, 2001). Little has been documented about the activities of the board of directors in mission hospitals. This therefore shows there is need to document the role of the board of directors as corporate governance agents in these institutions, as their importance in the society cannot be underscored.

1.3 RESEARCH PROBLEM

Failure of many organisations is attributed to non-performance of their respective boards. The frequent collapse of financial institutions (mainly commercial banks) in Kenya in the 1990s was blamed on incompetence and laxity by their respective boards, which did not know the performance of institutions they presided over. Boards were always the last organs to reckon that their organisations were in the red. Boards of directors have therefore become important agents in addressing issues of corporate governance in institutions (Andrews (1987), Lorsch (1995), Salmon (1995) and Demb and Neubaure (1992)).

Many mission hospitals have performed poorly in their management decision-making processes. They have not adequately balanced corporate governance and resource allocation. The net result of this failure has been the collapse of otherwise well meaning Christian health institutions. There have been competing interests from the mission agencies, the local people and the powerful political structures, which have not been well handled by hospital boards leading to plunder and destruction of resources meant for improving health conditions of the poor communities.

These challenges prompt this study to ask searching questions such as; how are hospital boards constituted?; what is the nature of boards membership?; what are the functions of such boards?; and how much power and authority is vested in such hospital boards?.

1.4 STUDY OBJECTIVE

This study's main objective is to assess the practices and features of boards of directors in mission hospitals in Kenya.

1.5 SCOPE OF STUDY

The study will cover the five major areas of the board's functions. These are; strategic planning, succession planning; monitoring and supervision of top management; resource allocation and lastly the care of shareholders interests. It also looks at the main features of the board in terms of size, structure, composition and committees. The study covers mission hospitals in Kenya.

1.6 IMPORTANCE OF THE STUDY

A survey of the performance of boards of directors in organisations and in particular mission hospitals is critical in the assessment of the performance of organisations and especially their boards. A study of mission hospitals boards is significant in the sense that it helps one appreciate the dynamics of communities in articulating their interests vis a vis the interests of supporting mission agency. This study is intended to benefit the mission hospitals in Kenya to improve their boards, management and to help plan for effective medical service delivery in order to meet their mission. It will assist scholars interested in studying corporate governance in general and its practice among mission hospitals in particular. The study will also provide hospital entrepreneurs with current information that could be useful in making investment decisions.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter evaluates what past researchers have contributed that is relevant to the current study with a focus on boards of directors especially in Mission Hospitals, as well as pointing out the weaknesses of past researchers with a view to suggesting possible remedial measures. It also isolates gaps that were left by past researchers, and offers possible ways of filling them.

2.2 Corporate Governance

Corporate governance has been defined as the system by which business corporations are directed and controlled. The corporate governance structure specifies the distribution of rights and responsibilities among different stakeholders in the corporation such as the board, shareholders, employees, managers and other stakeholders, and spells out the rules and procedures for making decisions on the corporate affairs. By doing this, it provides the structure through which the company objectives are set and the means of attaining those objectives and monitoring performance (OECD, April 1999).

The unification in operation of the various levels of management and the resulting harmonious and non-conflicting existence has largely come to embody the principles of corporate governance and management. In recent times, corporate management has emerged as a concept that implies all systems working together in a symbiotic manner to achieve unified goals of an organisation. The Capital Market Authority (CMA) has developed guidelines for good corporate governance practices by public listed companies. This is in response to the growing issues of governance both in developing economies and for promoting domestic and regional capital markets growth (PSICG 2002).

Corporate governance is thus concerned with the processes, systems, practices and procedures i.e. the formal and informal rules that govern institutions, the manner in which these rules and regulations are applied and followed; the relationships that these rules and regulations determine or create; and the nature of those relationships. Essentially, governance addresses the leadership role in the institutional framework. Corporate governance, refers to the manners in which the power of a corporation is exercised in the stewardship of the corporation's total portfolio of assets

and resources with the objective of maintaining and increasing shareholder value with the satisfaction of other stakeholders in the context of it's mission. It is the process that promotes corporate fairness, transparency and accountability (PSICG, November 1999).

Good corporate governance ensures that long term strategic objectives and plans are established, and that proper management and management structures are in place to achieve those objectives. At the same time making sure that the organisation's structures function to maintain its integrity, reputation and accountability to its constituents. The right systems of checks and balances should be the basis of merit for any corporate governance system.

It is asserted that good corporate governance helps to promote efficient, effective and sustainable corporations that contribute to the welfare of society by creating wealth, employment and solutions to emerging challenges; responsive and accountable corporations; legitimate corporations that are managed with integrity, probity and transparency; recognition and protection of stakeholder rights; an inclusive approach based on democratic ideals, legitimate representation and participation (PSICG, 1999).

Moreover, good corporate governance helps to find appropriate mechanisms for governing the relationships of stakeholders groups with the company so as to generate long-term value. This reduces the conflict of interests between various stakeholders and especially between the owners whose major interests is maximization of wealth and management whose interests are high salaries, bonus, status etc (PSICG, 1999).

Corporate governance also ensures that there is proper distribution of power and that the power is exercised in the best interests of the society. This ensures that there is no misuse of power by those entrusted in running the organizations.

In its governance responsibilities, the boards perform various activities. These activities produce a healthier organisation by helping management to stay focused on business requirements while at the same time containing irresponsible management behaviour (Cadbury, 1995). Many writers emphasize the following five broad activities as the ones contributing to good corporate governance; strategic planning; succession planning; allocation of resources; monitoring and evaluation of top management's performance; and; caring for shareholders.

To be successful, a company needs leadership. Leadership is a complex factor involving enthusiasm and drive balanced with wisdom and good judgment. The selection of a Chief Executive (CEO) is one of the most important decisions a board of directors makes. Not only does a chief executive have an enormous impact on the fortunes of an organization but the very process by which the executive is picked influences the way employees, investors and other constituents view the company and its leadership (Khurana et al, 1999). In regard to mission hospitals, this study endeavours to understand the role of boards in the selection process of CEOs (Chief Executive Officers), a factor that has a bearing on the overall performance of mission hospitals they preside over.

Salmon (1995) also asserts that if the board does not dominate the process of selecting the chief executive, then the incumbent CEO will want to ordain a successor in his own image. It is therefore up to the board to ensure that the process of selecting a CEO is rigorous, careful and perhaps most important – defensible. It is more so in non-profitable organizations such as the hospitals where in most cases the Chairman and the Chief Executive are different. The two must be able to manage their relationship well to avoid conflicts (McFarlan, 1999).

This practice has developed out of the conventional wisdom that, setting a practical and meaningful cause for any business requires listening to the objectives and concerns of the owners. Failure will lead the organisation to expose itself to corporate raiders. Put differently the board represents the wishes and desires of the shareholders and is at all times answerable to the company owner (Thompson, 1993, Johnson & Scholes, 1999).

A committee is a special task force that has been formed to perform certain duties. It consists of members drawn from the full board and as such has fewer members than the board. One advantage of the committee is that they are able to meet more regularly and to engage in speedy deliberations. The disadvantage is that if not checked they can usurp the role of the board. Examples of board committee include audit, finance, nomination, and remuneration (Drucker, 1998). Many mission hospitals have these committees and more often the Finance Committee appears to run the show, sometimes with devastating consequences.

The issue of governance permeates all kinds of organizations. That is from large to small organizations irrespective of industry. This means that, whether the organization is state owned, non-governmental, private or public, profit or non-profit, the issue of governance is of equal

importance to each. At the same time, one notes that corporate governance is not a "once size fit all" proposition, and therefore a wide diversity of approaches to corporate governance should be expected and is entirely appropriate. Moreover a corporation's practices will evolve as it adapts to changing environments (PSICG, 2002). In regard to mission hospitals this becomes a critical consideration given the differences in faith by the various mission agencies. The AIC for instance have a different approach in comparison to the Catholics and Anglicans.

2.3 Boards of Directors

The board of directors has for a long time been associated with four main features, which are listed below; size, structure, composition, and committees. Size refers to the total number of directors appointed in a particular board. According to Salmon (1995), an effective board should have not less than 8 and not more than 15 members. Drucker (1998) states that in non-profit making organizations the number of board members can be too big running to even 100 members. This is because board members are appointed from different interest groups who have a share in the organization, which makes these boards more complex than those in profit-making organizations. In mission hospitals, there is no standard number of board members. However, on many occasions, interest groups may as well exceed 15.

Structure is the style that governs board sitting. These are two types of boards. That is, one-tier board mostly found in UK, US or Kenya. In this kind of board, the outside or non-executive directors carry out the supervisory tasks of the board. The other type is the two-tier board mostly found in Continental Europe. In this type of board there are actually two boards, an executive board and supervisory board. The supervisory acts as a watchdog over the company executives (Salmon 1995, Dimsdale and Prevezer, 1992). This study undertakes to show the common structure of boards in mission hospitals and the resulting effects on management's performance.

The composition of the board is simply the presence of both executive and non-executive directors. The calibre and number of outside directors on the board should be such that their views carry significant weight in the board's decisions. They should bring independent judgment to bear on company standards and conduct. The role of the CEO and the chairman of the board should also be considered an issue in the process of composition and composition itself. An effective board should have a proper balance between the executive directors and non-executive directors (Newman, et al, 1989 Cadbury, 1995).

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As mentioned, the central function of a working board is to review the management's formulation and implementation of strategy. Strategic planning can be used as a tool for formulating mission, vision, values, goals, objectives, roles and responsibilities as well as timeliness among others. While sometimes these functions are delegated to top management, it is important that the board of directors understands them since they form a basis for assessment of the implementation of corporate strategy and the overall performance of the organisation.

Boards of directors should be aware of their organisations strategic plans since the conditions under which they exist are fast changing and thus unpredictable. The board should be able to; review and evaluate present and future opportunities, threats and risks in the external environment and current and future strengths and weaknesses relating to the organisation; determine strategic options, select those to be pursued, and decide who should implement such and support them; determine the organisation's strategy and plans that underpin the corporation and; ensure that the organisation's structure and capability are for implementing the chosen strategies.

Boards are expected to set key governance parameters in organisations. Some contradictions however arise in some mission hospitals where the supporting church hierarchically sets and controls policies thus making boards mere rubber stamps. This is common where development and operation resources (funds) emanate from a central source thus fulfilling the adage "he who pays the piper calls the tune". This study seeks to affirm the independence of boards in such circumstances. Many mission hospitals were conceived not by the local (environment) forces but rather an external demand driven by forces partially emanating from outside the point of hospital location. More often, the local congregation in such cases does not call the shots even though they may be adequately represented in the boards. The one who calls the tune would likely be an external force super-riding the board. This particular aspect is critical to this study in which hospitals faces forces that emanate from the external environment (PSICG 1999).

The board of directors should watch over the performance of CEO and top management and make a distinction between performance and mediocrity. As Andrew (1987) puts it, a working board will not only actively support, advice and assist management but also will monitor and evaluate management's performance in the attainment of planned objectives. Boards are now expected to exhibit in decision-making behaviour, their responsibility for legality, integrity and ethical quality of the corporation activities and financial reporting, and their sensitivity of the interest segments

of society legitimately concerned about corporate performances. This involves board scrutiny of the audit reports and the overall budget, not merely endorsing what the management team proposes as is often observed in hospital AGMs.

The need for the board to review company spending has developed out of reality that misuse of funds more often than not takes place. For genuine audit the board should appoint the auditors and not the management. At the same time the board should establish an audit committee with a majority of independent outside directors. This committee would offer the auditors a direct link with the outside directors enabling those directors to play a positive role in an important area of the boards work (Cadbury 1995).

The board's attention should be on the bigger picture and the willingness to adapt to changing circumstances that may entail formulation of the organisation's future mission in light of changing external factors such as regulation, competition, technology and customers. Since strategic planning process in itself is not a typically smooth flowing process, it requires creativity and fresh insight. A board with diverse background in terms of education, skill, age, gender and experience is better placed to give good results.

Drucker (1974) notes that the alternative to top management's developing an effective board for its own needs and those of the enterprise is the imposition by society of the wrong kind of board, especially on the large corporation. Such an imposed board will attempt to control top management and to dictate direction and decision. It will indeed become the "boss". It must consider itself an adversary of top management. It will not, indeed cannot, act in the interest of the enterprise. While Drucker is right in some sense in that some boards, depending on how they have been constituted have a tendency to become dictatorial. With the emergency of demands for corporate governance, many boards, that are well constituted provide room for growth as well as attain good corporate governance goals.

The malfunction of the board first became apparent in the German of the Weimar Republic. And it is Germany also where the first outside control has been imposed on the boards of large companies, in the form of "co-determination," that is, of legally required worker representation on the board, first for companies in the coal and steel industries and then for all large businesses. Of course, no worker representative sits on German company boards; the members are trade union officials. But this does not alter the fact the large-company board in Germany today has become a

battleground for contending factions. It will be interesting to establish how this position varies here in Kenya (Drucker, 1974).

A different development, but one pointing in the same direction, is under way in Sweden, where government now appoints members to the boards of the major banks. So far, people of stature and known integrity have been selected by and large. But once there are political appointees on the boards of individual companies, politics cannot be kept out of such appointments for very long. As soon as this happens, the board ceases to be able to work effectively as the review organ, the confidant, the advisor, and guide of top management. It becomes a regulatory, an adversary. (Sweden, since 1972, also requires that employee representatives be elected to the boards of large companies, including banks).

In the 1970s, there was mounting pressure in the United States to make boards "relevant" that is, to appoint as board members representatives of all kinds of groups: Black, women, the poor and so on. These appointees, no matter how distinguished the individual, cannot function as board members. Their role is to represent this or that outside group, this or that special interest. Their role must be to make demands on top management and to push special projects, special needs, and special policies. They cannot be concerned with, or responsible for, the enterprise. Nor should they be expected to hold in confidence what they hear at board meetings; their trust is not to the enterprise but to their constituents outside (Koontz, 1965).

This development demonstrates that society will not allow top management, and especially top management of large and visible businesses, to exercise its power without an appropriate and effective board. The board, as it has been conceived originally well over a century ago-has indeed outlived its usefulness. This, however, makes it an urgent top-management job to think through what kind of a board the enterprise and its top management need. The decay of the traditional board has created a vacuum. It will not remain unfilled.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter explains how the survey was undertaken. It also highlights research design, data sources and procedures in data collection and the analysis of research data.

3.2 RESEARCH DESIGN

The research design used was the cross-sectional survey. This is because primary data was collected by way of a questionnaire. The survey has been used in similar studies such as Aosa (1992), Karemu (1993), Wambua (1996) and Kiruthi (2001). The survey method is appropriate because data on the same items can be collected across several organizations. It is preferred in this kind of study because the population is large covering most parts of the country and also because it's economical.

3.3 THE POPULATION

In this study, the population was taken as all mission hospitals existing and functioning in Kenya and have both in-patient and outpatient facilities. The 'population' is thus a complete set of counts derived from all objects possessing one or more common characteristics, in this case being mission hospitals with In and Out Patient facilities. Such mission hospitals must ascribe to the Christian faith. They largely fall into two categories namely; The Kenya Catholic Secretariat (KCS), and; The Christian Health Associations of Kenya (CHAK). Based on this classification there are 52 such mission hospitals in Kenya (appendix 2). It is from this population that the research sample was drawn.

3.4 THE RESEARCH SAMPLE

All the mission hospitals in Kenya formed the population of the study. There are 52 mission hospitals situated all over the country and all of them were contacted. As expected with most studies of this nature, not 100% of the targeted population responded. This was in conformity to other studies (Aosa, 1992, Wabua, 1996, Karemu , 2001). Though a sample of thirty was targeted only 25 responded (see appendix). Those that responded were classified into two strata of the Kenya Catholic Secretariat (KCS), and; The Christian Health Associations of Kenya (CHAK) due to their different management structures.

3.5 DATA COLLECTION

Both primary and secondary data were collected. Primary data was collected from the field i.e mission hospitals. A research questionnaire was designed as a tool for collecting raw field data. Questions were designed to suit the required information in conformity to the stated objectives and nature of the survey. The questionnaire was preferred (appendix 1) since it affords personal contact with the interviewee: - a factor that establishes better communication and elaboration of aspects otherwise not well understood. Moreover, with a questionnaire, when an interviewer seems to overwhelm the interviewee, caution is exercised to prevent biased and incorrect answers. Personal questionnaire administration was also chosen as a means of reducing the problems of low response common with using other forms of data collection and administration tools that include postage of recording schedules.

In addition during the administration of the questionnaire, the interviewer is enabled to seek elaboration and expansion of issues that the recording schedule fails to address. Interviews were restricted to hospitals' management staff thought of having relevant information on the subject matter. Such staffs include; matrons, hospital supervisors, administrators and doctors (MOH) depending on the structure of the hospital in question. Summary notes were taken and later transferred into more readily usable information.

3.6 DATA ANALYSIS

Data collected in the field was then summarised into tables thus eliminating problems associated with analysis of raw unsorted data, which more often gives discordant results. In data analysis, descriptive and inferential statistical methods have been used in facilitating presentation of summarised data; enabling assimilation of data and; providing a quick comparison between different sets of raw data.

CHAPTER FOUR: RESULTS AND DISCUSSION

4.1 INTRODUCTION

This chapter presents the findings of the survey and the discussions thereof on the principles, practices and features of boards of directors in Mission Hospitals in Kenya.

4.2 FINDINGS

4.2.1 Board Composition

It has been observed that the mission secretariat, local church councils and special delegates conference both in KCS and CHAK affiliated hospitals have a profound influence on the appointment of board members, suggesting that the wishes and aspirations of the mission agencies/church were observed other than quality of the members.

The survey also establishes that only a few hospitals chose their members through AGMs. In most mission hospitals where there are no key shareholders but rather stakeholders such as a mission agency or church, it is difficult for the board to have a strong say in the management of the hospital. In such circumstance, this study attempts an understanding of how the different organs in a hospital set-up generate corporate balance (PSICG, 1999).

Also a significant proportion (55%) of mission hospitals do not have women executive directors. On boards where they are represented it is easy to note that it is only one or two women executives. Such women director's contributions were mainly in the medical field and precisely nursing.

4.2.2 Board Size

Most boards were also found to have more than ten members sitting in as board members. They thus strived to meet the legal conditions set by the government. They also served within the specified period before presenting themselves for re-election or re-appointment.

4.2.3 Strategic Planning

The study also shows that only a few boards of mission hospitals actively participate in strategic planning. Consequently the boards have a weak commitment to balance both short-term and long-term goals in a bid to mould the future.

4.2.4 Succession Planning

It is also shown that a significant percentage of mission hospitals do not have the succession policy in place. This erodes their commitment to the practice of succeeding CEOs with competent ones in a transparent manner. Most hospitals lacked procedures for the selection and removal of individual directors. Their ability to define limits of authority of the CEO and other top executives is questionable.

4.2.5 Power and Authority of Boards

A high percentage (89%) of boards of mission hospitals were vested with authority to hire and fire top management team. They also reviewed the performance on top management on a regular basis. Besides they approved the use of hospital resources. The limit of their power and authority converged at their mission agencies/churches, since the boards had to report to them.

Boards of most mission hospitals derived their power and authority from a myriad of sources. This made them susceptible to management inefficiencies thus paving way for proliferation of institutions without proper planning and infiltration by individuals who enjoy clout and who seek to satisfy their selfish schemes.

4.3 DISCUSSIONS

The results of the analysed research data reveal a number of issues that significantly relate to mission hospitals' boards vis a vis their membership, functions and the magnitude of power and authority vested in them. A preliminary explanation of variables based on the descriptive statistics and non-parametric correlation is discussed below.

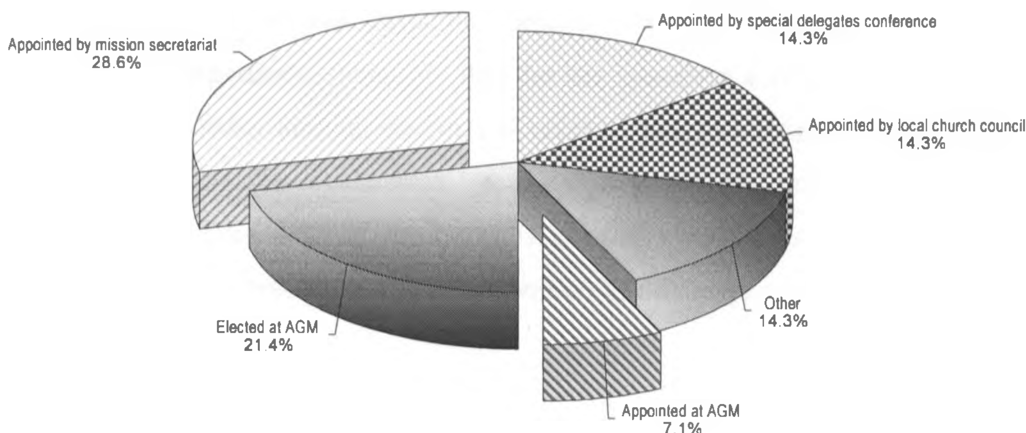
Features of the board

Board Composition, Size, Age, Gender and Education

The findings of the survey show that the way in which Mission Hospitals' boards are constituted plays a pivotal role in determining how efficient and effective the hospitals are run. As figure 1 indicates, 28.6% of the board members in hospitals affiliated to both KCS and CHAK were appointed by their specific mission agencies. Such a scenario suggests that the wishes and aspirations of the church mission agencies carry the day, casting doubt on the implementation of

principles of good corporate governance. One of the principle dictates that appointments to boards should, through a managed and effective process, ensure that a balanced mix of proficient individuals is made and that each of those appointed is able to add value and bring independent judgement to bear on the decision-making process.

Figure: 1: Criteria For Appointing Board Members



Source: Research Data 2003

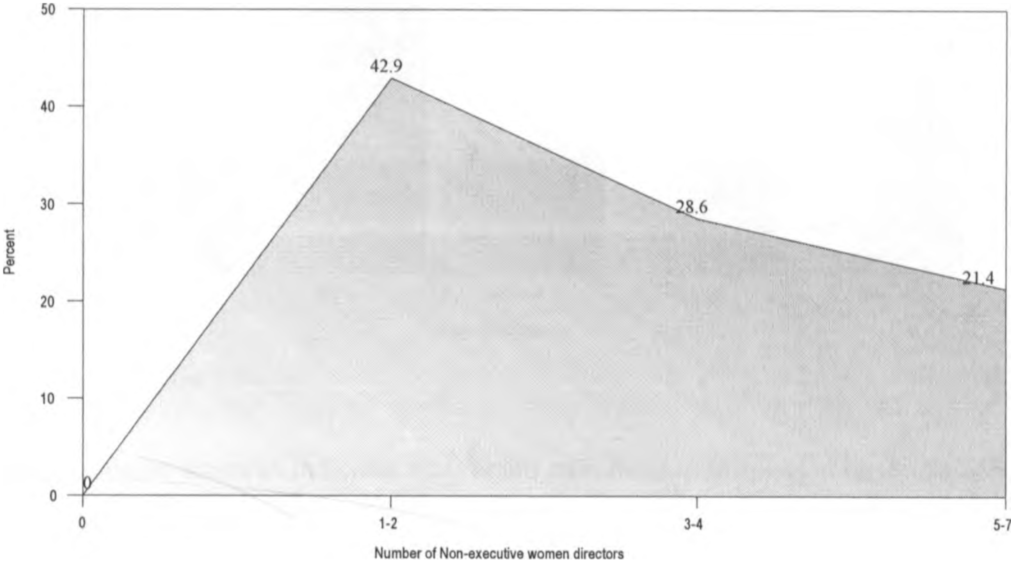
The implementation of this principle in some of the mission hospitals looks remote as the church/mission secretariat *perse*, which is the appointing body of boards, did not have the capacity to freely and fairly make appointments. The Mission Secretariats seems to lack independent Nomination Committees, which are to be charged with the responsibility of establishing transparent search mechanisms that would attract the very best candidates, hence the development of a pool of very qualified prospective directors. Appointments made out of prejudice or bias more often than not take centre stage, posing a great threat to apt management practices in these health institutions.

Nevertheless, as figure 1 shows, 21.4% of the board members' appointments in both of the two categories of KCS and CHAK affiliated hospitals were elected at AGMs. This scenario depicts stakeholders who jointly and severally protect, preserve and actively exercise the supreme authority of the hospitals in general meetings. They ensure that only competent and reliable persons, who can add value, are elected to the boards. Moreover, they ensure that the board is constantly held accountable and responsible for the efficient and effective governance of the

hospitals so as to achieve corporate objectives, prosperity and sustainability. Additionally, they can change the composition of a board that does not perform to expectation or in accordance with the mandate of the hospital. Such democracy should be encouraged in mission hospitals to negate imposition of directors who are deemed to be a stumbling block to the betterment of mission hospitals, especially as far as management issues are concerned.

On the issue of membership, the survey reveals that all the mission hospitals had a board consisting of more than ten members, with 28.6% having one to two executive directors, another 28.6% having three to four executive directors and 42.9% having five to seven executive directors. It is important to point out that the law conceives a board of directors as a collective agency acting together through meetings in order to take account of, and hence help remove, the harmful effects of the weaknesses, excesses, madness of sinfulness of individuals. Good corporate governance practice recommends at most eleven directors for any public entity to facilitate maximum efficiency and effectiveness. In this respect, the surveyed mission hospitals adhered to this practice.

Figure 2: Non-Executive Women Directors In Boards Of Mission Hospitals



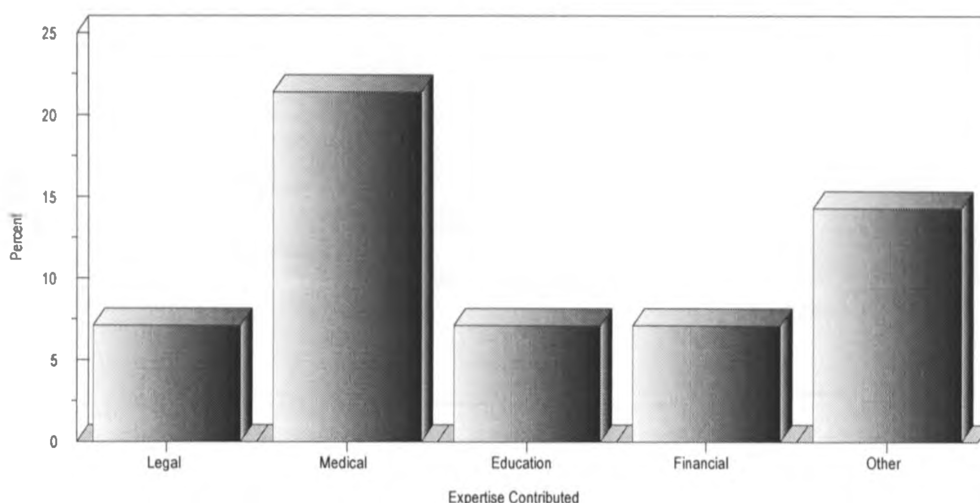
Source: Research Data 2003

In regard to age, most of the mission hospitals' boards had members whose age ranged between forty to fifty nine years. This is a welcome move since it depicts a group of people who have energy, skill, knowledge and experience. This allows them to add value that necessitates independent judgement on the decision-making process. Mission hospitals are thus seen as

guarding against senility, which comes with a plethora of issues, most of which are beyond commonplace solutions. More so, they are seen as abiding with the law which demands that disclosure should be made to stakeholders at an annual general meeting and in annual reports of all directors approaching their seventieth birthday that respective year. This is so because re-electing them is not encouraged.

Concerning gender balance, out of the total number of Mission Hospitals surveyed, 42.8% did not have women executive directors. Of the remaining 57.2%, 42.9% had between one to two executive women directors and 14.3% had between three to four. Additionally, as fig 2 depicts the highest number of non-executive women directors in the boards of mission hospitals was between one and two accounting for 42.9% of the mission hospitals surveyed. Their contribution was mainly legal and financial.

Figure 3: Women Executive Directors' Expertise



Source: Research Data 2003

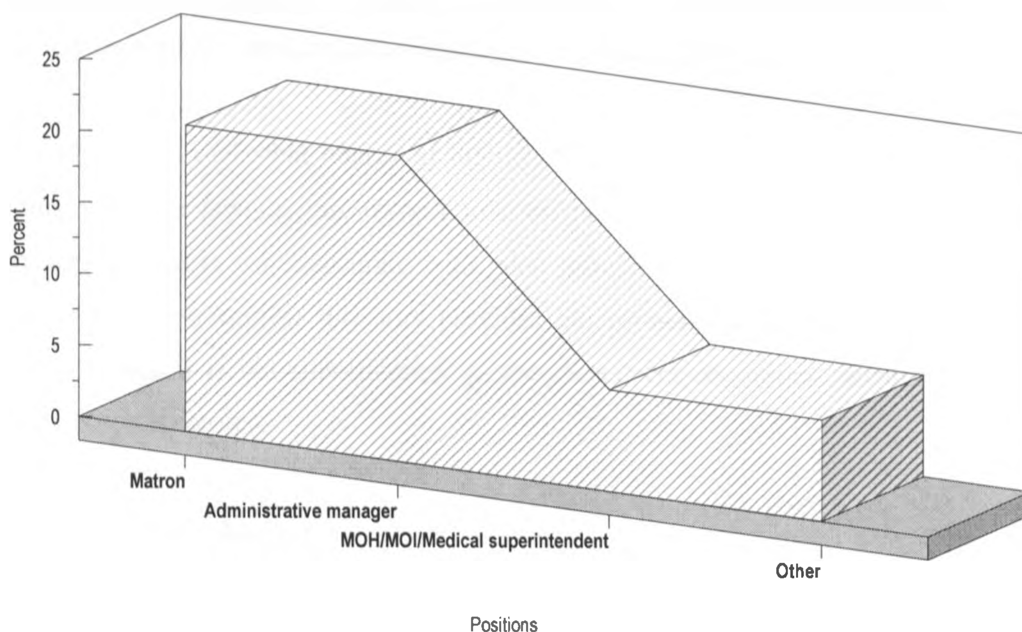
Thus, the above scenario indicates that; board membership in mission hospitals is a preserve for men. This insinuates that women's contribution towards management issues is relegated to a secondary place. As Fig 3 indicates, their substantial contribution, which is medical expertise, only accounts for 20% of the total expertise enshrined in these boards. Further, as Fig 4 points out, this expertise is effected through the functions of hospital matron.

Such a set up casts doubts on the ability of these boards to effectively tackle management issues especially where women related issues are concerned. A good composition of the board should

take into account gender balance, geographical distribution; ethnicity, age, occupation, experience, and education of all directors. Such a balanced board ensures that the wishes and aspirations of all stakeholders are taken into account without compromising performance.

Based on what is gathered from the survey, a good composition of the board seems to be a remote practice in most of the mission hospitals. A factor, that allows permeation of unrealistic and elusive objectives and goals.

Figure 4 Positions Held By Women In Mission Hospitals



Source: Research Data 2003

A good composition of the boards should take into account education of all directors. From the ensuing, 22.2% of the board members in KCS affiliated mission hospitals had college degrees. This was the highest level of academic qualification attained. Similarly, 20% of the board members in CHAK affiliated mission hospitals had attained the same. The least attained academic qualification in the hospitals surveyed was a high school certificate. This points to the fact that boards of mission hospitals have personnel who exhibit the required mix of skills that befit a board. Such skills include sound business judgement and acumen, integrity, general knowledge, common sense, breadth of vision, independence of thought, ability to work harmoniously within the board team, time to devote to the entity, ability to add value to the organization, and knowledge of government policies.

An example of the way some of the afore mentioned skills have been exhibited by boards in mission hospitals is the establishment of board Committees. This is an aspect of breadth of vision. It was therefore deemed prudent to call in other competent personalities to assist. The survey reveals that the entire CHAK affiliated mission hospitals had board committees and at least 90% of KCS affiliated ones. These board committees had non-executive directors. Their contribution were mainly medical, personnel and financial. Such a set up suggests that mission hospitals' boards delegate responsibilities for scrutiny, enabling the non-executive directors to contribute an independent judgement and play a positive role in areas they are experienced. The appointment of such board committees is therefore an important step in raising standards of corporate governance, and enhances healthy management practices.

The study also reveals that boards of mission hospitals had non-executive directors. This is in keeping with the law. In this respect mission hospitals are seen as upholders of the law, a characteristic that is commensurate with good principles of corporate governance. In addition, inclusion of non-executive directors provides independent judgement, outside experience and objectivity, which is not subordinated to operational considerations. Such a trait is critical in mission hospital set-ups.

Functions of the board

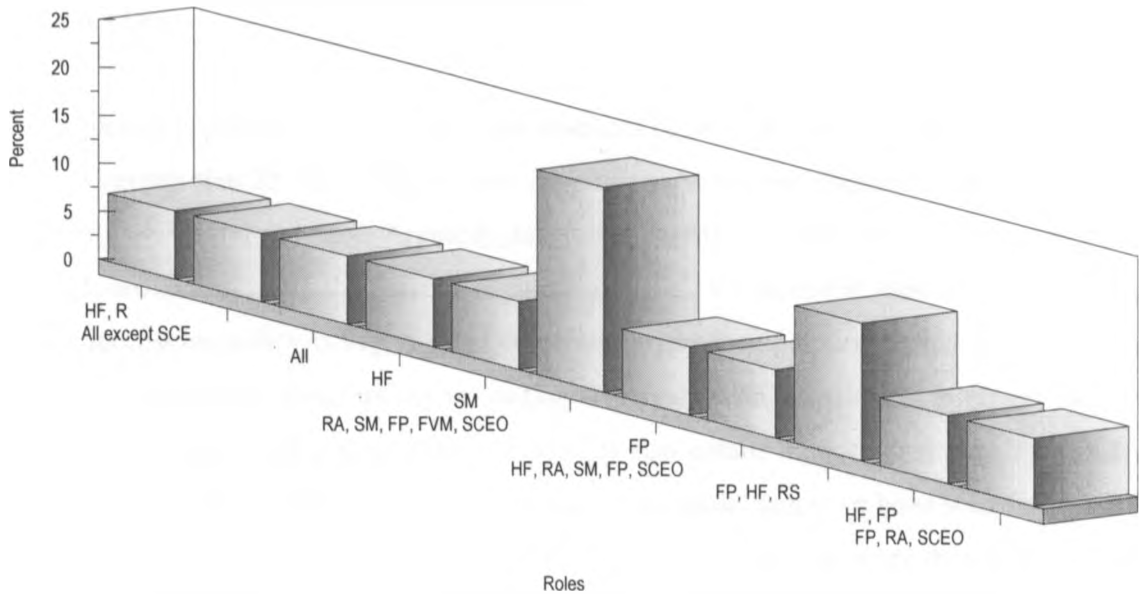
Functions of boards are an important aspect of any firm. They define the path to be followed by all players in the firm or an organisation. Malfunctioning boards are known to have caused their organisations irreparable damage, an anomaly that could otherwise have been avoided.

Strategic Planning

On the issue of Strategic Planning, the participation of boards in their formulation is a welcome strategy. We note that 70% of the total mission hospitals surveyed had boards and the management teams as main participants in the formulation of these plans. Boards have no choice but to anticipate the future, to attempt to mould it, and to balance short-range and long term goals. It is therefore important that such difficult responsibilities are not overlooked or neglected but taken into consideration. The future will not just happen if one wishes hard enough. It requires decision, it imposes risks, it requires action, it demands reasonable allocation of resources and hard work. Thus for boards and the management teams to come and integrate such issues into a

one unified plan of action nullifying guesses and misdirection is a credit to the management of mission hospitals.

Figure 5: Role Played By Boards In Mission Hospitals



Source: Research Data 2003

Key:

HF – Hiring and firing of staff, RA – Resource allocation, SM – Supervision of management
FP – Formulation of policies, FVM – Formulation of vision and mission of the hospital
SCEO – Succession of CEO

From the survey, boards of mission hospitals were found to play a number of roles. These roles include; hiring and firing of staff, resource allocation, supervision of management, formulation of policies, formulation of vision and mission of the hospital including SP and succession of CEO. Fig 5 gives a summary of these roles as played by mission hospitals affiliated to both KCS and CHAK.

Fig 5 one observes that 21.4% of the mission hospitals boards undertook the roles of resource allocation, supervision of management, formulation of policies, formulation of vision and mission of the hospital including SP and succession of CEO, while 7.1% undertook all the roles as mentioned earlier. They also took part in the strategic planning process of the hospitals through approving the plan and in some respects help in drawing it.

Succession Policy and Planning

In regard to the succession policy for CEO, the research reveals that for KCS affiliated hospitals, 22.2% of the hospitals had this policy formulated by the boards, while 11.1% of the hospitals had the management team formulating it. The remaining 66.7% did not have this policy in place. The scenario was different for CHAK affiliated hospitals, where 40% had this policy formulated by

the boards, with the management taking no part in the same. The remaining 60% did not have this policy in place.

A blur picture is presented by these mission hospitals concerning the succession of the CEO. The analysis reveals that 35.7% of the mission hospitals surveyed had this policy in place while the remaining 64.3% did not have. Arguably, this raises doubts on the extent to which most of these hospitals are committed to the practice of succeeding their CEOs and at least senior management. Where succession policy is key, a good corporate governance practice demands a fixed service contract for executive directors not exceeding five years with a provision to renew, subject to regular performance and stakeholders approval. It also entails a succession plan for top/senior management. To lack such a practice is suicidal for an entity since we have seen in the African context, the more one stays in power, the sweeter it becomes and the more they display despotic tendencies. Mission hospitals cannot afford to entertain such an anomaly. It is therefore imperative that those mission hospitals that do not have this policy in place take an express measure to have it.

It is disturbing to note that some mission hospitals lack a succession plan and policy for their CEOs. This leaves one to wonder whether boards of those hospitals have procedures for the selection and removal of directors (including the chairman and chief executive) to facilitate regular alteration of the mix and composition of the board ensuring relevant rejuvenation. As a result, doubt is cast on the ability of these boards to define the limits of authority of the chief executive and other top executives. For those hospitals that lack this policy, the ability of their boards to exercise leadership, enterprise, integrity and sagacious judgement in directing them so as to achieve continuing prosperity for the hospitals and to act in their best interests remains elusive. They thus need to speed up the process of having this policy in place.

From the foregoing, some boards of mission hospitals exemplify some tenets of good corporate governance. However, they have some work to do to reach the ultimate requirements of such governance. It is only by doing so, that they will be able to maximize stakeholders' value through effective and efficient management of corporate resources.

Every organization that attests to good governance should be headed by an effective board, which should exercise leadership, enterprise, integrity and judgement in directing the organization so as

to achieve continuing prosperity and to act in the best interest of the enterprise in a manner based on transparency, accountability and responsibility. One way in which this can be achieved is through developing an appropriate staffing and remuneration policy that includes the appointment of chief executive and senior staff, particularly the finance director and operations director among others.

Power and Authority

As highlighted above, some of the characteristics mentioned are reminiscent of the boards of mission hospitals surveyed. The survey reveals that, 90% of both CHAK and KCS affiliated mission hospitals had their boards vested with authority to hire and fire top management team. Table 2 gives a glimpse of how they exercise their authority regarding hiring and firing of top management.

TABLE. 1: CRITERIA OF HIRING TOP MANAGEMENT

Hospital Affiliation	Criteria Used To Hire Top Management (%)				
	AP	SC	HS	AP And SC	AP, SC And P
KCS	11.1	33.3	11.1	33.3	11.1
CHAK	60	20	20	0	0

Source: Research Data, 2003.

Key:

AP – Advertisement in the press, SC – Through search committee, HS – Head office seconding, P - Promotion

The survey also reveals that top management teams in the entire mission hospitals were answerable to boards through general reports, overall budget reviews, personnel reviews and evaluations or appraisal and operations performance of the hospitals. It was also observed that, the boards reviewed the top management's performance within a period ranging between three months and three years. Additionally, about 70% of the KCS affiliated hospitals had boards review CEO's performance, while 80% of CHAK ones did likewise with the period of review ranging from every quarter to every three years. On the issue of approving the use of hospital resources by boards, 67% of KCS affiliated hospitals had this in place compared to 80% of CHAK affiliated hospitals.

One predominant factor that was common in all the mission hospitals surveyed was the authority that the sponsoring church had on boards. It is noted that, all the boards were answerable to their church/mission agency or secretariat. It is therefore instructive to note that boards had power and authority vested in them but not a far as autonomy from the mission agency/church was concerned, since boards had to report to them. While one appreciates the concerns of these mission agencies, it is mind bogging whether under such a setting boards can effectively exercise leadership, enterprise, integrity and sound judgement in directing the hospitals so as to achieve continuing prosperity and to act in the best interests of the hospitals while respecting the principles of transparency and accountability.

More so, other functions of the boards are also put in jeopardy. For instance, in defining the hospitals' mission, strategy, goals, plans and objectives, the extent to which the boards can grapple with these issues appears limited to the wishes and aspirations of these mission agencies/churches. Thus identifying opportunities therein as well as principal risks in their operating environment including the implementation of appropriate measures to manage such risks or anticipated changes impacting on the hospitals' business becomes remote. When hospital boards take orders from their mission agencies/churches, the basic principle of good corporate governance is curtailed. As a result, mission hospitals' boards work half hearted not giving as much as they ought to.

Another scenario that is created by mission agencies vis a vis boards is the imposition of the wrong kind of a board in mission hospitals. Such an imposed board will attempt to control top management and to dictate direction and decision. It will indeed become the "boss". With this in mind, it will not act in the best interests of the hospital. Once there are political appointees on these boards, politics could not be kept out of such appointments for long. As soon as this happened, the boards ceased to work effectively. A similar predicament befalls mission hospitals where the dominance of mission agencies/churches in some hospitals is not checked.

Checking this drawback would be a shift from mission agencies/churches desire to include other stakeholders. The many workers who work in mission hospitals and the faithfuls who attend

churches affiliated to these agencies can be encouraged to be part of AGMs to which boards report. This will allow divergent views culminating in boards having the autonomy to think far and wide with ingenuity. However, in the euphoria of such autonomy, the underlying tenets of the mission agencies should not be compromised.

From the analysed data, it is observed that boards of mission hospitals are not effective, as they ought to be. The influence of mission secretariats/sponsoring churches coupled with a lack of comprehensive succession policies for top management in most mission hospitals cement this fact. It saliently emerges that mission hospitals need effective boards for them to serve their stakeholders well. Such boards' duty should be to demand top-management performance and remove top executives who do not perform adequately. They should ask inconvenient questions, insisting on being informed before an event occurs. This is their legal responsibility. They should not unquestioningly accept the recommendations of top management until they know why such recommendations have been brought forward. They should not rubber stamp the personnel decisions of top management but should be inquisitive to know, indeed to get personally acquainted with alternative candidates for senior appointments. It is only by doing so that mission hospitals will be in the forefront of championing good corporate governance. As it is they still have hurdles to overcome.

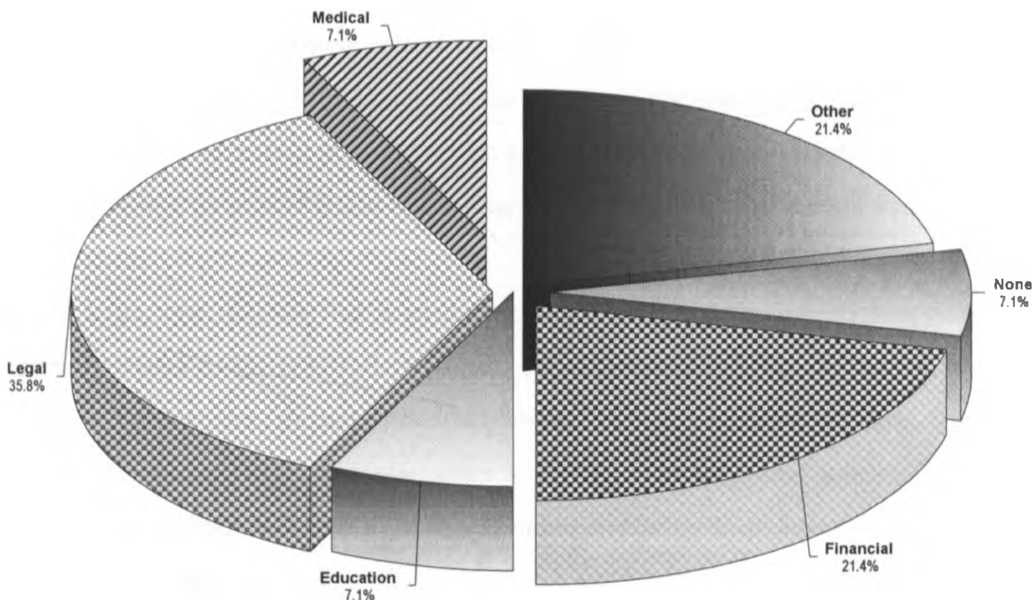
As far as the importance of a well thought composition of boards is concerned, every mission hospital ought to be headed by an effective board, which should exercise leadership, enterprise, integrity and judgement in directing the hospital so as to achieve continuing prosperity, and to act in the best interest of the entity in a manner based on transparency, accountability and responsibility.

To achieve this, appointments to boards should be done through a managed process, that ensures a balanced mix of proficient individuals and that each of those appointed is able to add value and bring in independent judgement to bear on the decision-making process. A balanced inclusion of executive and non-executive directors (including independent non-executive directors) in the board helps to avoid dominance of specific interests in the decision making process.

The study reveals that a number of mission hospitals had their boards appointed by mission agencies/churches, special delegates or local church councils. This to a large extent does not guarantee the above stated principles of good corporate governance. As earlier noted, the imposition of boards on the mission hospitals coupled with boards working half hearted because they do not have direct and full responsibility on the tasks assigned to them go a long way in explaining the inability of these boards to embrace the aforesaid principles of good governance. It is therefore of necessity that mission agencies, local church councils and special delegates off load some responsibilities to other stakeholders so that good corporate governance can be achieved in these hospitals.

On the issue of managing the boards of mission hospitals, an independent director who is not managing the hospital should chair the board. It is important to note that there are two key tasks at the top of the hospital; that of running the board and that of the chief executive responsible for running the hospital. Therefore as a general rule, there is a clear division of these roles to ensure that a balance of power and authority is maintained, and that no individual has unfettered powers of decision. Where these two roles are combined, the reasons thereof should be publicly explained.

Figure 6 Expertise Contributed By Women Non-executive Directors To Boards Of Mission Hospitals



Source: Research Data 2003

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Further, independent non-executive directors should be independent of management and free from any business or other relationship which would interfere with the exercise of their ability to bring out an independent judgement to bear on the issues of strategy, performance, resources, key appointments and standards of conduct. They should be relied upon in matters where there is potential for conflict of interests for example, in financial reporting, nomination and remuneration of directors and evaluation of board performance.

As figure 6 indicates, it is commendable that mission hospitals had non-executive directors on their boards who come with various expertises. Additionally, they were independent of management and free from any business or other relationships, which would interfere with the exercise of their ability to perform on these boards. Nevertheless, mission hospitals should strive to make a balance vis a vis the contribution of non-executive directors as we note that the bulk of their expertise is legal which accounts for 35.7% of their contribution. In addition, 21.4% of these women's expertise depicted as other in fig 6, accounted for information technology, spiritual nourishment, administration and business acumen. The fact that they are clustered together means that they were not substantial as to significantly reinforce these women's contribution to the boards of mission hospitals.

Moreover, it is also interesting to note that 7.1% did not account for any expertise. This represents non-executive directors whose presence in the boards was only to represent special interests. They are seen as individuals' whose role is to make demands on the top management and to push for special projects, needs, and policies. As such they are not concerned with, or responsible for, the hospitals performance. Nor should they be expected to hold in confidence what they hear at board meetings, in fact their trust is not in the hospitals but to their constituents outside.

By and large, one realises that a well-constituted board promotes efficiency and effectiveness. The study brings to the fore salient aspects of well-constituted boards that mission hospitals did not effect. For instance, the appointment of board members by local councils, special delegates or mission secretariats, does not guarantee a managed process that ensures a balanced mix of proficient individuals who are able to add value and bring in independent judgement to bear on the decision-making process.

Other issues that can better the management of mission hospitals include; that persons with full time employment in any company or organization should not hold many non-executive

directorships elsewhere (indicatively, not more than two), persons without full-time employment in one organisation (professional directors, consultants and the like) should not hold more than ten non-executive directorships, executives from subsidiaries, the mission secretariat or any other of its acquisitions cannot become non-executive directors of the hospital, suppliers, direct customers or other trading associates of the hospital cannot become non-executive directors of the hospital; persons with prior professional or social relationships with the directors of the hospital cannot become non-executive directors in the hospital; and that the hospital must always have a qualified, competent , fit and proper person as hospital secretary who must have the requisite knowledge and experience necessary to undertake the statutory duties and responsibilities of the post and advise the board. The hospital secretary should have the responsibility for ensuring that the hospital adheres to this code of best practice for corporate governance.

Boards have to satisfy stringent requirements to be effective. They are not simple structures. They will not work just because their members like each other. Indeed whether the members like or dislike each other is beside the point. A board must function no matter what the personal relationships between its members are. Whoever has primary responsibility in a given area has in effect, the final say. To have a functioning board requires further that no subordinate can appeal a decision by one member of the team to another. Every member speaks with full authority of the board.

TABLE. 2. POWER AND AUTHORITY VESTED IN BOARDS OF MISSION HOSPITALS.

Power And Authority Vested In The Board	Hospital Affiliation			
	KCS		CHAK	
	Yes (%)	No (%)	Yes (%)	No (%)
Approval of hospitals resources	66.7	33.3	80	20
Review of overall budget	100	0	80	20
Review of CEO performance	66.7	22.2	80	20
Review of top management's performance	44.4	56.6	80	20
Top management reports to board	88.9	11.1	100	0
Authority to hire and fire	88.9	11.1	100	0
Board reports to mission agency	88.9	11.1	100	0
Approval of strategic plan	33.3	66.7	80	20
Formulation of succession policy for CEO and top management	22.2	77.8	40	60

Source: Research Data, 2003.

Additionally, no member should make a decision with regard to a matter for which he does not have a primary responsibility. Should such a matter be brought to him, he will refer it to the colleague whose primary responsibility it is. Indeed it is a wise precaution for members of the board not even to have an opinion on matters that are not within their own areas of primary responsibility. Moreover, within his assigned sphere, a member of the board is expected to make decisions. But certain decisions are reserved. Here only the team itself can make the decision. At least the decision has to be discussed with the team before it can be made. It is desirable to think through in advance what these areas are or should be. It is such principles that guarantee streamlined authority

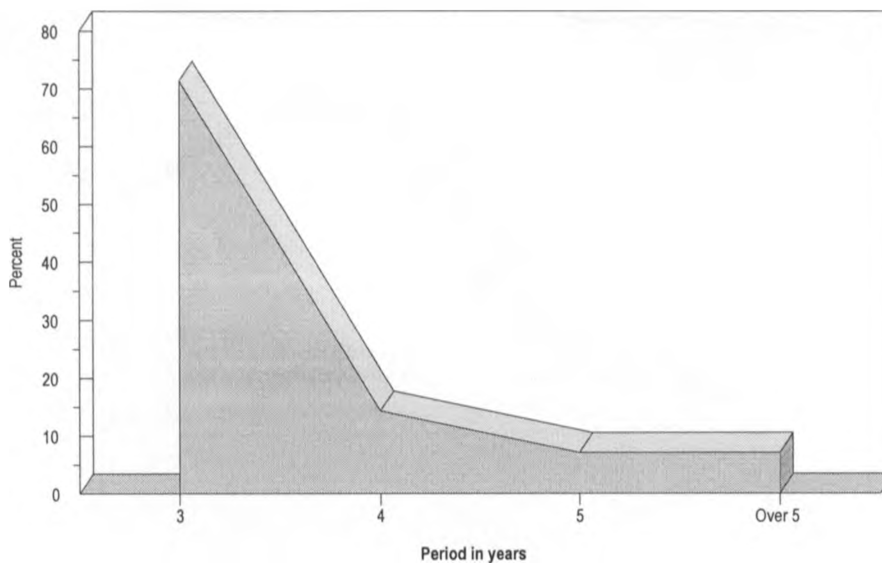
However, as far as mission hospitals are concerned, a grey area is brought to the fore. As table 3 depicts most of the tasks that are supposed to be performed by the board are shared out. Tasks such as approval of hospital resources, review of CEO performance and formulation of succession policy for CEO and top management among others are shared out. Such a scenario insinuates that boards of mission hospitals are confronted by the dilemma of making decisions, which in some quarters are disregarded. To this end, good corporate governance principle, which stipulates that boards should meet regularly and retain full and effective control over the institution to which they are called upon to govern, becomes elusive.

Moreover, boards ability to evolve procedures for the selection and removal of individual directors, including the chairman and chief executive, to facilitate regular alteration of the mix and composition of the board to ensure relevant rejuvenation, is jeopardised. As a result, these boards are found wanting in as far as the definition of the limits of authority of the chief executive and other top executives is concerned. It also follows that these boards are unable to put in place a proper management structure, that is, organization, systems and people. Further, where they are able to put such structures in place, doubt is cast on the ability of those structures to function in order to maintain the hospital's integrity, reputation and responsibility.

Consequently, since our analysed data reveals that there is power and authority emanating from other quarters, the possibility of having a person or group of people having unfettered powers in the management of mission hospitals cannot be over ruled. This comes with it imbalance of power so that a board cannot exercise objective and independent judgement. A precarious platform is therefore set, as far as the regular review of systems, processes and procedures are concerned.

The principle of good corporate governance in relation to security of tenure of boards reiterates the need first and foremost of a formal and transparent procedure in the appointment of directors to the board. Secondly it requires that all persons offering themselves for appointment, as directors to disclose any potential area of conflict that may undermine their position or service as directors. In lieu of this, no person should hold more than five directorships in any institution at any one time. However, it does not bar individuals from submitting themselves for re-election to the board provided that it will be at regular intervals of every three years.

Figure 7: Period Served By Board Members In Mission Hospitals

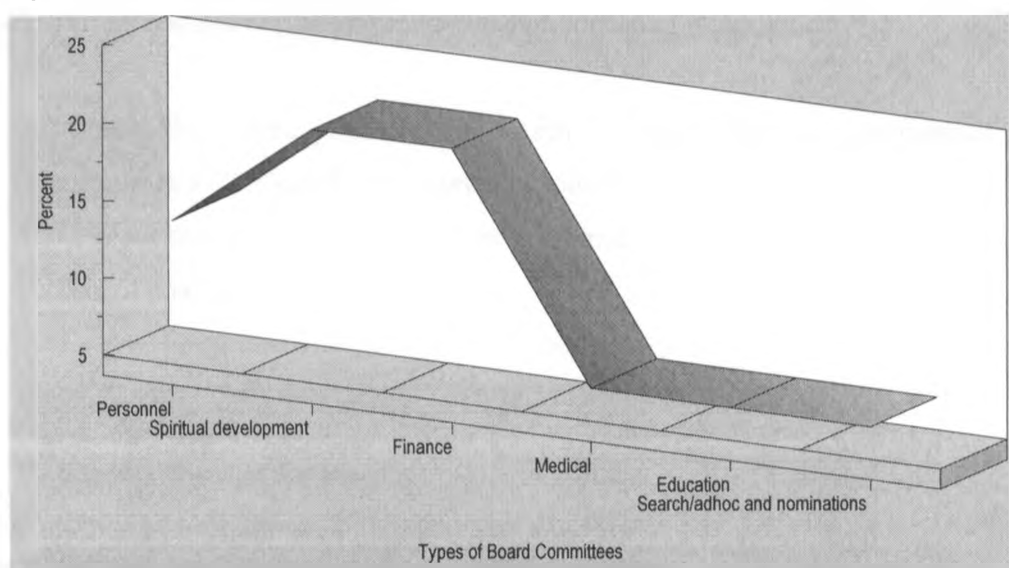


Source: Research Data 2003

The principle also emphasises the need to set up a search and nominations committee of the board. Such a committee based on the priority needs of the board and the institution, should recommend to the board qualified, competent, fit and proper persons to be nominated for election to the board. It further stipulates that executive directors should have a fixed service contract not exceeding five years with a provision to renew subject to regular performance appraisal and shareholders approval. In here disclosure has to be made to the stakeholders at the annual general meeting and in the annual reports of all directors approaching their seventieth (70th) birthday that respective year. This is so that directors who are seventy years and above are not encouraged to serve on boards.

Mission hospitals to some extent have shown to adhere to some of the aforesaid principles. We note that 71.4% of the hospitals had directors serve for three years. This reinforces their commitment to good corporate governance. However, regarding the set up of a search and nominations committee to oversee the whole process of recommending competent individuals to the board, a blur picture is painted. Fig 8 indicates only 7.1% of the mission hospitals had a search/adhoc committee to oversee the process of recommending competent individuals to the board. It thus follows that in other mission hospitals, this was assumed by mission agencies, local church councils and special delegates conference. Thus putting to question whether appointments of board members were free and fair.

Figure 8: Types of Board Committees



Source: Research Data 2003

This scenario explains why some mission hospitals as fig 7 shows, had in their boards, directors serving for more than three years with some going to over five. It also means that in such a setting there are no comprehensive procedures of succeeding directors, an aspect which is mind bogging.

Security of tenure for boards under such a set up balances on a thin rope, discouraging directors to give in their best. Such a setting also exacerbates the pursuance self interests at the expense of collective ones, since the perpetrators of such enjoy clout from the appointing bodies. This to a large extent demeans the whole essence of good corporate governance and is a recipe for court battles as happened in the Maua Methodist mission hospital.

It is conceived that boards of mission hospitals should serve the legitimate interests of all members and account to them fully. It should identify the hospital's internal and external stakeholders; agree on a policy or policies determining how the hospital should relate to, and with them, in offering medical services, creating jobs and the sustainability of a financially sound hospital while ensuring that the interests of stakeholders (whether established by law or custom) are respected, recognised and protected.

The boards should appoint the chief executive officer and participate in the appointment of all senior management, ensure motivation and protection of intellectual capital crucial to the hospital, ensure that there is appropriate and adequate training for management and other employees and put in place a succession plan for senior management

But from table 4, these principles appear remote since boards of most mission hospitals derive their power and authority from a myriad of sources. Only a setting such as one provided for by an AGM guarantees that all stakeholders both internal and external participate in the appointment or election of boards.

TABLE. 3: SOURCES OF POWER AND AUTHORITY OF BOARDS OF MISSION HOSPITALS.

Source of Power And Authority	Hospital Affiliation	
	KCS (%)	CHAK (%)
From AGM through appointment	0	20
From local church council	22.2	0
From AGM through election	22.2	20
From Mission Secretariat	11.1	60
From Special Delegates Conference	22.2	0
From District Development Committees of the church	22.2	0

Source: Research Data, 2003.

Power and authority that emanates from other sources, such as local council or special delegates conference in most cases does not allow for accountability and transparency. This is the case because such power and authority stems from a small click of individuals who may not have a wider picture of the state of affairs. Worse still they are susceptible to human prejudices and are dominated by vested interests, rendering their judgement fallible. As a result, the boards primary

role which is to ensure that no one person or bloc of persons has unfettered power and that there is an appropriate balance of power and authority on the board becomes difficult to realise.

Mission hospitals that are still dominated by local councils, mission secretariats and special delegates conference should learn from the mistakes of state corporations, and put in place comprehensive measures to avoid such anomalies.

CHAPTER FIVE: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.0 INTRODUCTION

This chapter gives a summary of the research findings and makes conclusions thereof. It also offers a number of recommendations useful to scholars, planners, policy makers and managers of hospital boards especially those run by missionaries.

5.1 SUMMARY

This study has observed that the mission secretariat, local church councils and special delegates conference both in KCS and CHAK affiliated hospitals have a profound influence on the appointment of board members, suggesting that the wishes and aspirations of the mission agencies/church carry the day. Appointments to boards by some mission hospitals leave a lot to be desired. In a few cases board members were elected at AGMs. This ensured that stakeholders had a profound say in the affairs of the institutions.

A significant percentage of mission hospitals do not have a succession policy in place. This erodes their commitment to the practice of succeeding officers with competent ones in a transparent manner. Many mission hospitals do not have women executive directors. Where women executive directors are present, their substantial contribution is limted to medical expertise.

Though boards exercised power, the extent to which they did this was limited, as a high percentage of them did not undertake all the roles they are supposed to take. Their responsibilities were shared with other bodies hence compromising their performance. Again, only a few boards participated in the formulation of strategic plans.

A high percentage of boards of mission hospitals were vested with authority to hire and fire top management team. Consequently, top management teams including the CEO in the entire mission hospitals were answerable to boards, with the latter reviewing the former's performance on regular basis. Boards also approved the use of hospital resources. However, the limit of their power and authority converged at their mission agencies/churches.

Due to the faulty appointment structures of board members there are cases of imposition of members who do not have direct and full responsibility on the tasks assigned to them, thus undermining the importance of a well-constituted board that guarantees effectiveness and efficiency.

Boards of most mission hospitals derived their power and authority from a myriad of sources. This made them susceptible to management inefficiencies that pave the way for collapse of otherwise important institutions.

5.2 CONCLUSIONS

Following the findings of this study it is concluded that; The credibility of most boards of mission hospitals to exercise leadership, enterprise, integrity and sagacious judgement in directing them was found wanting as these institutions lacked a succession policy for CEOs and top management; board's tasks should be clearly assigned to someone who has direct and full responsibility for them. The implementation of this principle was remote as most boards were found to be taking orders from their mission agencies. Their effectiveness to this end was not as it ought to be; the principle of appointing board members through a managed process was not implemented in some mission hospitals. This adversely undermined their efficiency and effectiveness; most of the tasks that were supposed to be performed by boards of mission hospitals were shared with other bodies. Doubt is therefore cast on the ability of these boards to retain full and effective control over these institutions; a very small percentage of mission hospitals had a search and nominations committee to oversee the process of recommending competent individuals to the board.

Thus, in many mission hospitals, mission agencies, local church councils and special delegates conference did the work of appointing members to the board and thus putting to question whether appointments of board members were free and fair. Also noted is that boards of most mission hospitals derive their power and authority from a myriad of sources which eventually negate the principle of accountability and transparency.

5.3 RECOMMENDATIONS

This study gives a number of findings from which various conclusions are based. From these recommendations are made which offers practical suggestions for those in search of knowledge in the field of corporate governance especially in the context of mission hospitals' development.

It is recommended that empirical studies be carried out as well as formulation of theoretical models for corporate governance as an element of mission hospitals' development in Kenya. Also the relationship between governance and succession calls for continuous research to chart out a proper path that corporate governance should follow into the future to ensure successful development of leadership.

From this study planners can now identify what boards need to practically apply in order to create an enabling environment for corporate governance to thrive. The necessity to develop apt management practises in mission hospitals that lack them is now clear and more urgent. The hospitals and by extension the areas that require such inputs are identified.

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APPENDICES

Appendix 1: The Research Questionnaire

THE UNIVERSITY OF NAIROBI
COLLEGE OF HUMANITIES AND SOCIAL SCIENCES
FACULTY OF COMMERCE
P.O BOX 30197
NAIROBI

RESEARCH QUESTIONNAIRE.

TOPIC:

A SURVEY OF THE PRACTICES AND FEATURES OF BOARDS OF DIRECTORS IN MISSION HOSPITALS IN KENYA

INTRODUCTION

THIS RESEARCH IS FOR AN MBA STUDENT OF THE UNIVERSITY OF NAIROBI. IT SEEKS TO EXAMINE AND EVALUATE THE IMPACT OF THE BOARD OF DIRECTORS IN THE DELIVERY OF MEDICAL SERVICES IN KENYA.

THIS STUDY IS ENTIRELY FOR ACADEMIC PURPOSES. NEVERTHELESS THE FINDINGS OF THIS STUDY IF IMPLEMENTED BY ANY HOSPITAL WILL;

1. HELP TO PLAN FOR EFFECTIVE MEDICAL SERVICE DELIVERY AND MANAGEMENT OF MISSION HOSPITALS IN KENYA
2. PROVIDE THE HOSPITAL ENTREPRENEURS WITH CURRENT INFORMATION THAT COULD BE USEFUL IN MAKING INVESTMENT DECISIONS
3. ASSIST THE GOVERNMENT IN MAKING POLICIES RELATED TO PARTICIPATION, UTILISATION AND PROVISION OF MEDICAL FACILITIES AND SERVICES BY PLAYERS OTHER THAN THE GOVERNMENT
4. PROVOKE STUDENTS IN THE MEDICAL ARENA TO DEVELOP INTEREST IN THE FIELD OF MEDICINE WITH A HOPE THAT THE GREY AREAS COULD BE IMPROVED

NOTE: ALL THE INFORMATION GIVEN WILL BE **CONFIDENTIAL**.

MEDICAL INSTITUTIONS QUESTIONNAIRE

CONFIDENTIAL
MANAGING DIRECTORS / ADMINISTRATIVE MANGERS

Date of study: ______________________

Name of the hospital: ______________________

Name of the parent church: ______________________

Year Established: ______________________

Number of employees: ______________________

Bed Capacity: ______________________

Number of patients seen per year in the hospital   Out patient: ______   In-patient. ______

1. Do you have a board of directors? (Tick one)

   Yes: ☐
   No: ☐

2. If YES, what is their qualification? (Tick where appropriate).

   High school ☐
   College degree ☐
   Graduate degree ☐
   Doctorate degree ☐

Other (specify)

3. What criteria are used in the appointment of board members? (Tick where appropriate)
   - ❖ Appointed at an AGM
   - ❖ Elected by an AGM
   - ❖ Appointed by a special delegates conference
   - ❖ Appointed by the Local Council
   - ❖ Appointed by the Mission Secretariat
   - ❖ Elected by a special delegates conference:

   Others specify: ____________________

4. What age bracket are most of the board members? (Tick where appropriate)
   - ❖ 20-29 years
   - ❖ 30-39 years
   - ❖ 40-49 years
   - ❖ 50-59 years
   - ❖ 60 and above

5. What period (years) does a board member serve on the hospital board? (tick where appropriate)

   1 Year
   2 Years
   3 Years
   4 Years
   5 Years
   Over 5 Years
   Infinity Years

6. How many board members do you have?
   - ❖ 1 – 2
   - ❖ 3 – 4
   - ❖ 5 – 7
   - ❖ 7 – 10
   - ❖ 10 +

7. How many executive directors do you have?
   - ❖ 1 – 2
   - ❖ 3 – 4
   - ❖ 5 – 7

8. How many executive directors are women?
   - ❖ 1 – 2
   - ❖ 3 – 4
   - ❖ 5 – 7

9. What positions do they (women) hold in the hospital? (Tick where appropriate)
   - ❖ Matron
   - ❖ Human Resource Manager
   - ❖ Chief Accountant
   - ❖ Administrative Manager
   - ❖ Operations Manager
   - ❖ Managing Director

   Others specify: ____________________

10. How many non-executives (women) sit in the board?
    - ❖ 1 – 2
    - ❖ 3 – 4

- 5 – 7 ☐

11. How many women do you have as non-executive members?
    - 1 – 2 ☐
    - 3 – 4 ☐
    - 5 - 7 ☐

12. What purpose or expertise do they contribute to the board? (Tick where appropriate)

    Legal ☐
    Medical ☐
    Business ☐
    Academic ☐
    Financial ☐

    Others (specify) --

13. Are there any board committees? (Tick where appropriate).

    Yes: ☐
    No: ☐

14. If **YES**, which ones? (tick where appropriate)

    Legal ☐
    Medical ☐
    Business ☐
    Academic ☐
    Financial ☐

Others (specify) --

15. What expertise do they contribute to the board? (Tick where appropriate).
    - Financial: ☐
    - Medical: ☐
    - Academic: ☐
    - Legal ☐
    - Business: ☐

    Others specify: ____

16. What role does the board play in this hospital? (Tick where appropriate)
    - Hiring and firing of staff. ☐
    - Resource allocation: ☐
    - Supervision of management: ☐
    - Formulation of policies. ☐
    - Formulation of vision and mission of the hospital ☐

    Others specify: ____

17. What is the **Mission Statement** of your (this) hospital?

    ____

18. Do you have a **Vision Statement** for your Hospital?

    Yes: ☐
    No: ☐

If **Yes**, what is the **vision** of the Hospital?

19. Do you have a **Strategic Plan** (SP)? (Tick where appropriate)

    Yes: ☐

No: ☐

20. Who are the main participants in the Strategic Planning (SP) process?

- ❖ The Board of Directors ☐
- ❖ The Management Team ☐
- ❖ The Planning department ☐
- ❖ Consultants ☐
- ❖ The Doctors ☐
- ❖ The Local Council ☐

Others specify: ______________________________

21. What role does the board play in strategic planning (SP) process?

- ❖ Approving the SP ☐
- ❖ Providing the Vision and Mission ☐
- ❖ Drawing the entire SP ☐
- ❖ Hiring the consultants ☐

Others specify: ______________________________

22. Does the hospital have a succession policy for CEO and top management? (Tick where appropriate)

Yes: ☐

No: ☐

If **YES**, who formulates this plan (**SP**)?

- ❖ The Board of Directors ☐
- ❖ The Management Team ☐
- ❖ The Planning department ☐
- ❖ Consultants ☐
- ❖ The Doctors ☐
- ❖ The Local Council ☐

Others specify: ______________________________

23. Is the board vested with the authority to hire and fire? (Tick where appropriate)

Yes: ☐

No: ☐

24. What criteria are used to hire or fire top management team?

____

25. Is the management team answerable to the board of directors? (Tick where appropriate)

Yes: ☐

No: ☐

If **YES**, in what way?

____

26. Does the board review the performance of the CEO? (Tick where appropriate)

Yes: ☐

No: ☐

If **YES**, how often?

Annually: ☐

Every Two Years ☐

Every Three Years ☐

Every Four Years ☐

Every Five Years ☐

Others specify

---

27. Does the board review the performance of the top management? (Tick where appropriate)

Yes: ☐

No: ☐

If **YES**, how often?

Annually: ☐

Every Two Years ☐

Every Three Years ☐

Every Four Years ☐

Every Five Years ☐

Others specify

---

28. Does the board of directors review the overall budget? (Tick where appropriate).

Yes: ☐

No: ☐

If **YES**, how frequent?

Every Two Months ☐

Every Three Months ☐

Every Four Months ☐

Every Six Months ☐

Once a year ☐

Others specify

---

29. Is it the board that approves the use of hospital resources? (Tick where appropriate)

Yes: ☐

No: ☐

30. Is the board answerable to the church / mission? (Tick where appropriate).

Yes: ☐

No: ☐

If **YES**, in what way? (Please try to give examples)

---

31. How does the board communicate with the church?

Appendix 2: Mission Hospitals Operating In Kenya As At 31.12.2002

No.	Name of Christian Hospital
1.	ACK Maseno Hospital
2.	AIC Githumu Hospital
3.	AIC Lokichogio
4.	AIC Kapsowar
5.	AIC Litein
6.	Christa Marianne (Kisii)
7.	Consolata Hospital Chuka
8.	Consolata Hospital Nkubu
9.	Friends Hospital (Kaimosi)
10.	Friends Hospital (Lugulu)
11.	Gaichanjiru Catholic Hospital (Thika)
12.	Getembe Hospital
13.	Holy Family Hospital (Nangina)
14.	Immaculate HM Hospital Thika
15.	Ivrea Sisters Congregation Migori
16.	Kacheliba Mission Hospital
17.	Kendu Adventist Hopsital Kendu Bay
18.	Kieni Consolata Hospital Embu
19.	Kijabe AIC Mission Hospital
20.	Kikoko Mission Hospital Nunguni
21.	Kikuyu PCEA Hospital
22.	Kima Mission Hospital
23.	Kiminini Mission Hospital Kitale
24.	Kiriani Consolata s Hospital Kiriani
25.	Maua Methodist Hospital Meru
26.	Mercy Hospital Eldama Ravine
27.	Misikhu Mission Hospital Webuye
28.	Mt Sinai Hospital Kisumu
29.	Mukumu Mission Hospital
30.	Mwea Mission Hospital
31.	Mwihila Mission Hospital
32.	Nazareth Hospital Kiambu
33.	Nursing Sisters District Hospital Thika
34.	Nyansiongo Mission Hospital Kisii
35.	Ortum Mission Hospital Kapenguria
36.	PCEA Chogoria Mission Hospital Chuka
37.	PCEA Tumutumu Mission Hospital
38.	Plateau RCEA Mission Hospital
39.	Rang'ala Mission Hospital Yala
40.	Sega Mission Hospital
41.	Sengere Mission Hospital Kisii
42.	Sololo Mission Hospital
43.	St. Annes Mission Hospital Ogoji
44.	St. Clares Mission Hospital Sotik
45.	St. Elizabeth Hospital Mukumu
46.	ST. J. Mission Hospital Nyabondo
47.	St. Joseph's Mission Hospital Kilgoris
48.	St. Joseph's Mission Hospital Migori
49.	St. Mary's Hospital Mumias
50.	St. Mary Hospital Nairobi
51.	Tenwek Mission Hospital
52.	Thabaka Mission Hospital Rongo

Appendix 3: Research Sample List of Mission Hospitals

NO	RAN	HOSPITAL	HOSPITAL AFFILIATION
1.	986	ACK Maseno Hospital	CHAK
2.	557	AIC Litein Hospital	CHAK
3.	522	Friends Hospital Lugulu	CHAK
4.	632	Kikuyu PCEA Hospital	CHAK
5.	072	Maua Methodist Hospital	CHAK
6.	292	PCEA Chogoria Hospital	CHAK
7.	798	PCEA Tumutumu Hospital	CHAK
8.	485	Plateau RCEA Mission Hospital	CHAK
9.	684	SDA Kendu Bay Hospital	CHAK
10.	674	Tenwek Hospital	CHAK
11.	159	Christa Marianne Hospital	KCS
12.	524	Consolata Hospital Nkubu	KCS
13.	149	Gaichanjiru Catholic Hospital Thika	KCS
14.	777	Holy Family Hospital Nangina	KCS
15.	374	Kacheliba Mission Hospital	KCS
16.	677	Kieni Consolata Hospital	KCS
17.	586	Kiminini Mission Hospital	KCS
18.	541	Mercy Hospital Eldama Ravine	KCS
19.	515	Misikhu Mission Hospital	KCS
20.	575	Ortum Mission Hospital	KCS
21.	165	St. Annes Mission Hospital	KCS
22.	944	St. Clare Mission Hospital	KCS
23.	203	St. Joseph's Mission Hospital Migori	KCS
24.	314	St. Mary Hospital Nairobi	KCS
25.	914	St. Mary's Hospital Mumias.	KCS

NB:

KCS:= Kenya Catholic Secretariat Affiliated Hospitals

CHAK:= Christian Health Association Affiliated Hospitals