INTEGRATED GOVERNANCE AND PROVISION OF QUALITY HEALTH CARE IN GOVERNMENT HOSPITALS IN KENYA

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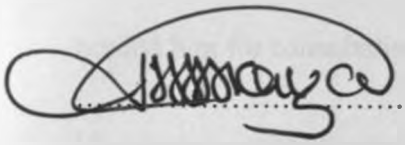
DECLARATION

This research project is my original work and has never been presented in any other University for the award of any degree.



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This research project report has been submitted for examination with my approval as the university supervisor.

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Above all I give all the glory and honour to the Almighty God for seeing me through the program and it's my prayer that. Will help me use the knowledge gained to His glory and in service of His people.

DEDICATION

This study is dedicated to my lovely wife Rhoda and my sons Sam and Vic. for their love, support and encouragement during the entire duration of the course.

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ABSTRACT

Governance has become an issue of global importance. The corporation has a vital role to play in promoting economic development and social progress. It is the engine of economic growth internationally and has become 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 therefore come to the head of international agenda.

The concept of "integrated Governance "refers jointly to the corporate governance and clinical governance duties of health care institutions. This study was concerned with studying integrated governance practices and provision of quality health care in government hospitals in Kenya. The research objectives of the study were to establish the governance practices in government hospitals in Kenya and also establish whether there is any link between integrated governance and provision of quality health care.

To facilitate and achieve the objectives of the study, a detailed questionnaire was used to gather information on the Hospital Management Boards (HMBs) and Clinical Governance in Government Hospitals in Kenya. Section A of the questionnaire which contained corporate governance issues was filled by the Health Administrative Officers while section B which contained clinical governance issues by the Medical Superintendents.

The research findings showed that, the Government Hospitals in Kenya do not generally correlate well with the best practices of Corporate Governance. The results further showed that there is correlation between integrated governance and provision of quality health care. However, there lacked clear written guidelines and policies in clinical

governance issues are addressed in an ad-hoc manner by different hospital clinical committees. It was also noted that other factors may contribute to the provision of quality health care which were not part of this study. This withstanding the, research objectives were met.

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LIST OF ACRONYMS

ANC	Anti Natal Clinic
BOD	Board of Directors
CEO	Chief Executive Officer
CME	Continuous Medical Education
DMSO	District Medical Services Officer
HMB	Hospital Management board
HMT	Hospital Management Team
KEPH	Kenya Essential package for Health
KQM	Kenya Quality Model
MOH	Ministry Of Health
MOPC	Medical Outpatient Clinic
PSICG	Private Sector Initiative for Corporate Governance

CHAPTER ONE: INTRODUCTION

1.1 Background of the study

Universal access to quality health care is an ideal and important goal for all nations. According to Qayad (2008), all Nations base their health development plans on this principal. Better health care is central to human happiness and wellbeing (WHO, 2009). It makes an important contribution to economic progress, as healthy populations live longer, are productive and save more leading to a prosperous nation just as the old adage goes "a healthy nation is a wealthy nation." As globalization and its effects on various aspects of human sets in, global health is increasingly becoming of international concern, especially with regard to disease prevention and control, and more so, promotion of good health worldwide.

All governments in the world play an important role in the provision of quality health care to their citizens. Tang, Eisenberg and Meyer (2004) notes that, Government's responsibility to protect and advance the interests of the society includes the delivery of high quality health care. They continue to argue that, market forces alone cannot ensure all citizens access to quality health care, the government must preserve the interests of its people by supplementing the market where there are gaps and regulating the market where there is inefficiency or unfairness. The ultimate goal of achieving high quality of care will require strong partnerships among federal, state and local governments and the private sector. Tang, Eisenberg and Meyer (2004) further advise that:

> "Translating general principles regarding the appropriate role of the government into specific actions within a rapidly changing, decentralized

quality health care delivery system will require the combined efforts of the public and private sectors"

One way among others of achieving quality health care is through proper management and governance of the health care institutions.

Governance refers to the manner in which power within an organization is exercised in the stewardship of the organization's total portfolio of assets and resources with the objective of maintaing and increasing shareholder's value and satisfaction of other stakeholders in the context of its mission. It is concerned with creating a balance between economic and social goals and between individual and communal goals while encouraging efficient use of resources, accountability in the use of power and stewardship and as far as possible to align the interests of individuals, corporations and society (Private Sector Initiative for Corporate Governance (PSICG) 1999). Governance is about the relationship between the management, the Board of Directors (BOD) and the owners or shareholders. Governance stipulates the responsibility and accountability for the overall operation of the organization.

1.1.1 Integrated Governance

The concept of 'integrated governance' has emerged to refer jointly to corporate governance and clinical governance duties in health care institutions (Scally and Donaldson, 1998). The integration of corporate and clinical governance is important because it brings about synergy between the Hospital Management Boards and Hospital Management Teams, leading to effectiveness and efficiency in quality health care delivery.

Cadbury (1999) defined corporate governance as the system by which companies are directed and controlled and that it is the way in which boards handle the affairs of the corporation. The Capital Market Act (Cap 485 A) in the Kenya Gazette Notice number 369 (2002), defines corporate governance as the process and the structure used to direct and manage business affairs of the company towards enhancing prosperity and corporate accounting with the ultimate objective of realizing shareholders long term value while taking into account the interest of stakeholders. According to Johnson and Scholes (2002), the issue of corporate governance has risen due to the practical need to separate ownership and management control and the increasing tendency to organizations more visibly accountable not only to owners , but also to other stake holder groups including the community at large.

In Kenya the need for corporate governance, as in the case of other parts of the world is becoming more pronounced as a way of safeguarding various stakeholders' interests. Corporate governance is now generally taken as an important ingredient for the economic health of companies and society in general (Manyuru, 2005).

The focus of corporate governance reforms has been on the board of directors where the presence of transparency and disclosure of relevant information has been strong. Disclosures should extend beyond the formal financial statements. It should comprise of company mission, prospects classification of the role of the board and desirably a clear distinction between direction and management. The selection of directors and the balance between executive and non-executive should be clear (Cadbury, 1999).

Cadbury continue to argue that boards need a mechanism to assess their performance. Companies should assess the impact of their business on society at large. One result is

that the pressure for performance and accountability demand more from individual board members. Higher standards of corporate governance should result in improved board effectiveness and this will depend on effective leadership by the chairman, already a task that requires different qualities from those of a Chief Executive Officer (CEO). According to Mwangi (2006), corporate governance can be an important contributor to provision of quality health care by ensuring designated responsibility for clinical governance at board level. The board should ensure that an annual review of clinical governance report on quality of health care and its maintenance is presented to the board. Clinical governance is the framework through which organizations are accountable for continuously improving the quality of their services and safeguarding high standards of health care by creating an environment in which excellence in clinical care will flourish (Scaly and Donaldson, 1998). This definition is intended to embody three key attributes: recognizably high standards of health care, transparent responsibility and accountability of those standards and a constant dynamic improvement.

1.1.2 Quality Health care

Everyone wants quality services, whether it's for auto service, repairs or health care. Quality health care is a measurement of the health care one receives at the doctor or dentist's office, the local emergency room or during a hospital stay. Quality goes way beyond the manners or attitude of health care providers. Quality health care encompasses all aspects of both traditional therapies and protocols to Human Resources development.

WHO (2009) defines Quality health care as the achievement of optimal physical and mental health through accessible, cost-effective care that is based on best evidence, is

responsive to the needs and preferences of patients and populations, and is respectful of patients' families, personal values and beliefs. It involves assessing the appropriateness of medical tests and treatments and measures to continually improve personal health care in all fields of medicine, from the aides that help a patient eat to the surgeon who removes a tumor from the brain.

According to Qayad (2008) some of the aspects involved in providing quality health care in any health facility include: accrediting or approving physicians, offices, hospitals or other health care providers. This is achieved through accreditation or inspection standards that ensure that proper procedures and staffing ratios are met. It also ensures that medical records are continuously reviewed in order to assess the effectiveness of treatments or procedures. Improving patient care is the driving force behind standards and regulations in quality health care, and is now known as performance improvement.

1.1.3 Government Hospitals in Kenya.

The provision of Health care services in Kenya is liberalized. There are Public (government) and private hospitals. Kenya s health care system is structured in a stepwise manner so that complicated cases are referred to higher levels of health care. Gaps in the system are filled by private and faith based run health facilities. The health structure is as depicted in figure Appendix1.

According to the records held in the office of Director of Medical services (2010, medical Quarterly reports) there are 266 hospitals which are managed by the government of Kenya through the Ministry of Medical Services (see Appendix 2). According to the KEPH s classification the hospitals are categorized into three levels depending on their abilities to deliver the various health services and the physical infrastructures available in

the hospital (MOH, 2006). These levels are: level 4 hospitals –which provide the general diagnostic, curative and rehabilitative services for both out and inpatients, major surgeries, basic radiology and mortuary services (these are the traditional Sub district and District hospitals as they were). Others are; Level 5 hospitals, which apart from offering the level 4 services, they serve as regional referral hospitals (the traditional provincial and general hospitals) and Level 6 hospitals which are the National Teaching and referral hospitals. Level 1, 2 and 3 health facilities are not hospitals. These are community health facilities, dispensaries and health centres respectively, commonly revered to as rural health facilities. The various levels of health care facilities in Kenya and how they link to each other are demonstrated in appendix 1.

The governance structure of Government hospitals in Kenya has two components: corporate governance and clinical governance. The leadership of corporate governance (Hospital management Board/Committee) consists of: chairman (nominated by the committee and appointed by Minister of Medical Services), the area District Commissioner (DC), District Medical Services Officer (DMSO), the person in-charge of the hospital (Medical Superintendent) who is the secretary to the board, the person in charge of the local authority where the hospital is located and the following persons, who are residents of the area of jurisdiction, appointed by the Minister: one person who shall have knowledge and experience in finance and administration matters, one person nominated by women groups, one person nominated by women groups and one person nominated by faith based organizations and not more than two persons nominated by recognized Community Based Development Organizations of whom one must be a woman. (Legal Notice No. 155, 2009).The Government Financial Management Act

(Legal Notice No. 155, 2009), stipulates the responsibilities of the Hospital Management Boards as: supervision and control of administration of the funds allocated to hospital; preparation of work plans based on estimated expenditures; preparation and submission of prescribed certified periodic financial and performance reports; and keeping of permanent records of all its deliberations.

The leadership of clinical governance in Kenyan hospitals in done through the Hospital Management team. This team is headed by the Medical superintendent, who is the head of clinical services. The other Executive officers are: the Health Administrative Officer (head of supportive hospital based services) and Nursing Officer in-charge/matron (head of the nursing services). A typical organizational structure of a GOK hospital is demonstrated in appendix 3.

1.2 Statement of the Problem

Government hospitals in Kenya face three main challenges that hinder their performance in the provision of quality health care. First, some do not have proper governance structures that help to ensure that hospital managers perform their duties as expected and where such structures exist there is no integration between corporate and clinical governance. Secondly, they often lack competition that would force efficiency. Most of the Government hospitals in Kenya are near-monopolies in their regions of operation. Finally they lack the ultimate barometer of business success, the profit measure. Although profits are not as relevant to the hospitals whose primary purpose is to improve the wellbeing of the society, alternative measures of performance are hard to find. All these challenges affect the delivery of quality health care by Government hospitals in

Kenya. Considering the pertinent problems faced by these hospitals as enumerated above, one way these institutions can address them is through the practice of a combination of good corporate governance and clinical governance, that is; integrated governance.

This study was done to investigate the role of hospital management boards (HMBs), their relationships with the Hospital Management Teams (HMTs) and how decision- making at the HMBs that could affect the delivery of health care services in Government hospitals.

As much as integrated governance is a very important subject, no research has been carried out in Government institutions such as hospitals in Kenya. Previous studies on governance have focused on corporate governance in private organizations. Some of the studies conducted in this area include: the case of companies quoted at Nairobi stock exchange (Manyuru, 2005), a survey of corporate governance practices in cooperative societies in Nairobi (Wangombe, 2003), a survey of corporate governance among insurance companies in Kenya (Mwangi, 2002), a survey of corporate governance practices in motor vehicle industry in Kenya (Mucavi, 2002), and a study of corporate governance: the case of quoted companies in Kenya (Jabet, 2001).

From the above cases, it can be seen that, no study has been carried out on integrated governance in government institutions in Kenya. Therefore this study was the first one of its kind. The study was done to investigate integrated governance and its role in the provision of quality health care in Government hospitals in Kenya. The study endeavoured to answer two main questions. First, what are the current governance practices in Government hospitals in Kenya? Secondly, is there any linkage between integrated governance and provision of quality health care?

1.3 Research Objectives

This study had two objectives:

1. To establish the current governance practices in Government hospitals in Kenya.
2. To establish whether there is any link between integrated governance and provision of quality health care in public hospitals.

1.4 Significance of the Study

The information obtained from this study would be useful to various stakeholders committed to supporting the continued development of health services in Kenya especially the Government of Kenya and the Ministries of Health (that is; Ministry of Medical Services and Ministry of Public Health and sanitation) that are charged with the overall responsibility of policy formulation and coordinating the provision of health services in the country. Development partners providing much needed financial and technical assistance directly or through implementing agencies may be able to appreciate some of the gaps within the clinical governance structure such as Research and Development, Risk Management and intervene through capacity building and financial support.

Health workers in general who have the interest of supporting the improvement of quality health care provision in the country will find the information on integrated governance useful as an additional tool to others which are already in existence.

Health professionals and Scholars who would like to make a contribution in supporting the improvement of health care in Kenya would be able to be updated on the current

governance issues in the government hospitals. In academics, the study will close the knowledge gap in the area of corporate governance in Government hospitals in Kenya. Hospital boards and management teams in government hospitals in Kenya will also use the information to address some of the problems that they face like ineffective hospital boards, conflict of interest in the tendering process, financial mismanagement and poor delivery of health care to the public. Other hospitals (private) can find the information useful in addressing governance issues.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter examines some of the available literature on corporate governance. The literature outlines the meaning of corporate governance and its relevance in public institutions. The chapter also highlights literature on clinical governance and its role in provision of quality health care in public hospitals.

2.2 Corporate governance

Corporate governance is a multifaceted subject. One of the most important themes of corporate governance deals with issues of accountability and fiduciency duty, essentially advocating the implementation of guidelines and mechanisms to ensure good behavior and protect shareholders, another key focus is economic efficiency, meaning that corporations should aim at optimizing economic results. Amidst growing reliance worldwide in the private sector, the issue of corporate governance has similarly risen in prominence (Goswami, 2001).

According to Steiner and Steiner (2003), corporate Governance is the overall control of activities in a normal corporation. It is concerned with the formulation of long-term objectives and plans and the proper management structure (organization, systems and people to achieve them. At the same time, it entails making sure that the structure functions to maintain the corporation's integrity, reputation and responsibility to its various constituencies.

The focus of corporate governance reforms has understandly been on boards of directors. They are the bridge between the shareholders and the executives in charge

of the running of an enterprise and they are for standing for their company in the community (Cadbury, 1999). Cadbury continues to argue that improvements in board accountability and performance are the aim of corporate governance reform. This has become a worldwide movement through the emergency of global markets. Issues for boards will include clear statements of business purpose, methods of selection, and need for independent directors, BODs, evaluation and directors training. Better and wider disclosure will be the basis for ensuring compliance by boards, but the dominance of the institution will require them to become more accountable.

However, in the non-profit sector the role of the board slightly differs from that of a typical publicly traded corporation. As indicated earlier, non-profits are subject to the non-distribution constraint. As a consequence there are no stake holders in non-profit and there is no one with clear claims over any residuals. Thus, the usual role of boards as a protector of stockholders'rights over the interests of management is absent in non-profit organizations. On the other hand, the donor in non-profit organization may need some protection against the possibility of expropriation. In this sense the board of the non-profit organization can be thought of providing protection for the customers. In a broader sense, given the tax exemption of non-profits, the board can be thought of providing protection to the public who have indirectly contributed to these tax savings (Oster, 1995). Herzlinger (1996) confers that non-profit organizations need to win public trust because they are entrusted with society's most important functions-educating our minds, uplifting our souls and protecting our health and safety. She continues to argue that, our collective perception of their value is evident in the monumental resources we devote to these institutions; revenues of

non-profits alone have grown from less than US$ 200 billion in 1978 to US$1.1 trillion in 1993.

Unlike public traded corporations, the performance of non-profits is shrouded behind a veil of secrecy that is lifted only when blatant disasters occur. However, because of the growing disenchantment of the public institutions, there have been more calls for greater reliance on non-profit organizations to solve important social problems. Herzlinger (1996) points out that, difficulties manifested in the non-profit organizations fall into four categories. First is the problem of ineffective organizations, that is, the ones that do not accomplish their social missions. Second are inefficient organizations, the ones that get too little mileage out of the money spent. A third difficulty is that of private investment, in which individuals who control tax exempt organizations attain excessive benefits for themselves. Investment may also involve managers, employees or board members using resources for their own benefits instead of the organizations social purpose. A forth kind of problem develops when organizations take excessive risk.

Iskander and Chamlou (2002) argue that, countries have realized that good corporate governance is a source of competitive advantage and critical to economic and social progress. With globalization, firms must tap domestic and capital markets in quantities and ways that would have been inconceivable even a decade ago. Increasingly individual investors, funds, banks and other financial institutions base their decisions not only on a company's outlook but also on reputation and its governance. It is this growing need to access financial resources, domestic and

foreign aid to harness the power of private sector for economic and social progress that has brought corporate governance in prominence the world over.

2.3 A Corporate Governance Framework

Iskander and Chamlou (2002) in their report to the world bank- Corporate Governance: A framework for implementation argues that corporate governance is still a topic of debate. They argue that corporate governance can be viewed from two perspectives; from the corporation's perspective and from the public policy perspective. From the a corporations perspective, the emerging consensus is that corporate governance is about maximizing value subject to meeting the corporation's financial and legal contractual obligations. This definition stresses the need for BODs to balance the interests of shareholders with those of other stakeholders- employee, customers, suppliers, investors and communities in order to attain long term sustained value for the corporation.

From the public policy perspective, corporate governance is about nurturing enterprises while ensuring accountability in the exercise of power and patronage by firms. The role of public policy is to provide firms with incentives and discipline to minimize the divergence between private and social returns and protect the interests of stakeholders. These two definitions from public and private perspectives provide a framework for corporate governance as depicted in appendix 4. The conceptual framework reflects interplay between incentives and external forces that together govern the behavior and performance of the firm. At the centre of this system is the BOD whose overriding responsibility is to ensure the long term viability of the firm and to provide oversight of management.

2.4 Evolution and Trends in Corporate Governance

Corporate governance has recently emerged as a discipline in its own right, although the strands of political economy it embraces stretches back through centuries. The importance is widely recognized, but the terminology and analytical tools are still emerging (Iskander and Chamlou, 2002). Corporate governance history is replete with cases of managerial opportunity: patronage, insider trading, extravagant rewards, unwarranted movement of funds from the company to another and investments in projects well beyond the bonds of prudence.

Herzlinger (1996) notes that one of the earliest government crisis was the bursting of the "south sea bubble" of 1720 to 1721 which dramatically changed business habits and regulation in Britain. New concerns about corporate governance were provoked by secondary banking crisis in the United Kingdom in the 1970s and USA savings and loan crisis in the 1980s. In the late 1980s financial scandals leading to the collapse of several prominent companies came to light in the United Kingdom. The corporate sector responded by the loss of confidence in financial reporting by setting up the Cadbury Committee in 1990 to develop a code of best practice.

In the recent past the importance of corporate governance has gone a notch higher as a result of major financial scandals. The collapse of Enron, the world's largest energy trading company, in October 2001, illustrate what can happen when the company's board and top managers fail in their governance responsibilities.

Here in Kenya, the subject of corporate governance has gained greater interest following major scandals such as the Goldenberg, collapse of many indigenous banks, and poor performance of public corporation such as the Kenya Railways and most recently the

Anglo leasing scandal. As a result of this awareness, the centre for Corporate Governance was set up in Nairobi in March 1999. The centre's mission is to develop institutions with human and technical capacity to promote the adoption, application and implementation of sustainable best practices in corporate governance in Africa through advocacy, information dissemination, monitoring, research and training.

2.5 Corporate Governance practices

This section highlights some of the best corporate governance practices. They border on issues such as: the balance in the composition of the board, transparency in the appointment of the board, remuneration of directors, disclosures of vital information, training and audit. Board structures and their functions are also discussed.

2.5.1 Board best practices.

The board of directors of any organization is ultimately responsible for the organization. Each director has a legal duty and responsibility to assure that the organization is run well and in compliance with all federal state and local requirements. Prior to inauguration of a board, each new member of the board should become aware of these duties and responsibilities as well as their potential personal liability. Best practices suggest that boards continually review and assess their level of knowledge and undergo regular governance training. According to (PSICG, 1999), some of the board best practices would include: a balance between the executive and non executive directors in the composition of the board, transparent procedures for nomination and appointment of new directors to the board and constituting an independent remuneration committee to determine the remuneration of each executive director. Other best practices include:

disclosures of any business that may create a potential conflict of interest. access to accurate. relevant and timely information in order to make informed intelligent. objective and independent judgments. Further the directors should undergo formal training on roles. duties. responsibilities. obligation . board practices and procedures on first appointment and lastly the directors should keep accurate books of accounts to enable them allow audits and disclosures.

2.5.2 Board Structure

There is no one-size-fits-all blueprint of the corporate governance. Several models of corporate governance have evolved that highlights the relative weight given to shareholders value or protection of stakeholders rights. According to Steiner and Steiner (2003) the average corporate Board had eleven members. The number varies in different industries. Banks for example average seventeen members. Aerospace companies average thirteen members. Board best practice generally recommends that. board size should reflect the complexity of the corporation and the need for effective decision making. fifteen members is the upper limit for board effectiveness in most cases. Steiner and Steiner (2003) indicate that issues to consider while looking at board structure include: board size. criteria for selection. composition. gender and method of recruitment to the board. They continue to argue that the board membership may include; both inside (managerial) directors and outside (non-management) directors. In recent years. the number of outside directors on boards has grown until today the average corporate body has nine outside and two inside directors.

Oster (2000) adds that non-profit boards typically consist of entirely of outsiders. non-employees of the organization. Staffing non-profit organization boards with outsiders

with relatively short tenure reduces the probability of the board capture by the executive director. The non-profit board often has large donors who serve directly on the board. The presence of large donors on board of an organization provides a direct way for them to monitor how well their funds are being used. Thus, a donor is put on board not as a benefit of giving, but as insurance for giving. It is no surprise, therefore, that trustees are active in the fund rising function. By their presence, such donor-trustees implicitly promise other potential donors that their funds will not be wasted. On the method of selection of selection to the board, Steiner and Steiner (2003) argue that, in the past, board members were usually suggested by the CEO to the board for approval. Today nominating committees on most boards have this responsibility, but CEOs still play a prominent role in the process. Once selected, the names of the nominees are presented to the shareholders for their approval or disapproval at the annual stockholders meeting.

2.5.3 Functions of the Board

The Business Round Table (1990), an organization of CEOs of the largest companies in the United States issued a statement on corporate board of directors. Overall, said the policy statement "the principal responsibility is to exercise governance so as to ensure the long term successful performance of the corporation". Specific responsibility duties are as follows: one is to regularly evaluate and if necessary replace the CEO, two; to review and where appropriate, approve the financial objectives, three: to provide advice and counsel to top management, four; to select and recommend to shareholders for election an appropriate slate of candidates for the BODs, evaluate board processes and performance and five review the adequacy of systems to comply with all applicable laws and regulations.

Drucker 1976) has the following other dimensions to these functions if the board is to be effective: asking critical questions actively as conscience. a keeper of human and moral values and helping the corporation be understood by its constituencies in the outside community. Herman (1990) identified five chief tasks of the boards of non-profit organizations. These include: selection and evaluation of CEO. defining and re-evaluating the mission of the organization. developing a plan for the organization. approving budgets and soliciting for resources. From the list of the board functions. quite a number of variations in the level of operations of the board can be seen. On the one hand. the board engages in the strategic level functions like setting a mission and selection of CEO. On the other hand. some of the functions are at the operating level like budget control and resources attractions. The existence of both operating and strategic functions for the board creates some clear problems in its operations. Principal among these is the unclear authority relationship that may develop between the board and the executive management of the non-profit organization. Thus lack of clarity in turn contributes to tension between staff and board and increases the overall noisiness of non-profit organization board.

2.6 Clinical Governance

Scaly and Donaldson (1998) have defined clinical governance as the framework through which organizations are accountable for continuously improving the quality of their services and safeguarding high standards of health care by creating an environment in which excellence in clinical care will flourish. Scally and Donaldson (1998) continue to add that there are six elements of clinical governance namely: Education and Training.

Clinical audit, Clinical effectiveness, Research and Development, Openness and Risk management.

Scally and Donaldson (1998) argue that, it is no longer acceptable for any clinician to abstain from continuing education after qualification. The continuous professional development of clinician is the responsibility of the board and clinicians themselves.

Clinical audits are the review of clinical performance, the refining of clinical practice and the measurement of performance against agreed standards or against "state of the art".

Clinical effectiveness is a measure of the extent to which a particular intervention works. The measure is enhanced by considering whether the intervention is appropriate and whether it represents value for money. In modern health services, clinical practice needs to be refined in the light of emerging evidence of effectiveness but also has to consider aspects of the efficiency and safety from the perspective of the individual patient and careers in the wider community. Good professional practice has always sought to change in the light of evidence from research. Research and development requires huge resource outlay, which can only be done with the support of the board. Processes which are open to the public scrutiny while respecting individual patient and practitioner confidentiality and which can be justified openly are an essential part of the quality assurance. Any organization providing high quality care has to show that it is meeting the needs of the population it serves.

Scally and Donaldson (1998) conclude by making the following comments about the components of risk management in health institutions. That, risks to patient would mean compliance with the statutory regulations that can help to minimize risks to patients and risks to practitioners would entail ensuring that clinicians are immunized against

infectious diseases and work in safe environment. They further state that, risks to the Organization would arise due to poor quality service which is a threat to any organization. Organizations need to reduce their own risks by ensuring high quality employment practices, a safe environment and well designed policies on public involvement

2.7 Board Governance and Provision of Quality Health Care

Pointer and Jennings (2002) states that, a board bears ultimate authority, responsibility and accountability for the organization performance. Kazemek (2000) report to the Institute of Medicine indicates that, approximately 98,000 people worldwide die annually due to medical errors. These statistics have intensified the need for hospital boards to oversee the quality of medical care, because Trustees are rarely familiar with patient care. They depend on the medical professionals to interpret clinical data and medical terminology used in quality reports.

Pointer and Orlikoff (1999) notes that, the responsibility for quality of services is unique to the boards of organizations. This aspect of governance typically causes health care board members their greatest concern. To fulfill this responsibility, a board must, one: define quality to reflect the aspects of specific practice, two: credential the medical staff and three: monitor data to assess the quality of care provided. Credentialing is the process that appoints and determines the clinical privileges of physicians (Pointer and Orlikoff, 1999). The purposes of this process is to ensure that only qualified doctors are hired and remain as the organizational medical staff and that they provide services within their scope of competence.

Robert and Connors (1988) states that, achieving the quality goals encompasses such abilities as rendering clinically appropriate care, meeting contemporary standards, achieving high levels of patients satisfaction and maintaining an environment of continuous quality improvement. Trustees therefore must establish the standards needed to provide necessary oversight. They further point out that the key features of these standards which are: a proactive approach to risk identification, a culture that reflects staff willingness to report and participate in risk reduction activities as well as measure their own and patient's perceptions of possible risks in the organization, a systematic approach to integrating all safety activities to ensure coordination and eliminate duplication, selection of one high risk process each year for assessment and risk mitigation and medical errors report given to the board at least once a year.

2.8 Quality Health care Services

Tang, Eisenberg and Meyer (2004) notes that, Government's responsibility to protect and advance the interests of the society includes the delivery of high quality health care. They continue to argue that, market forces alone cannot ensure all citizens access to quality health care, the government must preserve the interests of its people by supplementing the market where there are gaps and regulating the market where there is inefficiency or unfairness. The ultimate goal of achieving high quality of care will require strong partnerships among federal, state, and local governments and the private sector.

Many factors influence a country's ability to provide quality health services for its people (WHO, 2009). All around the world, governments hold the major responsibility for ensuring equitable access to such services for the populations they govern. While Ministries of health are important actors, so are supporting stakeholders including other

government departments, donor organizations, civil society groups or Non-Governmental Organizations and the communities themselves. For example, investments in roads can improve access to health services; inflation targets can constrain health spending; and civil service reform can create opportunities - or limits- to hiring more health workers. Developing countries in particular face wide and varied challenges in providing health care services, especially in the resources constrained environments within which the governments operate. The demand for health services far outstrips the available resources and therefore continuous efforts must be made by various stakeholders, to periodically assess performance of the health system, so as to strive for continual improvements in quality of health care services provided and increased access to the same by the population.

WHO (2009) defines Quality health care as the achievement of optimal physical and mental health through accessible, cost-effective care that is based on best evidence, is responsive to the needs and preferences of patients and populations, and is respectful of patients' families, personal values and beliefs. It involves assessing the appropriateness of medical tests and treatments and measures to continually improve personal health care in all fields of medicine, from the aides that help you eat to the surgeon who removes a tumor from your brain.

2.9 The Kenyan Quality Model and Health care

The Kenyan Quality Model (KQM) provides the conceptual framework for quality improvement in health care in Kenya. In the context of KQM, Quality is defined as the totality of features and characteristics of the Kenyan healthcare system that relates to its

ability to satisfy a stated or implied health need (ISO 9000 family, 2002). Quality improvement in healthcare is defined as a process which involves: to improve adherence to standards and guidelines, to improve structure – process – outcome of health services by applying quality management principles and tools and to satisfy patients'/clients' needs in a culturally appropriate way (Croll, 2000).

The Kenyan health standards are used in combination with the clinical and public health standards and guidelines to establish the expected performance levels within the Kenyan Health System, including both the public and private sector. The development and revision of standards and guidelines are expected to be evidence- based approach, considering the perspective of communities and respect clients' rights (MOH, 2006).

The assessment of compliance with this combination of standards serves as an entry point to quality improvement. A master checklist, which is based on KQM standards represents to assess expectations are met. Compliance with standards is monitored through self-assessment by providers and verified by health service inspectors. Health service inspectors monitor compliance with the minimum standards to ensure safety and minimize the risks of adverse effects of health services (Okeyo, 2003).

According to Qayad (2008) some of the aspects involved in providing quality health care in any health facility include: accrediting or approving physicians, offices, hospitals or other health care providers. This is achieved through accreditation or inspection standards that ensure that proper procedures and staffing ratios are met. It also ensures that medical records are continuously reviewed in order to assess the effectiveness of treatments or procedures. Improving patient care is the driving force behind standards and regulations in quality health care, and is now known as performance improvement.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Research Design

This study adopted a cross-sectional survey. According to Kothari (2003), a cross-sectional study is carried out at one point in time. This kind of study makes use of same variables across all respondents. The study was undertaken in some identified government hospitals, using a questionnaire. The findings have been used to make a descriptive analysis of integrated governance practices in government hospitals in Kenya and their linkages in the provision of quality health care.

3.2 The Population

The population of this study was made of the level 4 and 5 hospitals as depicted in appendix 1. These are the hospitals which are managed by the Government of Kenya through the Ministry of Medical services. According to the records held in the Ministry of Medical Services headquarters, there are 266 gazetted Government hospitals which fall under level 4 and 5. Therefore the population of this study consisted of the 266 hospitals which are contained in the list in appendix 2. Level 6 hospitals, that is, Kenyatta and Moi National Teaching and Referral hospitals are government parastatals created by different Acts of Parliament and therefore their governance structures vary from the other government hospitals and therefore they were excluded from this study.

3.3 The Sample

Kombo and Tromp (2006), states that, it is not possible to study the whole population to arrive at a generalization. This justifies the need to have a sample. A sample is a small

proportion of the population for observation and analysis. Purposive sampling was used as the research targeted a group of hospitals that have Hospital boards and management teams which were believed to be reliable to the study. According to Kothari (2003), a sample unit may be a geographical region, a district, village, or an institution. The researcher can choose one or all of the units for the study. In this study a government level 4 or 5 hospital formed a sample unit. Using the list of Government of Kenya gazetted level 4 and 5 hospitals obtained from the Ministry of Medical Services Headquarters (Appendix 2); five hospitals were picked from every province other than Nairobi. Out of these five hospitals; one was a Provincial General hospital, two District hospitals and two Sub-District Hospitals with highest bed capacities in each of the seven provinces. Since Nairobi province has only five GoK hospitals which are ran by the Ministry of Medical Services, all the five were picked to form the sample of the study. Using this criterion, out of the 266 level 4 and 5 hospitals, 40 were picked to form the sample of this study.

3.4 Data collection Methods and Instruments

The type of data used in this study was primary data. Primary data provides valid information which meets the objectives of the study and fills the gap between what is known and not known. The data collection instrument used was a questionnaire. Kombo and Tromp (2006) argued that, questionnaires when used have advantage in administration, since a large number of respondents can be involved to provide information with an easy accumulation of data. The researcher obtained authority from University of Nairobi and Ministry of Medical Services Headquarters to carry out the

study. The researcher visited two hospitals in Nairobi (Mathari and Mbagathi) for piloting the instruments. Issues arising from the instruments were addressed by amending the ambiguous questions. The Medical Superintendents of the sampled hospitals were notified through electronic mail (introduction letter, appendix 5) and the questionnaire as an attachment (appendix 6). These were followed by telephone calls to confirm receipt of the documents. The respondents were given one week to fill and email back the questionnaires. Section A of the questionnaire, which contain corporate governance issues was filled by the Health Administrative Officers while section B (which contain technical issues on clinical governance) were filled by the Medical Superintendents. The questionnaires were filled and returned online.

3.5 Data Analysis

Completed questionnaires were edited for completeness and consistency. The data was then coded and checked for any errors and omissions. The data was analyzed using both content analysis and procedures within statistical packages for social science (SPSS) _PC version 12.The responses from sections A and B of the questionnaire were analyzed to answer the first and second objectives respectively. The responses from the open ended questions were coded; the mean and percentages were used for likert-scale responses. Content analysis was also used in some of the open ended questions and in analyzing the in-depth qualitative data collected. This type of analysis has been used in past studies including Jabet (2001), Mwangi (2002) and Mucavi (2002). For closed questions a comparative analysis using tables and graphical analysis was done to improve the presentation of the analyzed results for ease of interpretation.

CHAPTER FOUR: FINDINGS/RESULTS AND DISCUSSIONS

4.1 Introduction

This research had two objectives namely: to establish the current governance practices in Government Hospitals in Kenya and whether there is any link between integrated governance and provision of quality health care in the government hospitals. Data was collected from 40 government hospitals. Out of the 40 questionnaires, 35 were filled and returned promptly. This represents a response rate of 87.5 % which is considered to be significant enough to provide a basis for valid and reliable conclusion with regard to integrated governance and provision of quality health care in government hospitals in Kenya. This is summarized in table 4.1 below Analysis and results are presented in the order of the objectives.

Table 4.1: Overview of Data collected

Population	Number of hospitals	Sample (t)	Returned questionnaires (q)	Non-response error (t-q)
PGHs	7	7	7	0
DHs	95	15	13	2
SDHs	162	16	13	3
Others	2	2	2	0
Totals	**266**	**40**	**35**	**5**

Key: t: sample = 40, q: returned questionnaires =35 t-q: non response error= 5 (12.5%)

PGHs- Provincial General hospitals, **DHs**- District Hospitals, **SDHs**- Sub-District Hospitals

Source: Research Data

4.2 .0 Governance practices in Government Hospitals in Kenya

The first objective was to establish the current governance practices in government Hospitals in Kenya. The Health Administrative officers of the sampled hospitals were asked to fill section A of the questionnaire. The research was set to establish the following specific dimensions of governance: Board composition, board structure, board meetings, roles of the board and general governance practices in Government hospitals in Kenya.

4.2.1 Board composition

The study was designed to investigate the composition of Hospital Management Boards (HMBs) in terms of numbers, gender, executive/non-executive directorship balance, skills represented/academic qualifications, method of selection and length of term. From the information collected it was found that most of the HMBs (85.7 %) have more than 9 members and the rest (14.3 %) have between 6 and 9 members. The data also revealed that, most of the HMBs (80%) have less than 3 women representation and Hospital management Team (HMT) representation is less than 3 members in all the hospitals. The results are summarized in table 4.2.1a below.

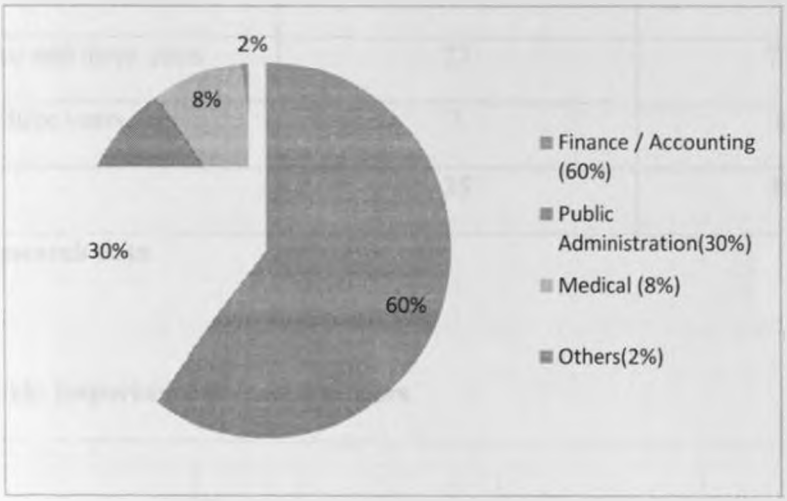
Table 4.2.1a: Composition of membership of HMBs

No. of Board members	No of Respondents (Board members)	%	No of Respondents (women representation)	%	No of Respondents (HMT representation)	%
Less than 3	0	0	28	80	35	[redacted]
3 to 6	0	0	7	20	0	[redacted]
6 to 9	5	14.3	0	0	0	[redacted]
More than 9	30	85.7	0	0	0	[redacted]
Totals	35	100	35	100	35	10

Source: Research Data

The study further revealed that, the skills represented in most of the HMBs are Finance/ Accounting, public administration and medical in that order of prevalence as shown in figure 4.2.1a below. However respondents felt that they would like to see the following specific skills added to the boards: legal, project management and more medical representation.

Figure 4.2.1a: Skills Represented



Source: Research Data

In most of the hospitals, it was found that members of the board are nominated /selected to the board by local politicians (57.2%). Others are nominated/selected by, DMSO (17.1%), Medical Superintendent (11.4%), and provincial administration (14.3%). The results are summarized in table 4.1.2 b below. Further the study revealed that for the a person to be selected/nominated, he/she must be of good standing in the society, be actively involved in community based activities in the area of jurisdiction and be willing to serve voluntarily. Most of the respondents (77.1%) indicated that, the board members

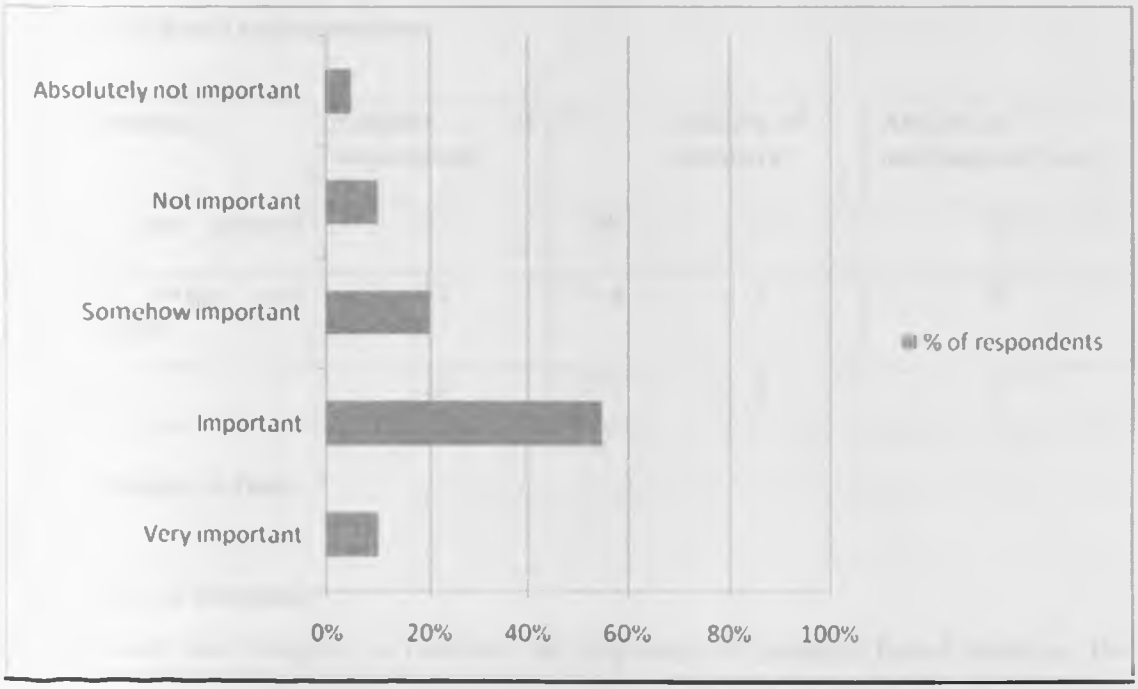
serve for a term of between two and three years which is not renewable (see table 4.2.1b below). Most of the respondents (55%) indicated that the office bearers are important in the proper functioning of the board. The results are summarized in figure 4.2.1b below.

Table 4.2.1b: Length of board term

Board term length	Number or respondents	percentage
Less than one	0	0
Between one and two years	5	14.3
Between two and three years	27	77.1
More than three years	3	8.6
Totals	**35**	**100**

Source: Research data

Figure 4.2.1b: Importance of Board officers



Source: Research Data

4.2.2 Board structure

The study wanted to establish; the board sub-committees, their functions, frequency of their meetings and the by-laws and statutes governing the boards. It was found from the study that most of the hospital management boards of Government hospitals in Kenya have at least 3 sub-committees namely; finance and general purpose, Medical, drugs and therapeutics and projects committee. The results are summarized in table 4.2.2 below. Most of the respondents indicated the general functions of the above committees are as follows: Finance and General purpose – responsible for budgeting and overseeing financial management of the hospital; medical, drugs and therapeutics –has the mandate to monitor and ensure that hospitals upholds high medical standards and advises the board on clinical and drugs situation in the hospital; projects committee – responsible for initiating and implementation of the hospital's projects. Further the study revealed that, on average the sub-committees meet 8 times per year and have an average of 3 members each. (See table 4.2.2 for summary of results). The study also revealed that, there are by-laws governing the number of board members, number of meetings per year and education qualifications.

Table 4.2.2: Board sub-committees

Sub committee	Number of respondents	%	Ava. No. of members	Ava.No. of meetings per year
Finance and general purpose	35	100	4	8
Medical, drugs and therapeutics	32	91.4	3	8
Projects	20	57.1	3	8

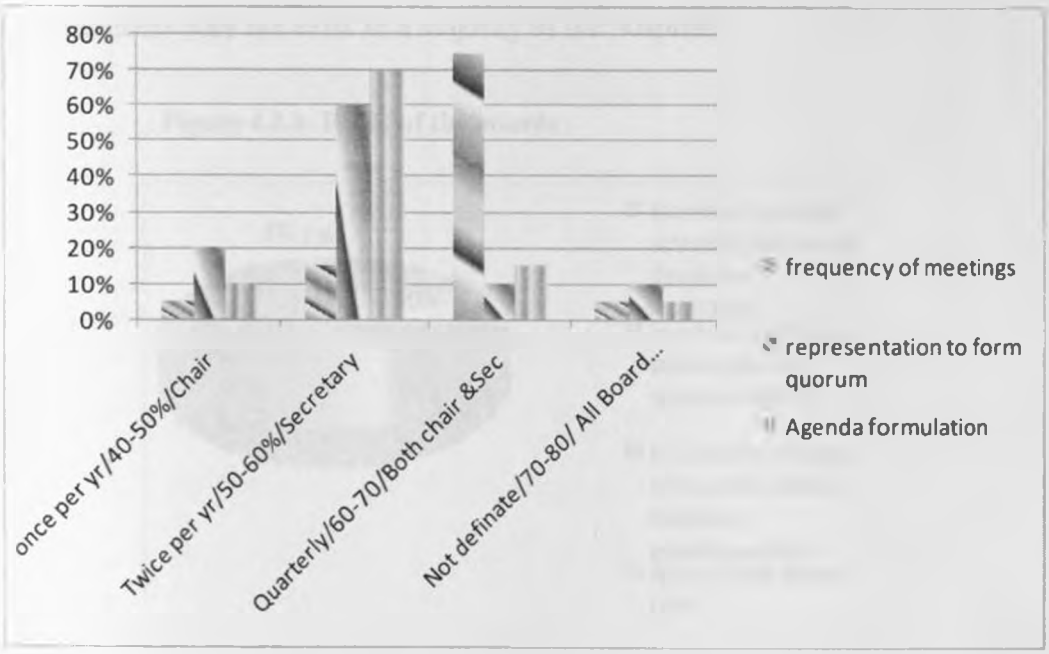
Source: Research Data

4.2.3 Board Meetings

The research was designed to establish the frequency of hospitals board meetings, the percentage of board representation required to constitute quorum, and the board members

who creates agenda for the meetings. According to the study, most of the boards (75 %) meet quarterly. Although there are no by-laws governing the number of members required to conduct business, it was found that, most the hospitals (60 %) at least 50 to 60% members are required to form a quorum in board meetings. 70 % of the respondents indicated that the secretary of the board creates the agenda for the meetings. The results are summarized in figure 4.2.3 below.

Figure 4.2.3: Frequency, Quorum requirements and Agenda formation for board meeting



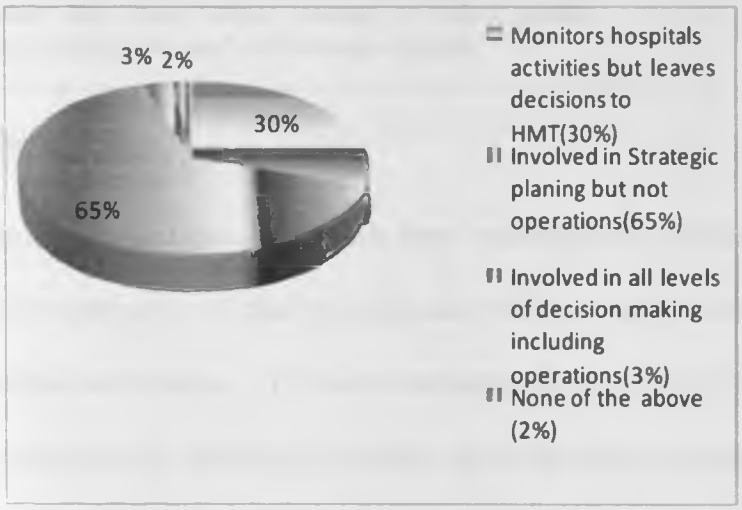
Source: Research Data

4.2.4 Role of the Boards

The research was set up to determine the boards' roles and their overall influence over the direction and control of the hospitals and whether the boards are trained and evaluated. According to the study findings, a majority of the hospital boards (65%) are involved in strategic planning and policy decisions (summary of the results are shown in Figure 4.2.4 below). Other functions of the boards include: monitoring and evaluating the

hospital performance, budget approvals, capital expenditure and ensuring quality of service. The boards' yields strong influence over the direction and control of the hospitals. In most cases the board approval is required when expenses exceeds a certain level and hiring and firing contract/casual workers. Most of the boards were found to be committed in attending the board meetings. The study further revealed that, most hospitals lack clear guidelines on how the chair performance is evaluated and there is no formal evaluation of the board performance. The research also revealed that training of board members does not exist in a majority of the hospitals.

Figure 4.2.4: Roles of the boards



Source: Research Data

4.2.5 Governance Practices

From the research findings, the stake holders of the various government hospitals are: employees, suppliers, patients, local community, development partners and the Government. On a scale of 1-5 the respondents rated the governance practices in there hospitals and disclosure of information that might crate potential conflict emerging the

popular practice among others with an average score of 4.5. The results are summarized in table 4.2.5.

Table 4.2.5: Rankings of Board practices in order of the most practiced to the least

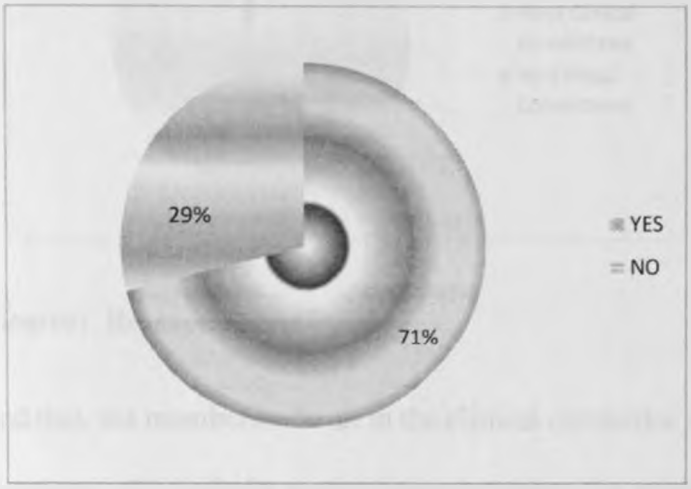
Board practice	Mean score	Rank
Disclosure of information that might create potential conflict	4.5	1
Access to accurate, relevant and timely information to make informed and objective decisions by the board	4.1	2
Balanced composition of the Board	3.5	3
Accurate book-keeping by the Board	3.4	4
Transparent procedures for nomination and appointment of new board members	3	5
Board members are given formal training on roles, duties, responsibilities, obligations and on first appointment.	1.2	6

Source: Research Data

Further the study revealed that, the boards have oversight role in the responsibility and accountability for provision of quality health care while the hospital management teams ensure operational compliance. The boards evaluates the provision of quality health care by having a representative committee member who is familiar with patient care practices sitting as an ex-officio in the clinical committee. Although most respondents (71%) indicated that, there is a link between corporate governance and clinical governance (i.e. integration between the two) most of them argued that consultants constantly monitor the environment created for clinical care. The results are summarized in figure 4.2.5 below. Some of the respondents suggested that, the HMBs should strengthen their relationship with HMTs by developing trust and increasing interaction. They further suggested that, good governance in hospitals could be improved by establishing more committees so that

more members participate in hospitals' affairs and that clinical governance need to be integrated more into the governance structure of the government hospitals in Kenya.

Figure 4.2.5: Integrated Governance in GOK Hospitals

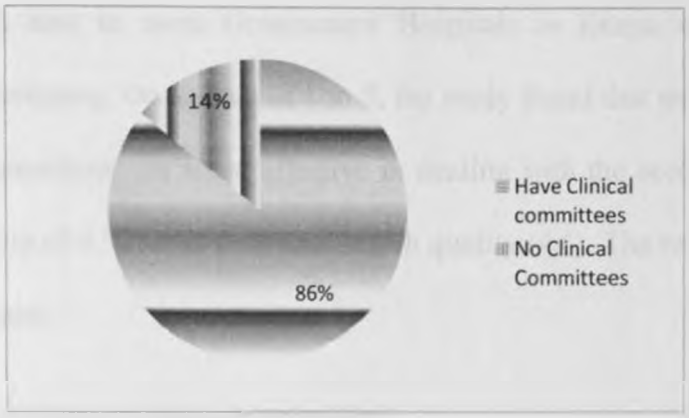


Source: Research Data

4.3 Clinical Governance in Government Hospitals in Kenya

The second objective of this study was to establish whether there is any link between integrated governance and provision of quality health care. Data was collected through a questionnaire (Section B: Appendix VI), where the Medical Superintendents of the sampled hospitals were respondents. The study found that 86% of the sampled hospitals have a Clinical committee which is responsible for quality health care in hospital (See summary in figure 4.3 below). However most of these committees lacked clear written and terms of reference. Moreover the study revealed that the committees are not represented in the board. but the Chairman of HMT (medical superintendent) sits on the board to advice on medical issues of the hospital he/she heads.

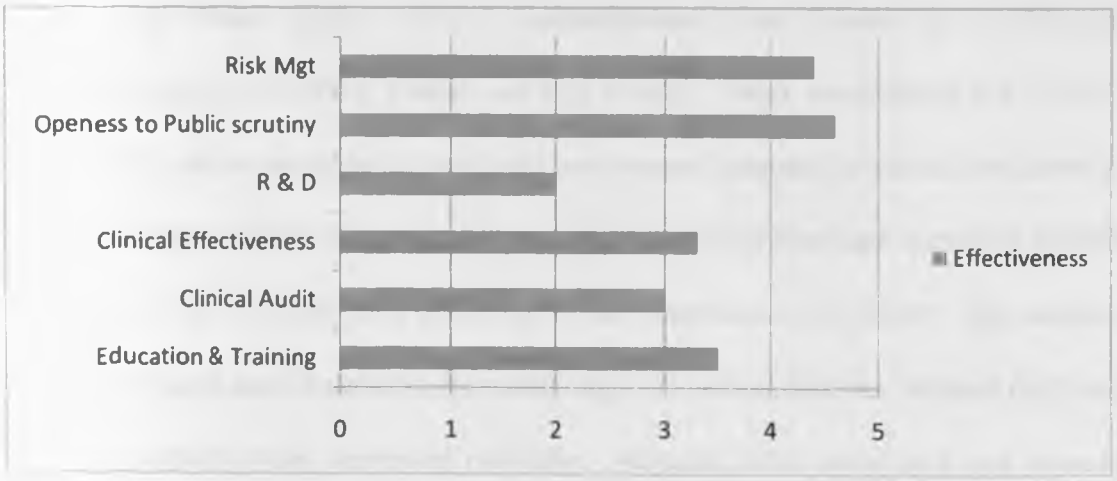
Figure 4.3a: Proportion of GOK hospitals with Clinical committees



Source: Research Data

The study found that, the members who sit in the clinical committee are mostly heads of the major departments who include: medical superintendent, the nursing officer in-charge, head pharmacist, head -laboratory services, head surgeon and head –radiology services. On a scale of five points the clinical governance area which scored highest (average of 4.6) as being the best issue handled by the clinical committee followed by openness to public scrutiny. The results are summarized in the figure 4.3 below.

Figure 4.3b: Effectiveness of clinical governance in handling clinical governance issues



Source: Research Data

4.4 Quality Health care

Quality health care in most Government Hospitals in Kenya was found to be of paramount importance. On a scale of 1 to 5, the study found that most hospitals' clinical governance committees are more effective in dealing with the access to primary health care (mean score of 4.72) and Technical health quality (4.6). The results are summarized in table 4.4 below.

Table 4.4: Effectiveness of clinical committees

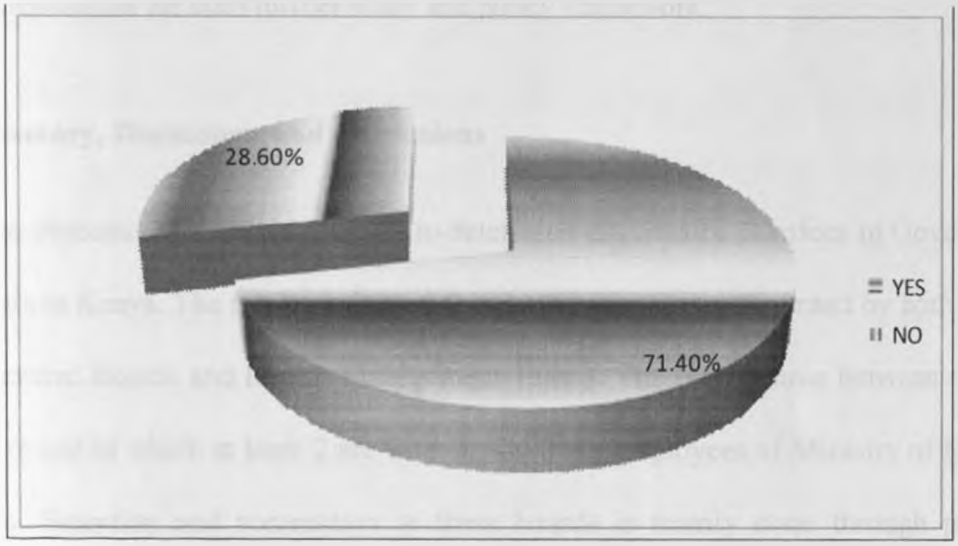
Aspect of quality health care	Mean score	mode	Rank
Access to primary health care	4.8	5	1
Technical health quality	4.6	4.5	2
Appropriateness of care	3.4	3.4	3
Outcomes of care	2.8	3	4

Source: Research Data

Further most of the respondents admitted that their clinical committees are effective and as a result they have successes in: increasing the proportion of the population having easy access to primary health care and the consumption of health care services through clinics such as Anti Natal Clinics (ANCs), Comprehensive Care Clinics (CCC), Medical Outpatient Clinics (MOPC), Dental and Eye clinics. Most respondents (i.e. 71.4%) attributed the above successes to integrated governance (summary of results are shown in figure 4.4 below). Some of the dimension of quality service that have improved in most hospitals in the last five years according to the respondents are: timely and accurate delivery of health care to patients, increased range of medical services, reduced child and maternal mortality rates, increased morbidity, increased ANC attendance and reduced

HIV/AIDS prevalence rate. Apart from health indicators, some respondents also conceded that financial management has improved in government hospitals due to integrated governance.

Figure 4.4: Integrated governance and improved quality health care



Source: Research Data

A majority of the respondents stated that good governance practices especially where corporate and clinical governances are integrated can lead to improved efficiency and effectiveness of clinical services in hospital. Some of the suggestions given by the respondents on how good governance practices can be used to improve provision of quality health in government hospitals were: increasing the number of board members with medical knowledge and executives so as to give technical advice on matters touching on the medical services, increase the representation of clinical committee in the board and forging a close working relationship between the HMB and HMT.

CHAPTER FIVE: SUMMARY, RECOMMENDATIONS AND CONCLUSION

5.1 Introduction

This chapter summarizes the findings and makes conclusions on this study of integrated governance in Government hospitals in Kenya. It also gives study limitations and recommendations for both further study and policy framework.

5.2 Summary, Discussions and conclusions

The first objective of this study sought to determine governance practices in Government Hospitals in Kenya. The results indicated that these hospitals are governed by both Health Management Boards and Health Management Teams. The HMBs have between 6 and 9 members out of which at least 2 are women and 2 are employees of Ministry of Medical services. Selection and nomination to these boards is mainly done through political influence.

The boards exercise strong influence over the direction and control of the hospitals. In most cases, the board's approval is required when expenditure exceeds a certain amount, introducing new service fees, hiring and firing contract workers, and when capital expenditure is involved. This is in line with the Business Round Table (1990), which issued a policy statement on corporate BODs. It outlined specific responsibility as follows: one; select, regularly evaluate and if necessary replace the CEO. Also determine management compensation and review succession plan. Two; review and where appropriate approve the functional objective, major strategies and plans for the corporation. Three; provide advice and counsel to top management. Four; review and

recommend to stakeholders for election an appropriate state of candidates for the board processes and performance. Five; review the adequacy of systems to comply with all applicable law/regulations. The results also showed that the HMBs are responsible for the preparation of annual financial statements.

It was found that most HMBs in Government Hospitals in Kenya have at most 9 members. This is in contrast to many authors like Oster (2000), Iskander and Chamlou (2002) advocates. Oster for example argues that, a large size of a non-profit BOD increases inter organizational contact, allows for more monitoring and control and reflects the importance of donors. The study also revealed that many areas of corporate governance in Government hospitals in Kenya fall short of best practices. These include: Lack of balanced board composition, transparent procedures for the nomination and appointment of new board members, methods of evaluating the performance of the chair and board members and training of new board members.

The second objective sought to determine whether to determine whether there is any link between integrated governance and provision of quality health care. The results indicated that, the clinical committees are responsible for quality health care in Government hospitals in Kenya. The officers who sit in these committees are the heads of major departments in the hospitals. This wide representation by managers from every department ensures that, all issues relevant to the vision and mission of the hospital are addressed. Scaly and Donaldson (1998) identified six elements of clinical governance as education and training, clinical audit, clinical effectiveness, research and development, openness to public scrutiny and risk management. The findings indicated that the hospitals' clinical committees address all these elements but give more weight to

openness to public scrutiny and risk management than other dimensions of clinical governance. The findings further indicate that the issues mostly addressed by the clinical committees that touch on quality health care are: access to primary health care, technical health quality and appropriateness of care.The boards evaluate the provision of quality of quality health care by having a representative of clinical committee sitting in board meetings as an ex-officio. This is in line with what Kazemek et al (2000) pointed out; that; since trustees of the board are not familiar with patient care, a medical professional should be there to interpret clinical data and medical terminologies. The study findings have shown that, the HMTs have the ultimate responsibility for the provision of quality health care. This does not concur well with what pointer and Orlikoff (1999) states, that is, "a board bears the ultimate authority, responsibility and accountability for organizations performance". Integrated governance was found to be a key prerequisite for provision of quality health care in most of the hospitals. However corporate governance and clinical governance were found to have weak links. The clinical committees were found not to have very strong representation in the boards, except for the Medical superintendents who sit in the boards to give advice on medical issues.

5.3 Limitations of the Study

The researcher encountered a number of limitations in this study. Time for the study was limited. The study did not consider other factors such as political, environmental, socio-economic and technological factors, which invariably influence the quality of health care regardless of the governance practices. Without taking these factors into consideration, it was therefore not possible to establish the extent of contribution of integrated governance on provision of quality health care.

5.4 Recommendations for further Research

A more comprehensive research should be carried out to cover the National Referral Hospitals, Private hospitals and Faith based organization hospitals, so as to establish the overall role of integrated governance in the provision of quality health care. In future studies integrated governance should be tied with other factors so that its exact contribution in the provision of quality health care can be establish.

5.5 Recommendations for policy framework

The research revealed that, there is under representation of the Hospital management Teams in the Hospital Management Boards, with the Medical superintendent being the only member of the HMT who sits in the board. A balance of representation is recommended. The study found out that, the ultimate authority, responsibility for provision of health care lies with the HMTs. It is recommended that, the HMBs be involved more in quality health care activities by having a representative of the board in the clinical committees. Performance of any board depends largely on the orientation and training of new board members on the roles and responsibilities. Since this is not done in most government hospitals in Kenya, the level and quality of contribution of some members may be affected. It is therefore, recommended that a training program through the Ministry of Medical Services, be established for the current and future hoapitals'board members. The size of board membership is too small and hence it is recommended that, it be expanded to allow additional skills and participation of board members in more hospitals' affairs.

REFERENCES

Cadbury, A. (1999). What are the Trends in Corporate Governance? **Long Range Planning**: Vol.3 No.1: Great Britain, Elsevier Science Ltd.

Croll, R. (2000). Between Evidence-based Practice and Total Quality Management: The implementation of cost-effective care. **International Journal for Quality Health Care**. London.

Drucker, P. (1976). "The Bored Board"; **Wharton Magazine**: Business, Government and society. New York, McGraw Hill Irwin.

Goswami, O. (2001). **The tide rises gradually: "Corporate Governance in India"**; OECD Development Centre Discussion paper, OECD Publishers.

Herman, R. (1990), Methodological issues in studying the Effectiveness on Non-Governmental and Non-profit organizations: **Non-profit and Voluntary Sector Quarterly**, Vol. 1990, pp2-3.

Herzlinger, R. (1996), Can Public Trust in Non-profit and Governments be restored: Harvard **Business Review**; March to April 1996.

Iskander,M.&Chamlou, N. (2002). **Corporate Governance**: A Framework for Implementation. The World Bank, Washinton D.C.

ISO 9000 Family (2002), **Quality Management Principles**: ISO 9000:2000

Jabet, C (2001): **A study of Corporate Governance**: The case of Quoted Companies In Kenya, Unpublished MBA Research Project, University of Nairobi.

Johnson, G. and Scholes, K.R. (2002), **Exploring Corporate Strategy**: 6th Edition, Prentice Hall, London.

Kazemek, E. (2000), **Effective Boards**: Working smarter to Meet the Challenge, Trustee 2000 May.

Kombo and Tromp (2006): **Proposal and Thesis Writing**; Nairobi; Pauline Publishers.

Kothari, C.R. (2003), **Research Methodology**: Methods and Techniques: 2nd Edition, New Delhi, India.

Legal Notice No. 155 (2009): Kenya gazette Supplement No.68: **The Government Financial Management Act** (No.5 of 2004).

Manyuru, J. (2005). **Corporate Governance and Organization Performance:** The case of companies Quoted At the Nairobi Stock Exchange, Unpublished MBA Research Project, University Of Nairobi.

Ministry of Health, (2006): **Facts and Figures at a Glance:** health and health Related Indicators, Nairobi.

MoH, (2006), **Kenya's Health Policy Framework**: Ministry of Health, Afya House, Nairobi.

Mucavi, M. (2002): **A survey of Corporate Governance Practices in Motor Vehicle Industry in Kenya**: Unpublished MBA Research Project, University of Nairobi

Mwangi, A.(2002) **a survey of corporate governance practices among insurance companies in Kenya,** Unpublished MBA Research Project, University of Nairobi.

Okeyo, T.M. (2003), **Health Professional Handbook on Quality Health care in Non-profit Institutions in Kenya**: Nairobi-London-Newyork. Centre for Quality Health Care, Nairobi, Kenya.

Oster, S. (2000), **Strategic Management for Non-profit Organizations**: New York: Oxford University Press.

Pointer. D. and Orlikoff. J. (1999), Governing Healthcare Organizations. **The internet Journal of Health Administration.** 1999 Vol.2 number 2.

PSICG. (1999). **Principles of Corporate Governance in Kenya.** Nairobi: Private Sector Corporate Governance Trust.

Qayed. M.G. (2008). **Health Care Services in Transitional Somalia**: Challenges and recommendations.

Roberts. C. and Connors. E (1998), Core Responsibilities of Responsibilities of Board Trustee. **Journal of Healthcare Management.**

Scally. G. and Donaldson. J. (1998),Clinical Governance and the Drive for Quality Improvement in the New NHS in England. **British Medical Journal.** 4th July. 1998: Vol

Steiner.G. and Steiner.J.(2003). **Business, Government and Society**. New York: McGraw-Hill Irwin.

Tang. N., Eisenberg. J.M and Merger. G.S (2004). **The Roles of Government in Improving Health Care Quality and safety**. Joint commission Journal on Quality and Safety: Harvard University. Boston. USA.

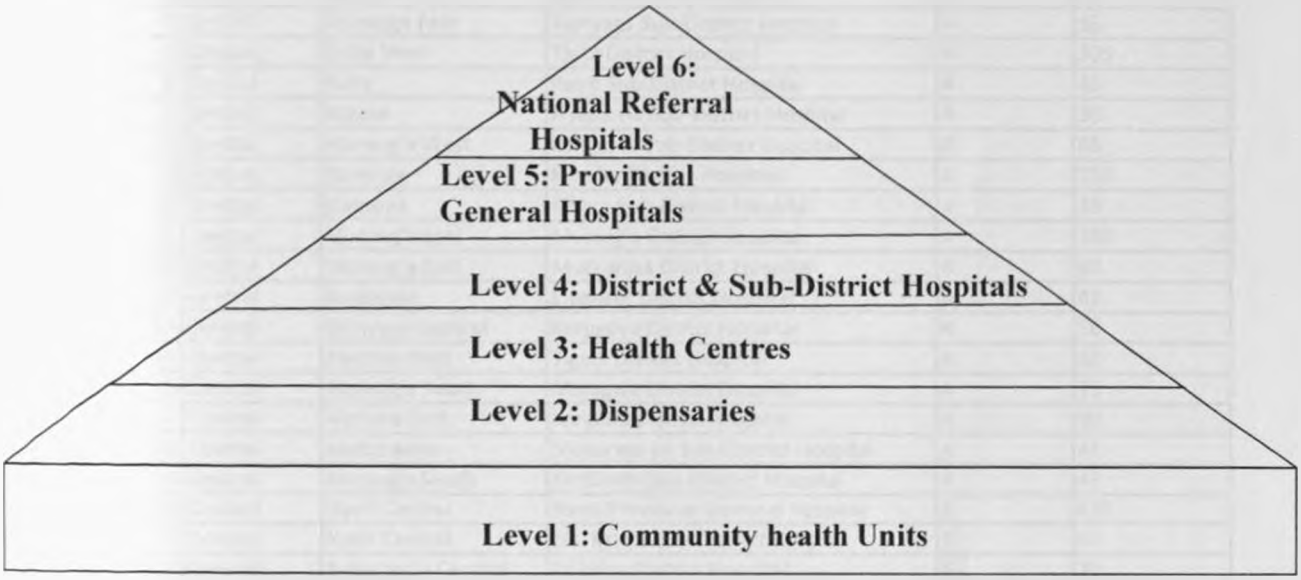
The Business Round Table. (1990). Corporate Governance and American Competitiveness**: New York Business Round Table.** March 1990.

The Capital Market Act (Cap 485 A) (2002): Guidelines on Corporate Governance Practices by Listed companies in Kenya. **Gazette Notice No. 369.**

Wang ombe. J. (2003). **A survey of Corporate Governance Practices in Co-operative Societies in Nairobi**: Unpublished MBA Research Project. University of Nairobi

WHO (2009). The World Health Report: **Primary Health Care now more than ever**: WHO library cataloguing-in-publication data.

APPENDIX I: LEVELS OF HEALTH CARE FACILITIES IN KENYA



Source: MoH, (2006), Kenya's Health Policy Framework: Ministry of Health, Afya House, Nairobi

APPENDIX II: LIST OF GOK GAZETTED HOSPITALS

S/NO.	PROVINCE	DISTRICT	NAME OF THE HOSPITAL	KEPH LEVEL	BED CAPACITY
1	Central	Gatanga	Kirwara Sub-District Hospital	4	35
2	Central	Gatundu North	Igegania Sub-District Hospital	4	40
3	Central	Gatundu South	Gatundu District Hospital	4	75
4	Central	Kirinyaga East	Kianyaga Sub-District Hospital	4	55
5	Central	Thika West	Thika District Hospital	5	305
6	Central	Ruiru	Ruiru Sub-District Hospital	4	45
7	Central	Kabete	Nyathuna Sub-District Hospital	4	30
8	Central	Murang'a West	Kangema Sub-District Hospital	4	65
9	Central	Kiambaa	Kiambu District Hosptial	4	210
10	Central	Kiambaa	Kihara Sub-District Hospital	4	43
11	Central	Murang'a East	Murang'a District Hospital	4	180
12	Central	Murang'a East	Muriranjas District Hospital	4	60
13	Central	Kinangop	Engineer District Hospital	4	43
14	Central	Kirinyaga Central	Kerugoya District Hospital	4	56
15	Central	Kiambu West	Tigoni District Hospital	4	67
16	Central	Murang'a South	Maragwa District Hospital	4	75
17	Central	Mathira East	Karatina District Hospital	4	90
18	Central	Mukurweini	Mukurwe-ini Sub-District Hospital	4	48
19	Central	Kirinyaga South	Kimbimbi Sub-District Hospital	4	43
20	Central	Nyeri Central	Nyeri Provincial General Hospital	5	610
21	Central	Nyeri Central	Mt. Kenya Sub-District Hospital	4	65
22	Central	Nyandarua Central	Ol'kalou District Hospital	4	70
23	Central	Nyandarua North	Nyahururu District Hospital	4	105
24	Central	Nyeri South	Othaya District Hospital	4	68
25	Coast	Bahari	Kilifi District Hospital	4	320
26	Coast	Chamgamwe	Port Reitz District Hospital	4	125
27	Coast	Chamgamwe	Tudor Sub-District Hospital	4	34
28	Coast	Tana River	Hola District Hospital	4	70
29	Coast	Ganze	Bamba Sub-District Hospital	4	34
30	Coast	Tana Delta	Ngao District Hospital	4	45
31	Coast	Kaloleni	Mariakani District Hospital	4	67
32	Coast	Kaloleni	Jibana Sub-District Hospital	4	45
33	Coast	Kinango	Kinango District Hospital	4	54
34	Coast	Kisauni	Coast Province General Hospital	5	890
35	Coast	Lamu East	Faza Sub-District Hospital	4	24
36	Coast	Lamu East	Lamu District Hospital	4	90
37	Coast	Lamu	Mpeketoni Sub-District Hospital	4	57
38	Coast	Likoni	Likoni Sub-District Hospital	4	34
39	Coast	Malindi	Malindi District Hospital	4	230
40	Coast	Kwale	Kwale District Hospital	4	55
41	Coast	Msambweni	Msambweni District Hospital	4	180
42	Coast	Mwatate	Mwatate Sub-District Hospital	4	45
43	Coast	Mwatate	Mwambirwa Sub-District Hospital	4	25
44	Coast	Taveta	Taveta District Hospital	4	70
45	Coast	Voi	Moi (Voi) District Hospital	4	98
46	Coast	Taita	Wesu District Hospital	4	78
47	Coast	Taita	Wundanyi Sub-District Hospital	4	45
48	Eastern	Meru Central	Kibirichia Sub-District Hospital	4	45
49	Eastern	Meru Central	Githongo Sub-District Hospital	4	64
50	Eastern	Imenti North	Meru District Hospital	5	240
51	Eastern	Buuri	Timau Sub-District Hospital	4	34

52	Eastern	Imenti North	Giaki Sub-District Hospital	4	45
53	Eastern	Imenti South	Kinoro Sub-District Hospital	4	53
54	Eastern	Imenti South	Mikumbune Sub-District Hospital	4	45
55	Eastern	Imenti South	Kanyakine Sub-District Hospital	4	34
56	Eastern	Isiolo	Isiolo District Hospital	4	80
57	Eastern	Garba Tula	Garbatulla District Hospital	4	23
58	Eastern	Kilungu	Nunguni Sub-District Hospital	4	23
59	Eastern	Kangundo	Kangundo District Hospital	4	74
60	Eastern	Kathiani	Kathiani Sub-District Hospital	4	65
61	Eastern	Makindu	Makindu District Hospital	4	65
62	Eastern	Nzaui	Matiliku District Hospital	4	34
63	Eastern	Nzaui	Sultan Hamud Sub-District Hospital	4	23
64	Eastern	Kibwezi	Kibwezi Sub-District Hospital	4	34
65	Eastern	Kitui Central	Kitui District Hospital	4	210
66	Eastern	Kitui Central	Katulani Sub-District Hospital	4	34
67	Eastern	Mutomo	Ikanga Sub-District Hospital	4	21
68	Eastern	Kitui West	Kanyangi Sub-District Hospital	4	23
69	Eastern	Kitui West	Kauwi Sub-District Hospital	4	12
70	Eastern	Machakos	Machakos District Hospital	5	504
71	Eastern	Makueni	Makueni District Hospital	4	88
72	Eastern	Embu West	Embu Provincial General Hospital	5	475
73	Eastern	Embu West	Kianjokoma Sub-District Hospital	4	45
74	Eastern	Mbooni West	Mbooni District Hospital	4	67
75	Eastern	Mbooni East	Tawa Sub-District Hospital	4	34
76	Eastern	Mbooni East	Kisau Sub-District Hospital	4	32
77	Eastern	Moyale	Moyale District Hospital	4	65
78	Eastern	Mutitu	Mutitu Sub-District Hospital	4	32
79	Eastern	Mwala	Mwala Sub-District Hospital	4	36
80	Eastern	Mwingi Central	Mwingi District Hospital	4	88
81	Eastern	Kyuso	Kyuso Sub-District Hospital	4	34
82	Eastern	Kyuso	Tseikuru Sub-District Hospital	4	23
83	Eastern	Mwingi East	Nuu Sub-District Hospital	4	20
84	Eastern	Mwingi West	Migwani Sub-District Hospital	4	25
85	Eastern	Meru South	Chuka District Hospital	4	67
86	Eastern	Maara	Magutuni Sub-District Hospital	4	45
87	Eastern	Igembe North	Mutuati Sub-District Hospital	4	24
88	Eastern	Embu East	Runyenjes District Hospital	4	56
89	Eastern	Marsabit	Marsabit District Hospital	4	60
90	Eastern	Mbeere North	Siakago District Hospital	4	36
91	Eastern	Mbeere North	Ishiara Sub-District Hospital	4	65
92	Eastern	Tharaka South	Tharaka (Marimanti) District Hospital	4	54
93	Eastern	Tharaka South	Kibunga Sub-District Hospital	4	35
94	Eastern	Igembe South	Nyambene District Hospital	4	76
95	Eastern	Igembe East	Muthara Sub-District Hospital	4	65
96	Eastern	Tigania East	Mikinduri Sub-District Hospital	4	43
97	Eastern	Tigania West	Mbeu Sub-District Hospital	4	45
98	Eastern	Tigania West	Miathene District Hospital	4	44
99	Eastern	Yatta	Matuu Sub-District Hospital	4	45
100	Nairobi	Dagoretti	Mbagathi District Hospital	4	128
101	Nairobi	Dagoretti	Spinal Injury Hospital	N/A	40
102	Nairobi	Dagoretti	Dagoretti Sub -District Hospital (Mutuini	4	43
103	Nairobi	Embakasi	Kayole II Sub-District Hospital	4	15
104	Nairobi	Kasarani	Mathari Mental Hospital	N/A	372
105	NorthEastern	Garissa	Garissa Provincial General Hospital	5	230

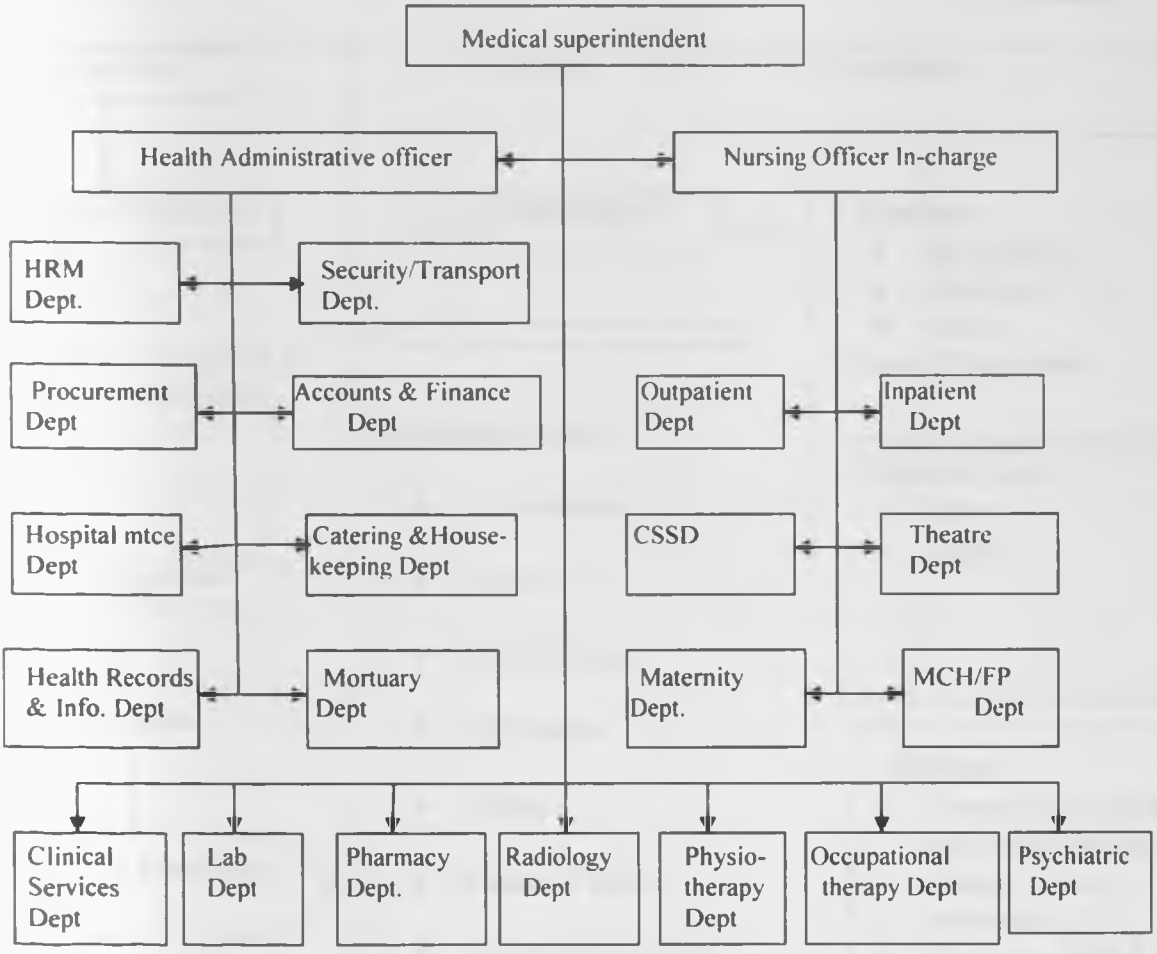
106	NorthEastern	Garissa	Mbalambala Sub-District Hospital	4	23
107	NorthEastern	Garissa	Iftin Sub-District Hospital	4	32
108	NorthEastern	Ijara	Masalani District Hospital	4	24
109	NorthEastern	Ijara	Hulugho Sub-District Hospital	4	26
110	NorthEastern	Lagdera	Dadaab Sub-District Hospital	4	20
111	NorthEastern	Lagdera	Modogashe District Hospital	4	24
112	NorthEastern	Mandera Central	Elwak Sub-District Hospital	4	47
113	NorthEastern	Mandera East	Mandera District Hospital	4	70
114	NorthEastern	Mandera East	Lafey Sub-District Hospital	4	45
115	NorthEastern	Mandera East	Rhamu Sub-District Hospital	4	32
116	NorthEastern	Mandera West	Takaba Sub-District Hospital	4	15
117	NorthEastern	Wajir East	Wajir District Hospital	4	67
118	NorthEastern	Wajir East	Khorof Harar Sub-District Hospital	4	34
119	NorthEastern	Wajir North	Bute District Hospital	4	21
120	NorthEastern	Wajir North	Buna Sub-District Hospital	4	15
121	NorthEastern	Wajir South	Habaswein Sub-District Hospital	4	23
122	Nyanza	Nyamache	Nyamache District Hospital	4	47
123	Nyanza	Nyamache	Nyacheki Sub-District Hospital	4	34
124	Nyanza	Gucha	Gucha District Hospital	4	67
125	Nyanza	Kisii South	Iyabe Sub-District Hospital	4	24
126	Nyanza	Kisii South	Etango Sub-District Hospital	4	23
127	Nyanza	Bondo	Bondo District Hospital	4	60
128	Nyanza	Bondo	Got Agulu Sub-District Hospital	4	43
129	Nyanza	Siaya	Siaya District Hospital	4	146
130	Nyanza	Siaya	Yala Sub-District Hospital	4	56
131	Nyanza	Rachuonyo South	Rachuonyo District Hospital	4	64
132	Nyanza	Rachuonyo North	Kandiege Sub-District Hospital	4	34
133	Nyanza	Rachuonyo North	Kendu Bay Sub-District Hospital	4	23
134	Nyanza	Rachonyo South	Kabondo Sub-District Hospital	4	43
135	Nyanza	Kisumu East	Nyahera Sub-District Hospital	4	32
136	Nyanza	Kisumu East	Kisumu District Hospital	4	156
137	Nyanza	Kisumu East	New Nyanza Provincial Gen. Hospital	5	368
138	Nyanza	Kisumu East	Victoria Sub-District Hospital	4	56
139	Nyanza	Kisumu West	Miranga Sub-District Hospital	4	45
140	Nyanza	Kisumu West	Chulaimbo Sub-District Hospital	4	56
141	Nyanza	Kisumu West	Kombewa Sub-District Hospital	4	57
142	Nyanza	Marani	Marani Sub-District Hospital	4	43
143	Nyanza	Manga	Nyangena Sub-District Hospital	4	45
144	Nyanza	Manga	Manga Sub-District Hospital	4	24
145	Nyanza	Masaba North	Esani Sub-District Hospital	4	22
146	Nyanza	Masaba North	Keroka Sub-District Hospital	4	34
147	Nyanza	Kuria East	Kehancha District Hospital	4	76
148	Nyanza	Kuria West	Ntimaru Sub-District Hospital	4	34
149	Nyanza	Kuria East	Isebania Sub-District Hospital	4	45
150	Nyanza	Mbita	Mbita Sub-District Hospital	4	45
151	Nyanza	Migori	Migori District Hospital	4	74
152	Nyanza	Nyando	Muhoroni Sub-District Hospital	4	45
153	Nyanza	Nyando	Masogo Sub-District Hospital	4	43
154	Nyanza	Nyando	Ahero Sub-District Hospital	4	45
155	Nyanza	Ndhiwa	Ndhiwa Sub-District Hospital	4	32
156	Nyanza	Ndhiwa	Rangwe Sub-District Hospital	4	26
157	Nyanza	Suba	Suba (Sindo) District Hospital	4	67
158	Nyanza	Suba	Ogongo Sub-District Hospital	4	45
159	Nyanza	Suba	Kisegi Sub-District Hospital	4	43

160	Nyanza	Nyamira North	Nyamusi Sub-District Hospital	4	25
161	Nyanza	Nyamira North	Ekerenyo Sub-District Hospital	4	26
162	Nyanza	Nyakach	Nyando District Hospital	4	65
163	Nyanza	Kisii Central	Ibeno Sub-District Hospital	4	32
164	Nyanza	Kisii Central	Kisii District Hospital	5	475
165	Nyanza	Kisii Central	Keumbu Sub-District Hospital	4	54
166	Nyanza	Masaba South	Ibacho Sub-District Hospital	4	43
167	Nyanza	Masaba South	Masimba Sub-District Hospital	4	23
168	Nyanza	Masaba South	Gesusu Sub-District Hospital	4	34
169	Nyanza	Nyatike	Karungu Sub-District Hospital	4	23
170	Nyanza	Nyatike	Macalder Sub-District Hospital	4	20
171	Nyanza	Homa Bay	Homa-Bay District Hospital	4	234
172	Nyanza	Rarienda	Madiany Sub-District Hospital	4	45
173	Nyanza	Rongo	Rongo Sub-District Hospital	4	21
174	Nyanza	Rongo	Awendo Sub-District Hospital	4	23
175	Nyanza	Gucha South	Nduru Sub-District Hospital	4	25
176	Nyanza	Borabu	Kijauri Sub-District Hospital	4	10
177	Nyanza	Ugenya	Ambira Sub-District Hospital	4	15
178	Nyanza	Uriri	Othoro Sub-District Hospital	4	18
179	Nyanza	Nyamira	Nyamira District Hospital	4	235
180	Nyanza	Kenyenya	Kenyenya Sub-District Hospital	4	46
181	RiftValley	Nandi South	Kaptumo Sub-District Hospital	4	34
182	RiftValley	Baringo Central	Kabarnet District Hospital	4	167
183	RiftValley	Marigat	Marigat Sub-District	4	23
184	RiftValley	Pokot East	Chemolingot Sub-District Hospital	4	26
185	RiftValley	Kericho	Kericho District Hospital	4	230
186	RiftValley	Bomet	Longisa District Hospital	4	98
187	RiftValley	Bomet	Sigowet Sub-District Hospital	4	43
188	RiftValley	Chepalungu	Sigor Sub-District Hospital	4	34
189	RiftValley	Buret	Kapkatet District Hospital	4	74
190	RiftValley	Pokot Central	Sigor Sub-District Hospital	4	46
191	RiftValley	Koibatek	Eldama Ravine District Hospital	4	78
192	RiftValley	Eldoret East	Huruma District Hospital	4	43
193	RiftValley	Eldoret West	Ziwa Sub-District Hospital	4	46
194	RiftValley	Nandi Central	Kapsabet District Hospital	4	78
195	RiftValley	Kajiado Central	Kajiado District Hospital	4	120
196	RiftValley	Kajiado North	Ngong Sub-District Hospital	4	24
197	RiftValley	Loitoktok	Loitoktok Sub-District Hospital	4	98
198	RiftValley	West Pokot	Kapenguria District Hospital	4	89
199	RiftValley	West Pokot	Chepareria Sub-District Hospital	4	56
200	RiftValley	Keiyo	Iten District Hospital	4	76
201	RiftValley	Keiyo	Kamwosor Sub-District Hospital	4	45
202	RiftValley	Keiyo South	Tambach Sub-District Hospital	4	60
203	RiftValley	Keiyo South	Kocholwo Sub-District Hospital	4	45
204	RiftValley	Keiyo South	Kaptarakwa Sub-District Hospital	4	43
205	RiftValley	Trans Mara West	Kilgoris District Hospital	4	65
206	RiftValley	Trans Mara West	Lolgorian Sub-District Hospital	4	28
207	RiftValley	Kipkelion	Londiani District Hospital	4	56
208	RiftValley	Kipkelion	Kipkelion Sub-District Hospital	4	34
209	RiftValley	Kipkelion	Fort-Ternan Sub-District Hospital	4	25
210	RiftValley	Konoin	Roret Sub-District Hospital	4	25
211	RiftValley	Konoin	Cheptalal Sub-District Hospital	4	56
212	RiftValley	Kwanza	Endebess Sub-District Hospital	4	43
213	RiftValley	Laikipia East	Nanyuki District Hospital	4	120

214	RiftValley	Laikipia East	Doldol Sub-District Hospital	4	15
215	RiftValley	Laikipia West	Rumuruti Sub-District Hosptial	4	24
216	RiftValley	Marakwet West	Chebiemit District Hospital (Marakwet)	4	68
217	RiftValley	Marakwet East	Tot Sub-District Hosptial	4	28
218	RiftValley	Kuresoi	Olenguruone Sub-District Hospital	4	30
219	RiftValley	Molo	Molo Sub District Hospital	4	65
220	RiftValley	Molo	Elburgon Nyayo Sub District Hospital	4	26
221	RiftValley	Nandi North	Chepterwai Sub-District Hospital	4	32
222	RiftValley	Naivasha	Naivasha Sub-District Hospital	4	98
223	RiftValley	Naivasha	Gilgil Sub District Hospital	4	68
224	RiftValley	Nakuru	Annex Hospital Nakuru	4	87
225	RiftValley	Nakuru	Nakuru Provincial General Hospital	5	436
226	RiftValley	Narok North	Narok District Hospital	4	187
227	RiftValley	Narok South	Ololulung'a District Hospital	4	32
228	RiftValley	Trans Nzoia West	Kitale District	4	189
229	RiftValley	Trans Nzoia West	Saboti Sub-District Hospital	4	35
230	RiftValley	Samburu West	Maralal District Hospital	4	70
231	RiftValley	Samburu East	Baragoi Sub-District Hospital	4	32
232	RiftValley	Nakuru North Subukia	Bahati District Hospital	4	30
233	RiftValley	Nandi East	Nandi Hills District Hospital	4	60
234	RiftValley	Tinderet	Meteitei Sub-District Hospital	4	45
235	RiftValley	Turkana Central	Lodwar District Hospital	4	67
236	RiftValley	Turkana North	Lopiding District Hospital	4	45
237	RiftValley	Turkana North	Lokitaung Sub-District Hospital	4	34
238	RiftValley	Turkana South	Kapedo Sub-District Hospital	4	23
239	RiftValley	North Pokot	Kacheliba Sub-District Hospital	4	32
240	Western	Teso North	Teso District Hospital (Kocholia)	4	43
241	Western	Teso South	Alupe Sub-District Hospital	4	67
242	Western	Bunyala	Port Victoria	4	56
243	Western	Butere	Butere District Hospital	4	68
244	Western	Butere	Manyala Sub-District Hospital	4	43
245	Western	Butula	Khunyangu Sub-District Hospital	4	34
246	Western	Kakamega South	Iguhu District Hospital	4	62
247	Western	Kakamega South	Shibwe Sub-District Hospital	4	34
248	Western	Bungoma South	Bungoma District Hospital	4	178
249	Western	Bungoma North	Kimilili District Hospital	4	103
250	Western	Bungoma North	Naitiri Sub-District Hospital	4	15
251	Western	Lugari	Lumakanda District Hospital	4	34
252	Western	Lugari	Matunda Sub-District Hospital	4	23
253	Western	Lugari	Mautuma Sub-District Hospital	4	34
254	Western	Lugari	Likuyani Sub-District Hospital	4	32
255	Western	Kakamega Central	Kakamega Provincial General Hospital	5	345
256	Western	Kakamega Central	Navakholo Sub-District Hospital	4	53
257	Western	Kakamega North	Malava District Hosptial	4	67
258	Western	Mt. Elgon	Mt. Elgon District Hospital	4	70
259	Western	Mt. Elgon	Cheptais Sub-District Hospital	4	45
260	Western	Mumias	Matungu Sub-District Hospital	4	34
261	Western	Busia	Busia District Hospital	4	124
262	Western	Samia	Sio Port District Hospital	4	34
263	Western	Bungoma West	Sirisia Sub-District Hospital	4	34
264	Western	Vihiga	Vihiga District Hospital	4	87
265	Western	Bungoma East	Webuye District Hospital	4	87
266	Western	Bungoma East	Bokoli Sub-District Hospital	4	43

SOURCE: MINISTRY OF MEDICAL SERVICES; QUARTERLY REPORTS FOR THE PERIOD ENDED 31ST MARCH 2010

APPENDIX III: A TYPICAL ORGANIZATIONAL STRUCTURE OF A GOK HOSPITAL

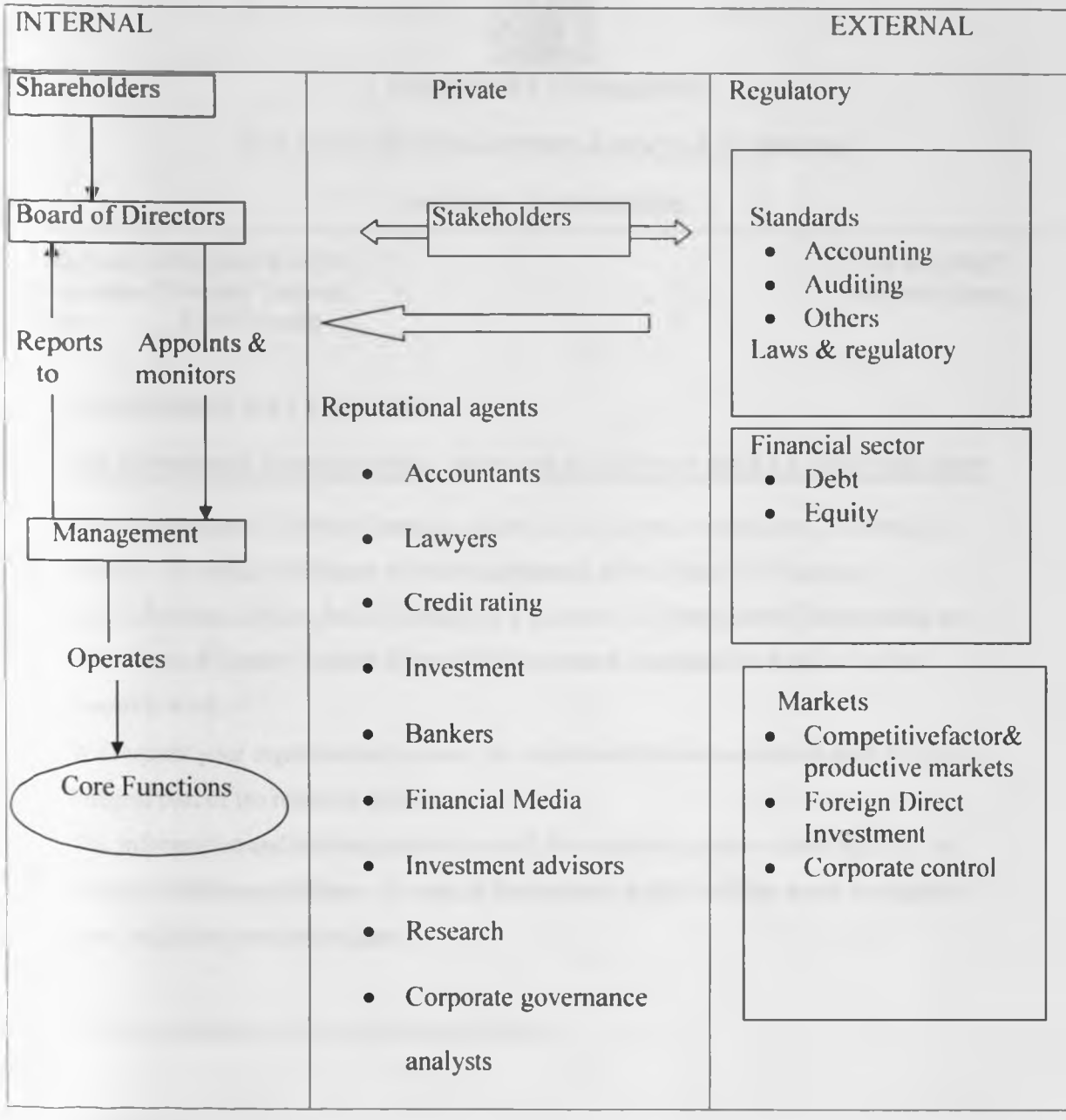


Key

CSSD- Central Surgical Sterilization Department
MCH/FP- Mother Child Health/ Family Planning Department
HRM- Human Resource Management Department

Source: Self

APPENDIX IV: CORPORATE GOVERNANCE FRAMEWORK



Source: Iskander and Chamlou (2000), Corporate Governance : A framework for implementation: World Bank, Washington DC, USA.

APPENDIX V: INTRODUCTION LETTER

UNIVERSITY OF NAIROBI

COLLEGE OF HUMANITIES & SOCIAL SCIENCES

SCHOOL OF BUSINESS

Telephone: 4184160-5 Ext 215
Telegrams: "Varsity "Nairobi
Telex: 22095 Varsity

P.O. Box 30197
Nairobi, Kenya

TO WHOM IT MAY CONCERN

RE: INTRODUCTION LETTER- RESEARCH: GIFTON MKAYA D/61/73001/2009

The above named is a Post Graduate student at the School of Business, University of Nairobi. In partial fulfillment of the requirements of the Master of Business Administration Degree, he is Conducting a research on **"Integrated Governance and Provision of Quality Health Care in Government Hospitals in Kenya"** for his research work.

We request your organization to assist the student with necessary data which forms an integral part of the research project.

The information and data required is needed for academic purposes only and will be treated in **Strict-confidence**. A copy of the research project will be made available to your organization upon request.

Your co-operation will be highly appreciated.

Thank you.

Gifton Mkaya
STUDENT

Dr. John Yabs
SUPERVISOR

APPENDIX VI: QUESTIONNAIRE

SECTION A (*To be completed by Health Administrative Officer*)

1.0 BOARD COMPOSITION

1.1 How many members are on your Hospital Management Board? (please tick one)

Less than 3 [ ] Between 3 and 6 [ ]

Between 6 and 9 [ ] more than 9 [ ]

1.2 Of these how many are ladies?

Less than 3 [ ] Between 3 and 6 [ ]

Between 6 and 9 [ ] more than 9 [ ]

1.3 How many Board members are employees of the Ministry of Medical Services?

Less than 3 [ ] Between 3 and 6 [ ]

Between 6 and 9 [ ] more than 9 [ ]

1.4 What skills are represented in your Hospital Management Board? (Please tick as appropriate)

Legal [ ] Finance /accounting [ ]

Medical [ ] Public Administration [ ]

Any other? Specify [ ].....

1.5 What additional skills would like to see added to your Hospital Board?

.....

1.6 What is the typical method used to nominate/select board members? (Please tick as appropriate).

i) By DMSO [ ] ii) By Medical Superintendent [ ]

iii) By local politicians [ ] iv) By provincial administration [ ]

v) Others (specify).....

1.7 What criteria are used to identify the board members?

.....

.....

1.8 What is the length of term for the board members? (Please tick one)

(i) Less than one year [ ] (ii) Between one and two years [ ]

(iii) Between two and three years [ ] iv) More than three years [ ]

v) No fixed term [ ]

1.9 Are board terms renewable? (Please tick one)

i) Yes, indefinitely [ ] ii) Yes, for a fixed period [ ]

iii) Yes, for a renewable period [ ] iv) No [ ]

1.10. What is the highest academic qualification of the chair? (Please tick one)

i) Less than O'level [ ] ii) O'level [ ]

iii) A' level [ ] iv) Graduate [ ]

v) others (specify).....

1.11. Who chooses the Chair?

i) Other board members [ ] ii) The DMSO [ ]

iii) The Local politicians [ ] iv) The medical superintendent [ ]

v) The provincial Administration [ ]

1.12 What is the length of term for the Chair? (Please tick one)

i) Less than one year [ ]

ii) Between one and two years [ ]

iii) Between two and three [ ]

iv) More than three years [ ]

v) No fixed term [ ]

1.1.3 Which office bearers does the board elect? (Please tick as appropriate)

i) Chair [ ] ii) Vice chair [ ]

iii) Treasurer [ ] iv) Secretary [ ]

v) Others (specify) .....

1.1.4 How important are the officers to the proper functioning of the board? (Please tick one)

i) Very important [ ] ii) Important [ ]

iii) Somehow important [ ] iv) Not important [ ]

v) Absolutely not important [ ]

2.0 BOARD STRUCTURE

2.1 List all the board committees that exist in your hospital for the proper functioning of the board in order of importance.

i) .....

ii) .....

iii) .....

iv) .....

v) .....

2.2 Please complete the following table that outlines the information about the board committees listed above.

	Committee	**Number of members**	**Number of meetings held per year**	**Responsibilities**
1				
2				
3				
4				
5				

2.3 Are there by- laws and statutes detailing the following issues? (Tick all that apply)

i) Number of board members [ ]

ii) Number of meetings per year [ ]

iii) Term length [ ]

iv) Quorum requirements [ ]

v) Education qualifications [ ]

3.0 BOARD MEETINGS

3.1 How often does the board meet?

i) Once per year [ ] ii) Twice per year [ ]

iii) Quarterly [ ] iv) Not definite [ ]

ii) Any other (specify).....

3.2 What percentage of board representation is required to constitute a quorum?

i) 40 to 50 % [ ] ii)50 to 60 % [ ]

iii) 60 to 70 % [ ] iv) 70 to 80 % [ ]

iv) Not definite [ ]

3.3 Who creates the agenda for the meetings

i) Chair [ ]

ii) Secretary [ ]

iii) Both chair and secretary [ ]

iv) All board members

v) Others (specify).....

4.0 ROLE OF THE BOARD

4.1 Which of the following descriptions best describes the nature of your hospital board? (Tick one)

i) Monitors the hospitals activities but leaves most decisions to the Hospital Management Team [ ]

ii) Involved in strategic planning and policy decisions but not in operation decision making. [ ]

iii) Actively involved in many levels of decision making including operational decisions.

iv) Has eyes on but hands off on the activities of the hospital. [ ]

v) None of the above.

4.2 What are the major roles of the board?

i. .....

ii. .....

iii. .....

iv. .....

4.3 For which operational activities is the board approval required? (Tick as appropriate)

i. Expenditures above certain limits [ ]

ii. Introducing new service fees for cost-sharing program [ ]

iii. Hiring and firing contract/ casual workers [ ]

iv. Opening of tenders [ ]

v. Others (specify).

.....

4.4 What is the board's overall influence over the direction and control of the Hospital? (Tick one)

i) Very influential [ ] ii) Fairly influential [ ]

iii) Influential [ ] iv) Not influential [ ]

4.5 How important is the inclusion of members from diverse professional background? (Tick one)

ii) Very important [ ] ii) Fairly important [ ]

iii) Important [ ] iv) Not important [ ]

4.6 What is the level of influence of non-executive board members in decision making? (Tick one)

i) Very high [ ] iii) Moderate [ ]ii) Hig [ ] iv) Low [ ]

v) Very low [ ]

4.7 What is your assessment of the board commitment as measured by the frequency and attendance of board meetings? (Tick one)

i. Very committed [ ] iii. Committed [ ]

ii. Fairly [ ] iv Not committed committed [ ]

4.8 a) Is the performance of the Chair evaluated?

Yes [ ] No [ ]

b) If yes, explain how it is evaluated.....

.....

4.9 a) Is the performance of the board evaluated?

Yes [ ] No [ ]

b) If yes, explain how it is evaluated.....

4.10 a) Is training of the board done?

Yes [ ] No [ ]

b) If yes, explain briefly how it is done.....

GOVERNANCE PRACTICES

4.1 Who are the stakeholders of your hospital?

i) .....

ii) .....

iii) .....

iv) .....

v) .....

vi) .....

4.2 To what extent do the following board best practices apply to your Hospital Management board?

Use a five point scale to answer: where 1=strongly disagree 2=Disagree 3=Not aware 4=Agree 5=strongly agree

i) The composition of the board is balance between the executives and non-executive. 1[ ] 2[ ] 3[ ] 4[ ] 5[ ]

ii) There are transparent procedures for the 1[]2[]3[]4[] 5[]
nomination and appointment of new board members.

iii) Information that might create potential conflict 1[]2[]3[]4[] 5[]
is disclosed.

iv) The board has access to accurate, relevant and timely1[]2[]3[]4[] 5[]

v) Information to make informed and objective decisions 1[]2[]3[]4[] 5[]

vi) Board members are given formal training on roles 1[] 2[]3[] 4[]5[
duties, responsibilities, obligations and procedures on
first appointment. 1[]2[]3[]4[] 5[]
Board keeps proper and accurate books of accounts1[]2[]3[]4[] 5[]

4.3 Who bears the ultimate authority, responsibility and accountability for provision of quality health care? (Tick one)

i) Hospital Management Board (HMB) [ ]

ii) Hospital Management Team (HMT) [ ]

iii) Both HMB and HMT [ ]

iv) None of the above [ ]

4.4 a) Are there any policies directed towards quality of health care\

Yes [ ] No [ ]

b) If yes, what are the policies?

.....

4.5 How does the board evaluate and monitor the provision of quality health care as underscored by your hospital "vision" and "mission statement"

.....

..... a) Is there any link between corporate governance and clinical governance in your hospital?

Yes [ ] No [ ]

b) If "yes", what are the linkages? .....

.....

c) If "no", what should be done to create these linkages?

.....

.....

4.6 Which aspect of broad-stake-holder relations is most in need of improvement?

.....

.....

4.7 Do you have any other suggestions on how to improve good governance specifically to your hospital?

.....

.....

4.8 Please give your suggestions on how good governance practices can be improved in government hospitals.

.....

.....

SECTION B (***To be completed by the Medical superintendent or medical officer in-charge of the hospital)***

1. Does your hospital have a committee responsible for clinical governance or quality health care ?

Yes [ ] No [ ]

2. If yes, what name is given to this committee? .....

.....

3. What is the mandate of the committee? .....

.....

4. Who sits in this committee and what skills does each member represent? (Answer by completing the table here under)

	Committee member	Skills
1		
2		
3		
4		
5		
6		
7		

5. What is the policy of your hospital in each area of clinical governance

   i) Education and training of staff:

   .....

   .....

   Clinical audit i.e. review of clinical performance:

   .....

   .....

   ii) Clinical effectiveness i.e. measure of the extent to which particular intervention works:

   .....

   .....

   Research and Development:

   .....

   .....

   Openness to public scrutiny:

   .....

   .....

   iii) Risk management.....

What is the effectiveness of the above committee in handling issues pertaining to the following clinical governance issues?

Use a five point scale to answer: where 1=Very ineffective 2=Ineffective 3=fairly effective 4=Effective 5=Very effective.

i)	Education and Training of staff	1[ ] 2[ ] 3[ ] 4[ ] 5[ ]
ii)	Clinical Audit	1[ ] 2[ ] 3[ ] 4[ ] 5[ ]
iii)	Clinical effectiveness	1[ ] 2[ ] 3[ ] 4[ ] 5[ ]
iv)	Research and Development	1[ ] 2[ ] 3[ ] 4[ ] 5[ ]
v)	Openness to Public scrutiny	1[ ] 2[ ] 3[ ] 4[ ] 5[ ]
vi)	Risk management	1[ ] 2[ ] 3[ ] 4[ ] 5[ ]

6. Is the above committee represented in the hospital board?

   Yes [ ] No [ ]

7. If yes, does it receive enough support from the board? Explain.

   .....

   .....

8. How effective is the clinical governance committee in dealing with the following aspects of quality health care?

   Use a five point scale to answer: where 1=Very ineffective 2=Ineffective 3=fairly effective 4=Effective 5=Very effective.

vii)	Access to primary health care	1[ ] 2[ ] 3[ ] 4[ ] 5[ ]
viii)	Technical health quality	1[ ] 2[ ] 3[ ] 4[ ] 5[ ]
ix)	Appropriateness of care	1[ ] 2[ ] 3[ ] 4[ ] 5[ ]
x)	Outcomes of care	1[ ] 2[ ] 3[ ] 4[ ] 5[ ]

9. In your own opinion what do you think are some of the successes of your hospital in provision of quality health care?

   .....

   .....

   Do you think integration of governance in the hospital has contributed to some of these areas?

   Yes [ ] No [ ]

10. If yes, state the exact dimensions of quality health care which have improved due to integrated governance over the last five years.

.....

.....

From a medical point of view, what do you think is the role of corporate governance in clinical governance?

.....

.....

Please give suggestions on how good governance practices can be used to improve the provision of quality health care in Government hospitals in Kenya.

.....

.....

THE END

APPENDIX VII: BUDGET FOR THE RESEARCH

	BUDGET ITEM	QUANTITY	RATE (KSHS)	TOTAL AMOUNT (KSHS)
1	Typing, printing and other computer services			14,000
2	Communication (airtime and internet)			15,000
3	Report preparation & binding	8 copies	625	5,0000
4	Travelling & subsistence	3 trips	2000	6,000
5	Final report preparation			10,000
6	General stationeries			5,000
7	Contingencies			50000
	TOTAL			**60,000**

APPENDIX VIII: WORK PLAN FOR THE YEAR 2010

ACTIVITY	APR	MAY	JUN	JUL	AUG
Development of topic	xxx				
Development of proposal		xxx	xxx		
Oral presentation (defense)				xxx	
Data collection				xxx	
Data analysis & report writing					xxx