FACTORS INFLUENCING IMPLEMENTATION OF COST SHARING PROGRAM IN PUBLIC HEALTH FACILITIES IN MACHAKOS COUNTY, KENYA.

BY

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DECLARATION

This research project report is my original work and has not been submitted to any other university or institution for any academic award.

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

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DEDICATION

I sincerely dedicate this work to my loving family for their unwavering support throughout this course.

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ABBREVIATIONS AND ACRONYMS

DHMB- District Health Management Board
FIF – Faculty Improvement Fund
GOK- Government of Kenya
HCFD- Health Care Financing Division
HRIO- Health Records Information Officer
KEPH- Kenya Essential Package of Health
KHPF- Kenya Health Policy Framework
MOH- Ministry of Health
NHSSP- National Health Sector Strategic Plan
OJT- On Job Training
OOP – Out of Pocket
P/PHC- Primary/ Preventive Health Care
SAPS- Structural Adjustment Programs
SPSS- Statistical Package for the Social Sciences
THE- Total Health Expenditure
UNICEF- United Nations Children's Fund

ABSTRACT

Provision of affordable and quality health care remains an issue of concern in Kenya just like in any other third world countries. Implementation of cost sharing program in Kenya then aimed at providing equitable and affordable healthcare at the highest possible standards for all citizens. Thus, the purpose of this study was to identify the factors influencing implementation of cost sharing program in public health facilities in Machakos County, Kenya. The study sought to establish how competence of employees, assess how internal controls, assess the extent to which attitude of employees and establish how public awareness influence the implementation of cost sharing program. The researcher used a descriptive survey research design to enable her capture attitudes of the respondents, which might otherwise be difficult to measure using observation method. Main instrument used for data collection was a questionnaire due to its practicability in reaching a large number of respondents. The study had a sample size of 263. This included managers, health care workers, clients and patients as program users and 2 key informants. Simple random sampling was used as a representation of the whole population. The data collected was analyzed using SPSS and was presented in tables and figures. The findings of the study showed that most of employees were not competent in issues related to cost sharing program. In fact a good number of the implementers did not know what the program entails as they had not been trained or updated. Their roles in the program were not clear. Internal control measures put in place-influenced implementation of the program in that most of them were ineffective, supervision was wanting and there capacity to detect fraud and corruption was quite low. Staff attitude, which was more of negative than positive was found to influence the implementation of the program. Most of the employees did not appreciate the importance of cost sharing and felt that collection and utilization of the funds was inappropriate. Public awareness about cost sharing was scarce, as the public knew little or nothing about the program thus influencing its implementation. The study recommended that the issues of staff incompetence need to be urgently addressed by ensuring proper training, communication and updates. Accountability and transparency are key issues that need to be checked through the financial control measures used. There is need for all concerned parties to address the need to change the negative attitude of the employees through communication and ensuring favorable working environment. Public awareness and involvement is key in implementation and sustainability of projects. There is urgent need for national and county governments to put in place measures that accommodate long-term awareness raising campaigns that become part and parcel of normal life of the public.

CHAPTER ONE
INTRODUCTION

1.1 Background to the study

Many countries in sub Saharan Africa are unable to provide adequate quality and coverage of health care services due to poor economic performance and dwindling resources. The sector is also largely under funded. This prompted many countries to advocate to the implementation of health sector reforms with a view to maximize the use of available resources, improving access, efficiency and quality of health care services provided.

Cost sharing which is also known as user fees/charges, cost recovery, direct payment matching, or Facility Improvement Fund (FIF) is that portion of project or program costs not borne by the funding agency. It includes all contribution, cash and in kind that a patient makes to an award. (Ministry of Health, 2008). User fee is a financing mechanism that has two characteristics, that is; payment is made at point of services and entails combination of drugs, other medical material costs and entrance fees that are paid for each visits to the health facility.

According to Robert Lowe, (2008), the combined effects of increasing demand for health services and declining real public resources were recently led by health facilities in the developing world to explore various health financing alternatives. One of the ways that health sector has put in place to raise funds to cater for medical expenses is by patients contributions towards medical services received. The economic debt crisis of the late 1980's formed the background for Structural Adjustment Programs (SAPS) in the health sector. The introduction of SAPS brought about reforms in the health sector, which were aimed at trying to correct system wide problems that hinder the delivery of quality health services. The economic debt crisis led to the diminishing financial abilities of governments to provide social services such as health and education. African governments were faced with the challenge of sourcing funds in order to continue financing social service provision. One of the ways of sourcing funds therefore was located in the potential to pay by users hence

the introduction of cost sharing (MOH,2006). This was meant to ensure adequate standardized health care services are received through purchasing benefit package and provision of good quality care at the lowest possible cost through the provided payment mechanisms. However a challenge remained as concerned the very poor and those unable to raise the funds for their medical care. This led to the introduction of the waiver and exemption facilities.

In Kenya cost-sharing program was mooted in 1984/ 1988-developmentplans and implemented in December 1989 through a cabinet paper. The main objectives of the policy was to encourage increased cost recovery from users of public health facilities to generate additional revenue and augment the financing of the under funded non-wage recurrent expenditure items, reduce excessive use of services, improve functioning of referral systems and improve access and quality of care by the poor to health services. The rationale was to charge those who make most use of the curative care and those most able to pay and channel the subsidies to those least able to pay (Mwabu, 2008).

The extra revenue generated from the FIF is invested to the health sector to better the services and increase demand for services and in the process offsetting the negative price effect. According Klitzin, Cashin and Jakab, (2010), effectiveness of cost sharing in the health facilities should be directed towards management for better quality of life. As noted by Wamai, (2008), Out Of Pocket (OOP) where user fee is included, remains the largest source of heath funds in Kenya contributing to about 51.1% of Total Health Expenditure (THE) in the fiscal year 2008/2009. However the government has never reached the Abuja target of 15% of its budget allocation to the health sector. The target has been between 7.9% in 2006/2007 financial year and 6.9%in 2009/2010.

This does not however mean that the government has ignored the health sector as over time the former has had increased expenditures on health. For example in 2010/2011 pumped US $ 614 million and US $ 8673.9m in 2011/2012 in the health

sector (GOK2009). Despite the attempted remedies to improve the quality of health status of all Kenyans through deliberate restructuring of health sector so as to make health services more effective, accessible and affordable, the sector has continued to experience a steady decline in resources, deteriorating facilities, poor maintained medical equipment, lack of vital medical inputs like essential drugs, laboratory reagents, increase in disease burden and inadequate capacities to effectively respond to existing and emerging health challenges.(GOK, 2010).

Besides cost sharing, health facilities also benefit from the government, donors like United Nations Children's Funds (UNICEF) and National Hospital Insurance Fund (NHIF) which has also been part of cost sharing program since 1993. However these funds have not been effectively utilized to cater for all patients' health expenses. Congressional Budget Office (2007) notes that in Kenya patients have been faced with low quality and unaffordable services. Capacity development in relation to utilization of the funds has not been seriously put into consideration. Health workers have negative attitude towards the program thus don't support it as expected.

That not withstanding, measures put in place by the government in collection, utilization and accounting of the funds are not quite clear to all. Accountability and transparency of the use of cost sharing has been a center of controversy with rampant cases of misuse being reported.(controller and audit report,2007/2008).Cases of fraud from health facilities has also been reported to the ministry of health (MOH) Communities do not own the cost-sharing program as they feel they serve the interest of the health workers.

Table 1.1 Utilization of funds generated through cost sharing

Activities	Percentage (%)
Maintenance of buildings and equipment	37
Drugs and dressing	20
Primary health care	9
Fuel, electricity and water	9
Transport	11
Cleansing materials	5
Patients food, oxygen and other expenses	9

An analysis of the use of cost sharing revenue for the period 1989-1993 by Quick and Musau, (1994) shows the activities and percentages in utilization of the funds collected. Most of the revenue went to maintenance of buildings and equipment as opposed to 5% for cleansing materials. Table 1.1 gives clear illustration in the utilization of the funds.

In fact various studies carried out express that since 1994 the use of cost sharing funds is being shifted more towards such non-priority areas as transport and food.
More than 2 decades after its implementation the cost-sharing program has not fully addressed the problems of the vulnerable and promoted access to modern health care. Implementation problems and institutional weaknesses mar the program and there has not been corresponding improvement in quality of health care despite increase in revenue collection.

1.2 Statement of the problem.

According to MOH (2008), cost sharing, which is also referred to as user fees co-financing, cost recovering recovery or facility improvement fund (FIF) is that portion of project or program cost not borne by the funding agency.
The economic debt crisis experienced in Kenya in the 1980's led to introduction of health sector reforms under the umbrella of structural adjustment programs (SAPS).
Various studies that have been undertaken to assess the impact of user fee on utilization and efficiency of health services in sub Sahara Africa has shown conflicting results. These include demand on quality improvement, tendency of

patients to migrate to private sector facilities, reduction in utilization of public services, drop in outpatient attendance for basic curative services as a result of lack of essential supplies, equipment and bribery (Mwabu and Wang'ombe, 2005).
Bruce and Christopher, (1999) highlight corruption as major issue indicated in the National Corruption Perception Survey of June 2007.

Cost sharing fund is not effectively managed right from its collection, budgeting and expenditure. Most of the clients seeking for services in the public health sector do not get value for their money. Policy guidelines need enforcement. Usage of funds is highly misappropriated; structure put in place has loopholes, and efficiency in collection and use of the funds raise audit queries.

As noted by Huskamp, (2003), most of the health facilities in the third world where Kenya belongs are faced with challenges of incompetent personnel who are unaccountable for the cost-sharing funds. Issues that intended to be solved through cost sharing are still prevailing. This then raises the big question of whether there is need for implementation of cost sharing program. If yes, then what needs to be done to have its goals achieved?

Hence, there was need to carry out this study which sought to identify the factors influencing implementation of cost sharing program in public health facilities in Machakos County.

1.3 Purpose of the study.

The purpose of this study was to identify the factors influencing implementation of cost sharing program in public health facilities in Machakos County.

1.4 Objectives of the study

The study was guided by the following objectives;

1. To establish how competence of employees' influences implementation of cost sharing program in public health facilities in Machakos County.

2. To assess how internal controls influence implementation of cost sharing program in public health facilities in Machakos County.
3. To assess the extent to which attitude of employees influence implementation of cost sharing program in public health facilities in Machakos County.
4. To establish how public awareness influences implementation of cost sharing program in public health facilities in Machakos County.

1.5 Research questions.

The study sought to answer the following questions.

1. How does the competence of employees influence implementation of cost sharing program in public health facilities in Machakos County?
2. How do internal controls influence implementation of cost sharing program in public health facilities in Machakos County?
3. To what extent does employees' attitude influence implementation of cost sharing program in public health facilities in Machakos County?
4. How does public awareness influence implementation of cost sharing program in public health facilities in Machakos County?

1.6 Significance of the study.

The study was aimed atgenerating both quantitative and qualitative data and to critically examine why cost-sharing program has not effectively peaked to meet the expected goals. Presently there is limited data on all aspects of cost sharing thus this study attempts to fill the gaps. Further more the findings of this study may enable the stakeholders in the health sector in the government to formulate polices useful in improving the efficiency of cost sharing program.

Other beneficiaries of the study are the managers in the health facilities in Machakos County, as the information gathered will hopefully advance knowledge and understanding of key issues in cost sharing. Other employees will also benefit as the information is not only restricted to the managers.

With the use of the findings of the research, improved efficient, quality health care

and effective use of the cost-shared revenues may be achieved.

Future researchers may use the information in this study to find out more about cost sharing in health facilities.

Technocrats in other fields can as well use the study findings to improve in their fields of specialization.

The community members may be better informed about cost sharing. Information is power thus empowerment of the society and so improvement in decision-making.

1.7 Limitations of the study.

The following were some of the limitations of the study.

1. The researcher had limited funding and was faced by shortage of finances. Financial cost was incurred in traveling as the health facilities are far apart from each other. Poor road networks characterize Machakos County.
2. Communication barrier was an issue as majority of the respondents communicates in their mother tongue.
3. The sample size was small considering the study was carried out in three sub-county hospitals and not everyone was interviewed thus limited information.

1.8 Delimitations of the study.

The researcher using the public health facilities not so far apart from each other resolved the limitations explained above. She also solicited for funds from Well-wishers, friends and donors.

The research study aimed at identifying the right personnel to avoid any issues with communication thus collect as much information as possible.

The research personnel were from Machakos County where the research was conducted to ensure that they have the basic knowledge, embrace culture and know the geography of the area of study. The researcher ensured non-bias selection of respondents through random sampling.

1.9 Basic Assumptions of the Study.

The basic assumptions of this study were:-

1. Data collection method chosen was the most appropriate for the study.
2. Respondents answered questions correctly and truthfully.

1.10 Definition of Significant Terms.

Accounting Records.

These are the documents and books of account of money coming into and going out of the charity and record of assets and liabilities kept by the organization.

Budget.

This is a plan drawn up by the owners, which sets out the planned income for future financial period, often a year and the planned spending for that financial year. The budget estimates the amount and source of future incoming funds, the amount and nature of planned expenditure for a particular future accounting period.

Cost sharing Program.

This is a planned series of events where the client or patient pays a subsidized amount of money for the services offered.

Effective Cost Sharing.

This refers to the funds being used in the intended activities as stipulated by the governing document.

External Audit.

This is a regulated activity and refers to the statutory audit of the accounts. An eligible person under charities Act 2011 who is a statutory auditor for a Law company undertakes an audit. The auditor expresses his/her professional opinion as to whether the accounts are true and fair and undertakes procedures necessary to form that opinion in accordance with international auditing.

Governing Document.

This is any document that sets out organization purposes and usually how it is to be administered. It may be articles of association, constitution, circulars, policy guidelines just to mention but a few.

Internal Audit.

This is part of the internal control arrangement. The internal auditor usually reports directly to the trustee or an audit committee set up by the organization. Internal auditors look at all risks facing an organization and measures taken to manage those risks. These risks include reputation risk, operational risks or strategic risk.

Program.

A planned series of future events, activities and performances.

Quality Health Services.

Quality health care is hooked upon certain indicators like availability of essential and emergency drugs, basic laboratory reagents, reasonable waiting time, conducive environment, affordable charges, friendly client/patient- employee relationship and many more.

1.11 Organization of the Study.

The study is organized in three chapters. Chapter one gives the background of the study, statement of the problem, purpose of the study, objectives of the study, research questions and research hypothesis. It further goes on to describe the significance of the study, limitation and delimitations of the study, basic assumptions and finally definition of significant terms.

Chapter two deals with the review of literature based on the objectives of the study. A theoretical framework is discussed in relation to the study. A conceptual framework used to show the variables of the study and their indicators.

The chapter is concluded with a summary of the literature review.

Chapter three is about research methodology, which captures, the design, target

population, sample size and sampling technique, research instruments, data collection procedure, data analysis technique, ethical considerations and operationalization of variables.

Chapter four includes data analysis, presentation and interpretation, while chapter five concludes with summary of findings, discussions, conclusion and recommendations.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

The chapter reviews the literature on factors influencing implementation of cost sharing program in health sector. These factors include competence of employees, Internal control systems, attitude of employees towards the program and government regulatory policy framework. It further seeks to highlight the gaps, theoretical and conceptual frame works within which the study is to be carried out.

2.2 Implementation of Cost sharing

Access to basic health services of acceptable quality is still denied to many of the world's poorest people. Against a backdrop of severely under funded health systems, governments are faced with dilemma. Payment for health services in the form of user charges is likely to present a barrier to access. On the other hand, shortage of resources at the facility level contributes to failure to deliver quality services and this too represents a barrier to access (MOH, 2009).

According to Sealy, Stephanie and Rosbath, (2011) identify the impact of poverty on people's health as related to cost-sharing policy. A study carried out in 2007 showed that 38% of sick Kenyans did not seek health care as they lacked money, while one third resorted to self-medication, and 15.3% sell personal assets to offset health care. The rich are able to access better services in better equipped facilities while the poor get low-quality services from cheap health care providers with poorly equipped facilities.

The essence of introducing user fees was to combat three aspects within health sector which include:

Improve efficiency by moderating demand, containing cost and mobilize more funds for health care other than the existing sources provided (Ministry of medical services 2008)

Proponents of the user fees relate it to improved equity, quality care and efficiency.

Opponents of the program on the other hand argue that user charges do not improve the Qualities of care and cause medical services to be priced higher than those charged by private health care providers.

This view relies on studies indicating drastic and sustained decreases in health care service utilization following the introduction of user fees in Zambia, Cambodia, Rwanda and Uganda in the early 1990s. (Shaw and Griffin, 1995).

Although current revenue from user fee charges is totaling to 35% in China, the negative effects on service utilization and quality of care do not rule in favor of cost sharing.

As a conclusion therefore, user fees are found not to be the perfect solution to inadequate funding for health care sector. Secondly, user fees have proven to be ineffective as a stand-alone policy, and lastly the improvement in quality of care as a result of implementation of cost sharing is yet to be realized. (GOK, 2010).

2.3 Review of Related Literature

A review of related literature on factors influencing cost sharing program that is competence of employees, internal controls, employees, attitude, and government regulatory framework are discussed below.

2.4 Influence of Competence of Employees and cost sharing program

Competence refers to the ability of an individual to do a certain job or task properly. It is a combination of practical and theoretical knowledge, cognitive skills, behavior and values used to improve performance. It can be acquired through training, grow through experience and extent of an individual to learn and adopt and willingness to undertake work activities in accordance with agreed standards, rules and procedures. (Robinson 2010). According to Robinson, (2007), a high performing, effective health care system is important for the viability of communities and improvement in human health around the world. The World Bank's 1999'' Better Health for Africa ''report suggested that poor management of the already existing resources mostly inhibits progress in some countries. The need for health system strengthening especially in

developing countries is urgent and demanding of practical solutions and interventions. Organization and their employees have to meet the worldwide requirements and standards so as to gain competitive advantage in the global market. (Noe, 2006). In any society, work activity becomes more complicated as knowledge rapidly gets out dated and the requirements for employees' competence constantly increase. Thus there is need for organizations to create conducive conditions for their employees that motivate them to be involved in long life learning process.

Benefits of competencies as highlighted by Rowen and Stephenson, (2006) include aligning initiatives of the organization to the overall business strategy. Organizations can better recruit and select the right employees. This makes performance management, succession planning and carrier development quite easy. MOMS (2008) clearly identify the key staff and their responsibilities for the cost sharing activities in the public health facilities. The staff includes the medical superintendent, hospital matron, heath administrative officer, accountant, cashier/revenue clerk, nurses' in-charge of wards and outpatient department, NHIF clerk, health records and information officers (HRIO) and heads of any generating departments. For the above team to work effectively there is need for refreshment of initial training to ensure workers remain competent. In cases of changes in work equipment, system of work or introduction of new equipment additional training may be required. (GOK, 2010).

Employee training is the responsibility of the organization while employee development remains a shared responsibility of the management and the individual. The management provides right resources and environment that supports growth and development needs of the individual employee. Success for training according to (MOH, 2009) entails a well crafted job description, required training, good understanding, knowledge, skills and abilities, training opportunities and encouragement of staff to develop individual development plans. Training on the other hand can be achieved through certain cost effective methods like; On job training (OJT) or experience, Relationships and feedbacks and lastly classroom training.

Robinson, (2010) stresses on how competence and qualified employees can be got through competence management criteria. Competent employee should undergo some recruitment phase where he is assessed for the right qualification and competence through an interview. Once selected, he is given some job experience or trained as per need. While on job, he is assessed after the training to ensure he is doing the right things in the right way as expected. He continues to be assessed, updated, retained and develops capacity throughout.

According to Devos and Soens, (2008), new career patterns make it increasingly important for employees to continuously invest in the development of their competencies. Different scholars have come up with theoretical models of developing employees' competency. Among them is Dess and Sakcal, (2003). The model consists of the following steps.

The first step is the formation of positive organization's attitudes towards learning. This connects non-formal training and informal learning. This should be made as one of the organizations core values. For example mistakes should be taken as learning sources and not subject for punishment. Innovations and changes demand learning and opinion differences are valuable learning sources.

Another step of concern is evaluation of employees' motivation factors. Managers need to design a learning supportive environment after identifying different motivators that may influence employees' decision to develop competence. Reward systems inform of recognition, promotions, bonuses, and compensation are good motivators to employees. The last but quite important step is identification and classification of the gaps related to training needs. The individual as well as the management identify the required training as per arising need.

In conclusion, competency development is making its entry into a lot of organizations nowadays and is becoming a crucial strategic management tool in today's work environment, (Wallace, 2009). Successful and well prospering institutions/

organization ensure that their employees are well equipped with current information, required skills and knowledge, supportive supervision, are well appreciated and recognized.

2.5 Influence of Internal Control Systems and cost sharing program

An internal control system in any organization refers to the processes by which the organization maintains environments that encourages in corruptibility and deter fraudulent activities by management and employees. Some of the measures taken into account especially in this study will include financial controls, records maintenance competent personnel, management integrity, segregation of duties and safeguards. An organization's component of internal control is evaluated during the planning phase of an independent financial statement audit.

According to Sharon, Teresa and Jannifer, (2005), internal financial controls are essential checks and procedures that help health facility management meet their legal duties to safeguard assets, administer finances, manage risks and ensure the quality of financial reporting. This can be achieved through keeping adequate accounting records, and preparing timely and relevant financial information. Health facilities will achieve their aims in effective utilization of cost sharing funds if the management ensures proper use of assets and funds.

Internal financial controls reduce, but do not eliminate the risk of losses through theft and fraud, bad decisions, human error, breaches of controls, management override of controls and unforeseeable circumstances. Some of the measures put in place to ensure financial controls include use of information technology controls in accounting and miscellaneous receipt books among others.

To provide reasonable assurance that internal controls involved in financial reporting process are effective. The internal/ external auditors who scrutinize the internal controls of the organization and the reliability of its financial reporting test them. (Anderson, 2008) The auditors assess whether the controls are properly designed,

implemented and working effectively, and make recommendations on how to improve internal control.

Good management of internal controls is the backbone for effectiveness in the utilization of cost sharing revenues in health faculties. It is important that those working in the health facilities whether shareholders, staff or volunteers take the issue of internal controls seriously. Making controls work should be the responsibility of all working in the institution. However the management and Board of Directors should be on the forefront and lead by example by embracing a culture of adhering to internal controls put in place.

An internal control framework needs to be put in place. Management integrity is vital as this sets the overall tune for the organization. The internal control environment should be that of high practice of integrity and ethical behavior. Human resource policies and procedures should be followed. Of concern is the risk assessment whereby the likely risks are identified and measures of mitigating them put in place.
Continuous monitoring and reviewing of the effectiveness of the internal controls is a key aspect of ensuring that all is well. Assess whether controls are relevant and appropriate for the health facility and not too erroneous or disproportionate. (Mitchel,2009).

Communication plays an important role in any organization. The management ensures communication of the expectations, changes, duties and responsibilities of the staff involved. Communication can be done through meetings, use of policy manuals, accounting manuals financial reporting manuals and any other relevant reading materials.
Control activities cannot be ignored. The management ensures that errors/ irregularities are prevented from occurring by maintaining adequate systems of internal controls.
Detective control measures, which identify when an error/irregularity has occurred, need to be put in place.

Corrective control measures, which focus on recovering from, repairing the damage from or minimizing cost of an error/irregularity is also put up. Competent personnel also act as internal control whereby an organizations ability to recruit and retain competent personnel indicates management intent to proper record accounting transactions.

Retention of employees increases the comparability of financial records from year to year. Reliability of the personnel increases the confidence of the auditors in the underlying accounting records, thus reduction of the auditor's assessment of the risk of misstatement in the financial statements. Delegation of duties is critical to effective internal control as it reduces the risk of mistakes and inappropriate actions. An effective system separates authoritative, accounting and custodial functions. Maintenance of appropriate records ensures existence of proper documentation in the organization. The records are well stored and safeguarded. Proper back up prevents manipulation especially in accounting records. Good record management reduces operating costs, improves efficiency and minimizes the risk of litigation (Sharon et al 2005)

To ensure security of assets and records, safeguards like door locks and computer software passwords need to be protected. These safeguards prevent unauthorized personnel from accessing valuable company assets like blank cheques, company letterhead, signature and stamps among others. Other ways of ensuring that internal controls are not misused or tampered with is by the management ensuring that the computerized services of collecting cash is connected to their computers so that they can easily detect issues related to fraud. Cashiers should be reshuffled frequently and without prior notice to curb getting used to the systems and possibilities of manipulation of some services.

2.6 Attitude of employees and cost sharing program

Emotions have a profound effect on almost everything we do in the work place. Attitudes represent cluster of beliefs, assessed feelings and behavioral intentions towards a person, object or event. Attitudes largely determine how employees will perceive their environment, commit themselves to intended actions and ultimately behave. Most organizations rely in product knowledge and skills training to improve performance and increase productivity. Although both improve competency, neither addresses the need to develop positive employee attitudes. Unless people have the right attitude, no amount of training will improve performance. (Greg and Geoffrey, 2010)

Non-productive attitude in the work place may include laziness, tiredness, rudeness and rumor mongering among others which all-lower overall morale. Negative altitudes could be due to personal problems, work place events like firing, pay decrease, unethical behaviors like fraud, corruption and misuse of funds, at the work place leading to discontent. Congressional budget, (2007) highlights that the health workers have a negative attitude towards cost sharing program and reluctantly support it. Accountability and transparency of cost sharing revenues has been a center of concern and cases of misuse and fraud reported.

A single person's negative attitude can have a huge effect on the operations of an organization. Bad attitudes can also trickle from the manager downwards. These negative attitudes have detrimental effect on performance causing employees become apathetic, despondent and eventually slow output.Unhappy customers as a result of encounters with bad attitudes from employees may make the former never come back to the facilities. Monitoring the performance of employees with negative attitudes may be difficult but the more effective approach to deal with the underlying causes of disconnect is to raise the morale of the entire work place.

However, the negative attitude by the employees can be improved thorough certain ways. Regular employee feedback helps a lot. The manager needs to be proactive

and alert to act quickly and decisively to nip any negative attitude in the bud. This may be difficult but well worth it in the long run if it improves employee morale. High morale has been shown to lead to better performance and happier customers (Joseph, Joel and Crano, 2010). Constant updates and communication are key principles, which can change the negative altitude of workers. According to Calson, (2010), Motivating staff can also work miracles if only managers can recognize and appreciate the good work by all cadres of staff.

2.7. Public awareness and cost sharing program.

Public awareness is the public's level of understanding about the importance and implications of services offered to them. It involves explaining issues and disseminating knowledge to people so that they can make their own decisions. It can also be defined as knowledge that something exists or understanding of a situation or subject at the present time based on information or experience (Wyart and Tallon, 2009). High public awareness occurs when a significant proportion of the society express that the issue at hand is of great importance to all the citizens. Low public awareness on the other hand occurs when a majority of the people does not know or do not care about the issues at hand.

The major objectives of creating awareness are to promote broad public awareness as an essential part of a global education effort to strength attitudes, values and actions, which are compatible with sustainable development. It is important to stress the principle of developing authority, accountability and resources to the most appropriate level with preference given to local responsibility over activities. Public awareness makes people have a common understanding of the importance of the issues at hand and how they relate to them. The public has to behave and share value, that this is an important issue in the community. With public awareness, the community is able to build sustainable communities.

According to Sayers, (2006), there is considerable lack of awareness of health issues /activities due to inaccurate or insufficient information. Developing countries in

particular lack relevant technologies and expertise. There is need to involve the public in solving their issues and foster a sense of personal responsibility and greater motivation and commitment towards sustainable development. Some of the ways of raising public awareness are public awareness campaigns, use of posters, websites, documentaries, newspaper articles, schools, workplaces and workplaces and any other available public media. By taking difference approaches at different times, awareness can be raised all over.

Methodically sound approaches to raising awareness together with sufficient exposure have been shown through social science research to have an effect on knowledge attitude and behavior. It is usually more effective to create a coordinated long-term awareness raising campaign than to create large, short-term campaign. This is because when the Concept of cost sharing for example is talked about overtime; its importance becomes normalized that is it becomes a normal part of people's everyday lives. On the other hand, if there is a single campaign, people may forget about the issues once the campaign is over. (Cummin,2007). These approaches include Public awareness campaign, which is a comprehensive effort that includes multiple components (messaging, grassroots, outreach, media relations and government affairs) to help reach a specific goal. Seoullos, (2002) goes ahead to explain the component of the campaign as follows: Messaging is use of words or phrases that are not persuasive to key audience based on specific research.

Public education is utilizing messaging to help proactively engage key audience in your issue and asking them to respond to specific call to action to help achieve a certain goal, while Public Relation stands for a variety of activities that help an organization and its stakeholders adapt, learn and understand more about one another. A Public awareness toolbox is quite critical. This includes things like the right software whereby the organization looks for a web and data based platforms for communication. This allows one to segment and personalize email communication that gives the audience the ability to directly engage with their organization and provide technical support.

Another component of the toolbox is grass root outreaches. This is the proactive gathering of support at the local level. It results in a network of supporters that can act on behalf of the organization. Certain methods like writing letters and making calls can be used. The desire is usually unpaid and is motivated by a desire for change. Gathering the support of community leaders (grass top) is part of the outreach. Other supporters in form of grass tops include, superintendents, business leaders, funders and policy makers. Grass root supporters include parents, teachers and parent organizations.

Developing champions is also another way of creating public awareness. The champions are individuals or groups that ensure they are active on behalf of the campaign. The champions are selected from the grass root. Strong champions are critical to grass root success and cover all campaign efforts. Effective government affairs work begins with relationship development with local, state and public officials. This should start by educating public official about the project or program to be implemented. A comprehensive implementation plan needs to be developed. The document describes the goals and tactical activities attached to each component of public awareness campaign.

The document helps one understand and track the success of each activity.

A strong media relation's strategy should be created. This will help push forward every campaign component. The most common used media strategies include social hubs like Facebook, twitter and instagram. Other ways of conveying information is by use of Earned (these are articles placed in news outlets at no cost) and Paid (advertisements and information is paid for.) The specific media strategies should always fit the goals, target audience and resources available. It is advisable to create collateral materials to ease communication. Develop materials specifically for the goals and tactics of the campaign. General materials about the organization will not suffice, nor will they reflect the strategy and messaging demands of the campaign. Examples of these materials include: talking points, fact sheets, strategy specific brochures and training materials.

Many researchers have gone an extra in search of activities that can assist nations in improving public awareness. Mathew and Anwar, (2003) cannot be ignored as they found that countries need to strengthen existing advisory bodies or establish new ones in development of information and coordinate activities with non-governmental organizations and media. There is need to encourage public participation in discussions of health policies and assessments. Governments should facilitate and support nationally local networking of information through existing networks. Systematic surveys of the impact of awareness programs, recognizing the needs and contributions of specific community groups are necessary.

Elder, (1997) identifies the need to avail education materials of all kinds to all audience on the best available scientific information. It is important if governments promote a cooperative relationship with the media, entertainment and advertising industries by initialing discussions to mobilize their experience in shaping public behavior and consumption patterns and making wide use of their methods. Such cooperation would also increase active participation in the debate on health. Governments need to employ modern communication technologies for effective public outreach. National and local authorities and relevant agencies should expand as appropriate the use of audio-visual methods, especially in rural areas by producing television and radio programs involving local participation, employing interactive multimedia methods and integrating advanced methods with folk media. The government needs to encourage mobilization of both men and women in awareness campaigns.

2.8 Conceptual frame work

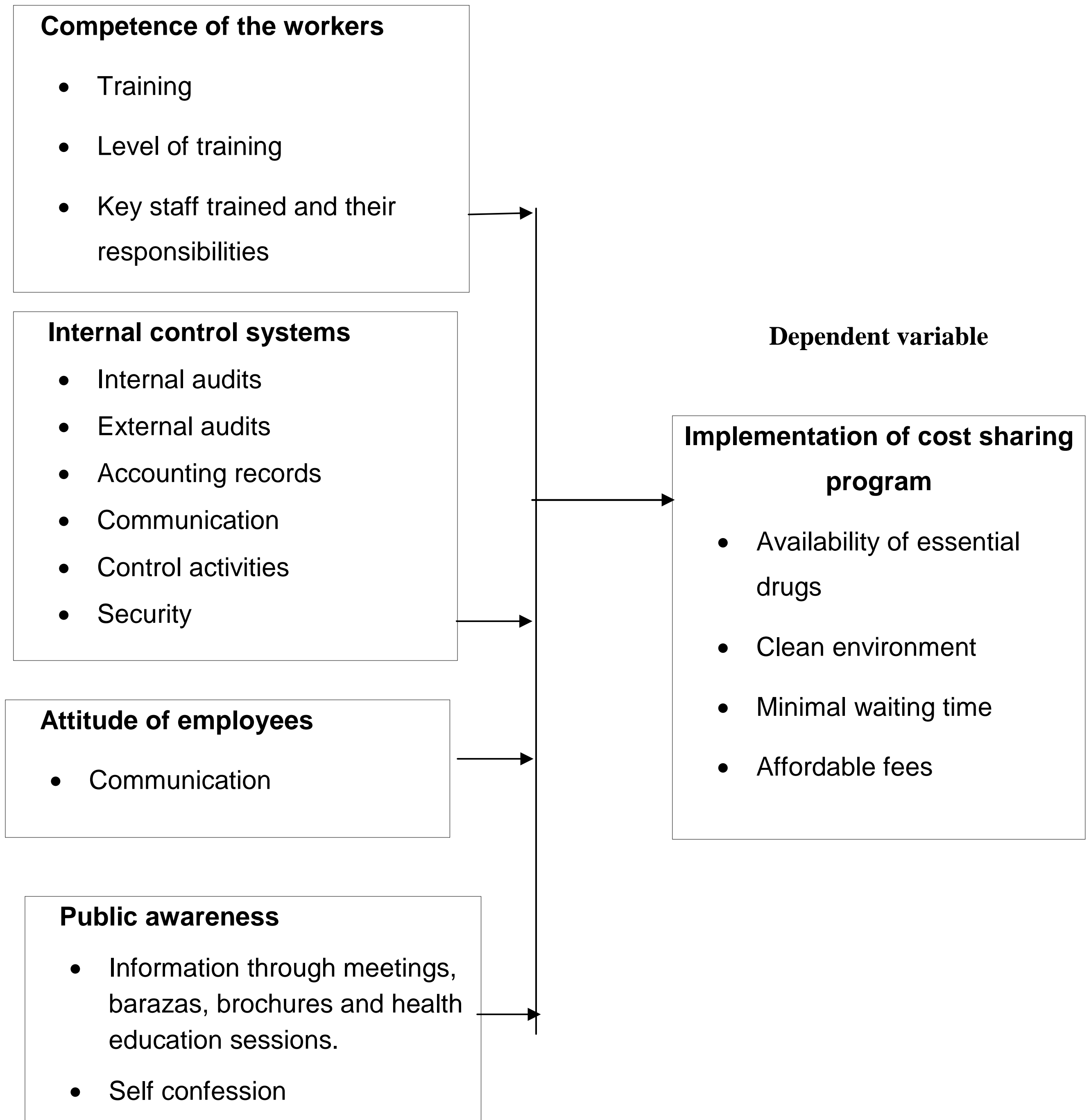

Figure 1. A conceptual framework of influencing implementation of cost

The conceptual framework in figure 1 highlights the factors that influence implementation of cost-sharing program which are competence of the workers, internal control systems, attitude of the employees and public awareness. If the mentioned factors are well taken care of then the possibilities of successful/effective implementation of the program will be guaranteed.

2.9 Summary of Literature Review

Good health services in health facilities depend on best management of cost-sharing funds whereby accountability from providers and patients should be well monitored to improve results. Effectiveness in utilization of cost-sharing funds is an approach that is necessary to bend the cost curve and improve quality of care, ensure continued provision of services through supply of drugs, maintenance and expansion of facilities and ensure accessible, affordable and efficient health care services to all Kenyans (Leighton and Matt, 2005). Cost effectiveness in utilization of these funds will enable good prioritization of health expenses and ensure patients' get timely and quality services.

From the study certain gaps associated with implementation of cost sharing program were identified. They included incompetent workforce, unreliable internal control measures coupled with inadequate supervision, unmotivated employee and ignorant public due to lack of awareness.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

The chapter outlines the research methodology that was used in the research project. This includes the study design, target population, sample size and sampling techniques, data collection methods, validity and reliability of research instruments, data presentation and analysis, ethical issues and lastly operationalization of variables.

3.2 Research Design

The study employed a descriptive survey research design. The design seeks to establish the factors associated with certain occurrences, outcomes, conditions or types of behavior. The design is a scientific method of investigation in which data is collected and analyzed in order to describe the current condition/gap (Alasuutari, Bickman and Brahnen 2008). The design enables an in depth studies of the case, requires minimal investment to develop and administer and is relatively easy for making generalizations.

3.3 Target Population

This refers to the entire set of units for which the survey data used to make inferences. In other words it is the eligible population that was included in the research work. The target population of this study was 380. A total of 20 managers, 150 heath workers and 210 out patients constituted the target population. The target population was from the three sub-county hospitals in Machakos County namely Matuu, Mwala and Kathiani hospitals as shown by the table below. The number depended on staff establishment and outpatient workload in the selected health facilities. The patients were those who attained eighteen years of age and not mentally challenged.

Table 3.1 Explains the distribution of the target population of the participants.

Table 3.1 Target Populations of 380 Participants

Population	Matuu Sub-County Hospital	Mwala Sub-County Hospital	Kathiani Sub-County Hospital	Totals
Managers Health	10	3	17	20
Workers	51	45	54	150
Outpatients	80	50	80	210
Total	**141**	**98**	**151**	**380**

3.4. Sample Size and Sampling Procedures

Sampling is the process by which a relatively small number of individuals, object or event is selected and analyzed in order to find out something about the entire population from which it will be selected (Saunders, Lewis &Thorn hill ,2003).

The participants constituted of key informants whom the researcher felt would provide the data required. The sample consisted of people who possessed characteristics relevant to the study.

Morgan and Krejcie, (1970) table was used to determine the sample size.

All departmental heads were considered to be the managers. Stratified simple random sampling was used to select the one hundred and fifty Health Workers (HW) who consisted of all trained medical personnel working in the selected hospitals. On the other hand, the researcher used systematic sampling to get a sample of the outpatients. Every third patient was sampled. Table 3.2 shows sample size alongside the target population.

Table 3.2-sample size of 263 participants

Categories	Target Population	Sample size
Managers	20	19
Health workers	150	108
Out Patients	210	136
Totals	**380**	**263**

3.5 Data collection instruments

Questionnaires and interview schedules were the main instruments of data collection. A questionnaire is series of questions asked to individuals to obtain statistically useful information about a given topic. When properly constructed and responsibly administered, questionnaire becomes a vital instrument by which statements can be made about specific groups or people or entire populations. Questionnaires are frequently used in quantitative marketing and social research. They are a valuable method of collecting a wide range of information from a large number of respondents. Adequate questionnaire construction is critical to the success of a survey. Inappropriate questions, incorrect ordering of questions, incorrect scaling, or bad questionnaire format can make the survey valueless, as it may not accurately reflect the views and opinions of the respondents. A useful method of checking a questionnaire and making sure it is accurately capturing the intended information is to pretest among a smaller subset of the target population. Generally, interviews and questionnaires are considered to be appropriate methods because of their perceived easiness to use and assessment. Further more interviews and questionnaires are seen to be effective, low in terms of cost and obscurity. The researcher and selected enumerators administered the questionnaires. Both open ended and closed ended questions were used. Open-ended questions allowed the respondents provide sufficient details while closed ended questions allowed easy quantification of the results by use of SPSS computer software. With SPSS analytic software, the researcher was able to predict with confidence what would happen next so that one could make smarter decisions, solve problems and improve outcomes.

3.5.1. Piloting the Instruments

A useful method of checking whether the information in the questionnaire is accurate, meaningful and relevant is by pretesting the questionnaire. The pretest or piloting was done in a smaller subset of the target respondents. Adjustments, corrections and areas of concern were addressed accordingly. The researcher and the selected enumerators administered the questionnaires.

3.5.2. Validity of the Instruments.

Validity according to Mikantha (2007) is the quality that a procedure, instrument or a tool used in research is accurate, correct, true and meaningful. The research used content validity as a measure of the degree to which data collected using the questionnaires represented the objectives of the study. The instrument was given to the group of lectures in the panel during the defense of the research proposal. The team assessed what the instrument tried to measure and their views and opinions were incorporated in the final questionnaire.

3.5.3 Reliability of the Instrument

Merril (2010) says that reliability is concerned with estimates of the degree to which a research instrument yields consistent results after repeated trails. For the purpose of this research, reliability was determined by use of half –split form of pilot study whereby half of the respondents in the smaller subset of the target population had the questionnaires administered to them. The other half had the questionnaire administered to them after two weeks. The half- split method was critical and effective as it helped avoid issues related to respondent maturity and thus quite reliable. Interviewers were instructed to carefully identify ambiguous, inappropriate, unclear or offending questions. Their valuable opinions were used to modify the final questionnaire.

3.6 Data Collection Procedure

A tool kit comprising of a questionnaire and face-to-face interviews guide was used as the best type that sought to establish the factors influencing implementation of cost sharing program in public hospitals in Machakos County.

The questionnaire was presented based on extensive review of the literature on cost sharing program. Data collection tools were piloted before finalizing the questionnaire. A five point likert scale was used to answer most of the questions in the survey. The study utilized a self administered questionnaire and in-depth interview techniques as well as access to secondary data.

3.7 Data Analysis Technique

Data analysis is the process of packaging the collected information, evaluating it, putting it in order and structuring its main component in a way that findings can be easily interpreted. Data collected was crosschecked for completeness, clarity and consistency. Data was coded cleaned and validated to achieve a clean data set. Quantitative data was presented using frequency tables and percentages. Qualitative data was categorized in themes as per research objectives and reported in narrative form alongside quantitative presentation and used to reinforce quantitative data. SPSS 16.0 computer software was used in analyzing the statistical data.

3.8 Ethical Issues

All the government authorities were informed prior to the study to avoid any suspicious speculations from the community. Due to the sensitivity of the study, consent was sought from the respondents whose participation in the study was on voluntary basis. Confidentiality of the identity of the respondents and the information they provide was guaranteed.

3.9 Operationalization of Variables.

Objectives / Research Questions	Types of variable	Indicators	Measurement Scale	Methods of data collection	Instrument /data collection tool	Data analysis technique
To establish how competence of employees influences implementation of cost sharing program in public health facilities in,Machakos County	Independent variable. Competence of employees	- Level of education. - Training and updates	Nominal	Survey	Questionnaire	Descriptive.Central tendency
To assess how internal controls influence implementation of cost sharing program in public heath facilities in, Machakos County	Independent variable. - Internal Controls	-Internal/ External audits -Security Accounting documents	Nominal	Inspection	Questionnaire	Descriptive central tendency

To assess the extent to which attitude of employees influence implementation of cost sharing program in public health facilities in Machakos County	Independent variable. - Attitude of employees	Communication	Nominal	Observation	Questionnaire	DescriptiveCentral tendency`
To establish how public awareness tendency Influences implementation Of cost sharing Program In public health Facilities InMachakos county	Independent variable. public awareness	Information	Nominal	survey	Questionnaire	descriptive Central

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND INTERPRETATION OF FINDINGS

4.1 Introduction

The chapter presents data analysis, presentation and interpretation of findings for this study on factors influencing implementation of cost sharing program in public health facilities in Machakos County. The data collected was collated and reports produced in form of descriptive tables.

4.2 Questionnaire return rate

An analysis of the rate at which questionnaires distributed were returned and completed is discussed in this section.

Table 4.1: Return rate by respondents

Category	Respondents		Percentage %	
	Managers	Health workers	Managers	Health workers
Response	16	96	84.2	88.9
Non Response	3	12	15.8	11.1
Total	19	108	100	100

The data was collected from a cross-section of health facility in charges and major departmental heads. Out of the 19 questionnaires given out to the respondents, 16 were submitted back to the researcher, giving a return rate of 84.2% and a non- return rate of 3 (15.8%). The return rate was above 40% and therefore a representative sample of the population.

The research was conducted and data collected from various cadres of health personnel who work in the selected health facilities. That is Matuu, Mwala and Kathiani Sub County Hospitals. Out of the 108 questionnaires given to the

respondents, 96 (88.9%) were submitted back while 12 (11.1%) were not given back. This was a good indication that the return rate was quite adequate for the study.

4.3. Characteristics of the respondents

The population under study had characteristics, which were vital to the study. These include experience in cost sharing program, level of education, functional position and the role one plays in relation to cost sharing program.

4.3.1. Experience in cost sharing program

The researcher intended to find out whether the years one had been in a facility determined expertise and adequate knowledge on cost sharing program. Table 4.2 below describes the outcome.

Table 4.2: Distribution of level of experience of respondents

Category	Respondents		Percentage %	
	Managers	Health workers	Managers	Health workers
Below one year	0	5	0	5.1
1-3 years	3	30	18.6	31.3
4-6 years	7	52	43.8	54.2
More than 6 years	6	9	37.6	9.4
Total	16	96	100	100

From Table 4.2, 7 (43.8%) of managers have worked in the facilities for between 4-6 years. There is no manager in the category of below year. However, 6 (37%) had worked for more than 6 years. 3 (18.6%) had been in the facility for between 1to 3 years. This shows that the managers have had humble and quite some good experience to ensure implementation of cost sharing program.

A high Percentage of 52 (54.2%) are employees who have been working in the facilities for between 4-6 years. The group is expected to have had good experience with the existing systems thus quite effective. Very few people 5 (5.1%) had been working in the facilities for less than a year. Quite a good Percentage of the

respondents 30 (31.3%) had been in the facilities for between one to three years while 9 (9.4%) had been there for more than six years. From the data, it can be noted that all the staff had adequate experience.

4.3.2. Level of education of respondents.

Table 4.3 shows that more than half 9 (56.3%) of the managers had undergone university education while 7 (43.7%) had attained college (tertiary) level of education.

Table 4.3: Distribution of level of education of respondents

Category	Respondents		Percentage %	
	Manager	Health workers	Manager	Health workers
University	9	18	56.3	18.8
Tertiary	7	78	43.7	71.2
Secondary	0	0	0	0
Primary	0	0	0	0
Total	16	96	100	100

From Table 4.3, 78 (71.2%) of health workers were qualified in their career as 18 (18.8%) had also either upgraded to university level or attained university education immediately after secondary education. The data from the table reveals that all the employees were qualified.

4.3.3. Role one plays in cost sharing program.

Data was collected to find out the role played by the concerned stakeholders in the implementation of cost sharing program. Table 4.4 explains the findings

Table 4.4: Role one plays in cost sharing Program.

Category	Number of respondents	Percentage %
Supervisor	11	9.8
Implementer	49	43.8
Both roles	23	20.5
Not sure	24	21.4
No response	5	4.5
Total	**112**	**100.0**

The data collected cut across all question and 96 health workers. From Table 4.4, it is clear that a relatively small number of 11 (9.8%) of the hospital staff supervised the implementation of cost sharing program while 49 (43.8%) were implementers. Surprisingly, 23(20.5%) played the role of both implementer and supervisor. 24 (21.4%) of the respondents were not sure of whether they were implementers or supervisors. To curb it all 5(4.5%) did not even know the role they played so they did not respond to the question. This data clearly indicates that there is acute shortage of staff to supervise the implementation of cost sharing program. The double role played by the 23 (20. 5%) is likely to compromise a successful implementation of the program. Ambiguity also arose when 5 (4.5%) of the respondents did not know their roles as shown by Table 4.4

4.4. Influence of competence of employees and implementation of cost sharing Program

An analysis of the influence of the competence of employees in implementation of cost sharing program is discussed in this section. The responses were distributed to cover staff knowledge, motivation levels, training needs, involvement and state of working environment. Table 4.5 shows distribution of knowledge of respondents.

Table 4.5; Distribution of knowledge of respondents on cost sharing program

	Category	Respondents		Percentage%	
		Manager	Health workers	Manager	Health worker
I know about cost sharing program	To a small degree	2	80	12.5	83.3
	To a moderate degree	11	16	68.8	16.7
	To a great degree	1	0	6.2	0
	To a very great degree	2	0	12.5	0
	Total	16	96	100	100

Table 4.5 shows that 80 (83.3%) of the health workers to a small degree knew about cost sharing. On the contrary, 2 (12.5%) of the managers to a small degree knew about the program. It is important to note that no health worker knew about the program to a great or to a very great degree. The data provides an indication that with such a huge number 80 (83.3%) ignorant of the program, then it may be hard to have the program succeed in its implementation.

Motivation is key in implementation of any program. The researcher assessed the levels of motivation amongst the employees and the following were the findings.

Table 4.6: Motivation levels of respondents in cost sharing program

	Category	Respondents		Percentage%	
		Manager	Health worker	Manager	Health workers
I strive to ensure cost sharing is successful	To a small degree	1	42	6.3	43.8
	To a moderate degree	2	37	12.5	38.5
	To a great degree	3	16	18.7	16.7
	To a very great degree	10	1	62.5	1.0
	Total	16	96	100	100

The managers were out to ensure the program succeeds as shown by the figures 10 (62.5%) and 3 (18.7%). On the other hand, the health workers 42 (43.8%) and 37 (38.5%) told it all that there was no motivation towards the success of implementation of cost sharing program.

Competence that goes along with trainings was also an issue of concern. The following findings were observed.

Table 4.7: Staff trainings and updates

	Category	Respondents		Percentage%	
		Manager	Health worker	Managers	Health workers
I have undergone several trainings and updates on cost sharing program	Not at all	0	82	0	85.1
	To a small degree	8	11	50	11.5
	To a moderate degree	6	3	37.5	3.1
	To a great degree	2	0	12.5	2.1
	Total	16	96	100	100

With the 82 (85.1%) of the health workers not trained or updated and 11 (11.5%) trained to a small degree on cost sharing matters, then it was difficult to implement the program as they were the implementers. 8 (50%) of the managers had trainings to a small degree. The data implies that the staff was not well prepared in terms of knowledge and skills to enable them implement cost sharing program.

Successful implementation of any program needs the stakeholders involvement. In this case the employee's involvement was assessed and findings were as shown below.

Table 4.8: Involvement in the achievement of the program

	Category	Respondents		Percentage%	
		Manager	**Health worker**	**Manager**	**Health worker**
I feel part and parcel of the people involved in the achievement of the program	Not at all	0	49	0	51
	To a small degree	3	27	18.6	28.1
	To a moderate degree	10	18	62.5	18.8
	To a great degree	2	2	12.5	2.1
	To a very great degree	1	0	6.3	0
	Total	16	96	100	100

A small percentage of the health workers only 2 (2.1%) accepted the program and were ready to support its implementation and ultimately the achievement of its goals. The managers too moderately 10 (62.5%) were involved in the achievements of the program. Table 4.9 shows the distribution of competence of the respondents.

Table 4.9. Competence of the respondents

	Category	Respondents		Percentage%	
		Manager	**Health worker**	**managers**	**Health workers**
I am competent enough in relation to cost sharing	Not at all	0	72	0	75
	To a small degree	5	11	31.3	11.5
	To a moderate degree	6	10	37.5	10.4
	To a great degree	2	3	12.4	3.1
	To a very great degree	3	0	18.8	0
	Total	16	96	100	100

Table 4.9 shows that 72 (75%) of the health workers were incompetent, 11 (11.5%) were to a small degree competent, 10 (10.4%) to a moderate degree, 3 (3.1 %) to a great degree and none to a very great degree. Moderately, 6 (37.5%) of the managers

were competent and relatively 5 (31.3%) were competent to a small degree.

Conducive working environment is a motivator to any worker. Table 4.10 shows the status of the findings of the perception of the employees towards their working environment.

Table 4.10: State of working environment

	Category	Respondents		Percentage%	
		Managers	**Health workers**	**Managers**	**Health Workers**
The environment in terms of availability of recording tools, drugs, laboratory reagents and motivation among others is conducive	Not at all	0	8	0	8.3
	To a small degree	3	39	18.8	40.6
	To a moderate degree	10	28	62.5	29.2
	To a great degree	3	10	18.8	10.4
	To a very great degree	0	11	0	11.5
	Total	16	96	100	100

Most of the health workers felt that the environment surrounding implementation of cost sharing was to a small degree conducive. 39 (40.6%) supported this. The managers however felt that the environment was to a moderate degree conducive as shown by 10 (62.5%).

4.5: Influence of Internal Controls Systems and implementation of cost sharing

Internal control systems put in place are considered to play a role in implementation of cost sharing program**.** To answer research question number 2, that required responses on influence of internal control systems in implementation of cost sharing program, the sampled staff responded to questions on awareness of the existing control systems, effectiveness of the control systems, effectiveness of management and fraud detection. The level of awareness of the existing internal control measures

is stipulated in Table 4.11.

Table 4.11: Respondents awareness of internal controls

Category	Respondents		Percentage %	
	Managers	Health workers	Managers	Health workers
Yes	16	90	100	93.8
No	0	6	0	6.2
Total	16	96	100	100

Table 4.11 shows that all 16 managers were aware of the internal control systems. From the table, not all the employees were aware as 90 (93.8%) knew while 6 (6.2%) did not know. The internal controls included receipt books, computer services, steel doors, locks and saves as indicated by the majority of the respondents.

The respondents also assessed effectiveness of internal control measures.

Table 4.12: Rating of effectiveness of internal control systems by respondents

Category	Respondents		Percentage %	
	Managers	Health workers	Managers	Health workers
Very high	8	2	50	2.1
High	3	13	18.8	13.5
Fair	5	22	31.2	22.9
Low	0	59	0	61.5
Total	16	96	100	100

The managers rated the effectiveness of internal controls at very high 8 (50%), high 3 (18.8%), fair 5 (31.2%) and none at low**.** The table shows that the internal control systems put in place were not quite effective in collection and safeguarding of the funds. This is supported by the fact that a very high number 59 (61.5%) of the health worker respondents felt that the control systems were of low effectiveness.

The employees wanted to find out how effective the management was as regards to supervision of the control measures in place. The following were the results.

Table 4.13: Rating the effectiveness of management by respondents

Category	Respondents		Percentage %	
	Managers	Health workers	Managers	Health workers
Highly effective	2	10	12.5	10.4
Effective	10	15	62.5	15.6
Slightly effective	4	21	25	21.9
Non effective	0	50	0	52.1
Total	16	96	100	100

The managers themselves also felt that they did not do their best in ensuring that the control systems are well used. 2 (12.5%) felt they are highly effective, 10 (62.5 %) were effective and 4 (25%) were slightly effective.

Table 4.13 shows that the management teams had not been aggressive in ensuring that the internal controls were well used. 50 (52.15%) of the health workers rated no effectiveness by the management, 21 (21.9%) slightly effective, 15 (15.6%) effective and 10 (10.4%) highly effective. The laxity by the management largely contributed to ineffectiveness in use of available control measures.

The control measures used were also rated for their effectiveness in fraud detection.

Table 4.14: Respondents rating of the effectiveness of internal controls in fraud detection

Category	Respondents		Percentage %	
	Managers	Health workers	Managers	Health workers
Very high	3	0	18.8	0
High	10	3	62.4	3.1
Fair	3	29	18.8	30.2
Low	0	64	0	66.7
Total	16	96	100	100

Table 4.14 shows that a big number of manager respondents 10 (62.4%) supported the internal control measures put in place. 3 (18.8%) felt the internal controls were of very high and of fair impact on fraud detection respectively. Most of the health workers 64 (66.7%) found that the internal controls put in place were lowly effective

in fraud detection 29 (30.2%) found the measures fairly detect fraud while 10 (3.1%) feel control measures were high in fraud detection. This clearly showed that the internal control measures did not effectively serve the purpose intended to.

4.6. Influence of attitude of employees and implementation of cost sharing

Attitude of employees is seen to be one of the factors that influence implementation of cost sharing program. In response to research question 3, the sampled population rated the following concerns on a five-point liker scale. These include: importance of cost sharing, understanding of the program, motivation and utilization of the funds. Importance of cost sharing program is perceived by the employees was also rated and the following findings were recorded.

Table 4.15: Rating the importance of cost sharing.

	Category	**Respondents**		**Percentage %**	
		Managers	**Health workers**	**Managers**	**Health worker**
I feel cost sharing is important	Not at all	0	52	0	54.2
	To a small degree	0	30	0	33.3
	To a moderate degree	0	7	0	7.3
	To a great degree	4	7	25	7.3
	To a very great degree	12	0	75	0
	Total	16	96	100	100

The Table clearly indicates that 52 (54.2%) of the heath workers felt cost sharing is not important at all, 30 (33.3%) appreciate a small degree the importance of cost sharing, 7 (7.3%) to a moderate degree, 7 (7.3%) to a great degree and none to a very great degree. The managers felt that cost sharing is very important. This was supported by 12 (75%) while 4 (25%) supported cost sharing to a great and to a very great degree respectively. The findings clearly show that the managers unlike other

health workers were motivated to support the implementation of cost sharing program. This shows that the program did not have the support of the implementers who are the health workers thus may have challenges in implementation. Table 4.16 shows the respondents understanding of cost sharing program.

Table 4.16: Respondents' understanding of cost sharing program.

	Category	**Respondents**		**Percentage %**	
		Managers	**Health workers**	**Managers**	**Health Workers**
I understand why cost sharing is there	Not at all	0	14	0	14.6
	To a small degree	0	42	0	43.6
	To a moderate degree	0	25	0	26
	To a great degree	15	8	93.8	8.4
	To a very great degree	1	7	6.2	7.4
	Total	16	96	100	100

From Table 4.16,15 (93.8%) of the managers understood why cost sharing is there to a great degree, while 1 (6.2%) understood to a very great degree. 14 (14.6%) of the health workers did not understand why cost sharing is there, 42 (43.6%) understood to a small degree, 25 (26%) to a moderate degree, 8 (8.4%) to a great degree and least 7 (7.4%) to a very great degree. This again is an indication that the huge bulk of the implementers did not understand the program thus hard to implement.

The researcher was also eager to know more about motivation rates of the employees. The rating was as shown below.

Table 4.17: Rating motivation of employees

	Category	Respondents		Percentage %	
		Managers	**Health workers**	**Managers**	**Health worker**
I am motivated to support cost sharing program	Not at all	0	49	0	51
	To a small degree	4	31	25	32.3
	To a moderate degree	7	13	43.8	13.6
	To a great degree	3	3	18.7	3.1
	To a very great Degree	2	0	12.5	0
	Total	16	96	100	100

Over a half of the health workers 49 (51%) were not motivated at all, 25 (32.3%) were at a small degree, 13 (13.6%) at a moderate degree and 3 (3.1%) to a great degree. The managers enjoyed motivation to a moderate degree of 7 (43.8%), 4 (25%) to a small degree, 3 (18.7%) to a great degree and 2 (12.5%) to a very great degree, which was enjoyed by none of the health workers. When only a small number of employees are motivated the implementation of the program will be difficult.

Table 4.18 shows the rating of the collection and utilization of cost sharing funds.

Table 4.18: Rating collection and utilization of cost sharing funds.

	Category	Respondents		Percentage %	
		Managers	Health workers	Managers	Health workers
I appreciate the way cost sharing funds are collected and utilized	Not at all	0	69	0	71.8
	To a small degree	2	18	12.5	18.8
	To a moderate degree	5	9	31.3	9.4
	To a great degree	6	0	37.5	0
	To a very great degree	3	0	18.8	0
	Total	16	96	100	100

From Table 4.18,69 (71.8%) of the health workers did not appreciate the use of the funds at all,18 (18.8%) appreciate at a small degree and nil to a great and a very great degree. 2 (12.5%) of the managers on the other hand appreciate the use of the funds to a small degree, 5 (31.3%) to a moderate degree, 6 (37.5%) to a great degree and 3 (18.8%) to a very great degree. When funds collected are not utilized as expected, then this causes dissatisfaction and lack of trust leading to low or no morale to ensure successful implementation and more so to the implementers.

4.7. Influence of public awareness and implementation of cost sharing

The section deals with the influence of public awareness in implementation of cost sharing. The responses were got from the clients who sought for various services from the health facilities. Of concern were issues to do with perception about cost sharing, respondents" knowledge, source of information, service charges, waiting time, state of cleanliness, staff attitude and level of satisfaction with service delivery. Therefore, to answer research question 4, the following data was analyzed as shown in the tables below. The return rate of the questionnaires is as shown by Table 4.19

Table 4.19: Return rate by respondents

	Number of respondents	Percentage %
Response	107	78.7
Non response	29	21.3
Total	136	100.0

Out of the 136 respondents, 107 (78.7%) gave back their questionnaires while 29 (21.3%) did not give back the questionnaires.

Gender distribution of the respondents was also considered as shown.

Table 4.20: Gender of the respondents

	Number of respondents	Percentage %
Male	39	36.4
Female	68	63.6
Total	107	100.0

The distribution of males verses females who filled the question is as shown by the table above. From Table 4.20,39 (36.4%) were males and 68 (63.6%) were females.

The researcher classified the respondent in order of the facilities they attended. The following were the findings.

Table 4.21: Name of the hospital attended.

Category	Number of respondents	Percentage %
Mwala	32	29.9
Kathiani	35	32.7
Matuu	40	37.4
Total	107	100.0

Table 4.21 describes the distribution of patients as per facilities with Mwala at 32 (29.9%), Kathiani at 35 (32.7%) and Matuu at 40 (37.4%)

The respondents perception towards cost sharing program was as shown by Table 4.22.

Table 4.22:Perception of cost sharing by respondents

Category	Number of respondents	Percentage %
Free services	55	51.4
Service fees partly paid by the government	29	27.1
All services fees are paid by the patient	17	15.9
None of the above	6	5.6
Total	107	100.0

From Table 4.22, 55 (51.4%) did not know what the program entails, 29 (27.1%) of them thought the payment is by the government while 17 (15.9%) thought the patient pays the fees. Surprisingly 6 (5.6%) were not sure of what cost sharing is thus none of the option was applicable.

Respondents' knowledge of the program was also assessed and Table 4.23 shows the findings.

Table 4.23: Respondents' knowledge on cost sharing program

Category	Number of respondents	Percentage %
Yes	46	43.0
No	61	57.0
Total	107	100.0

Out of 107 respondents' 46 (43%) had some information about cost sharing while 61 (57%) had no information about the same.

The researcher wanted to know the source of information about the program.

Table 4.24: Source of information.

Category	Number of respondents	Percentage %
From the hospital staff	20	18.7
Chief's baraza	21	19.6
Medical brochures	13	12.1
Media	9	8.4
Newspapers	14	13.1
Others	30	28.0
Total	107	100.0

Those who were informed however got the information from different sources. 20 (18.7%) got the information from hospital staff, 21 (19.6%) from Chief's barazas, 13 (12.1%) from medical brochures, 9 (8.4%) from media, 14 (13.1%) from newspapers and 30 (28%) from other sources like friends and relatives. This tells a lot about public awareness whereby most of the information is not official and could be misleading.Service charges determine the level of utilization of any health facility. Therefore the researcher found it necessary to assess the feelings of the respondents as pertains to the charges.

Table 4.25: Charges of services.

Category	Number of respondents	Percentage %
Cheap	33	30.8
Reasonable	29	27.1
Expensive	45	42.1
Total	107	100.0

For the charges 45 (42.1%) found the charges were expensive,33 (30.8%) found the charges cheap and 29 (27.1%) found the charges reasonable

The waiting time determines the level of attendance to the health facility. The shorter the waiting time the higher the attendance by clients.

Table 4.26: Waiting time

Category	Number of respondents	Percentage %
Very long (more than 1 hour)	63	58.9
Long (30 min to 1 hour)	25	23.4
Short (10 to 30)	19	17.8
Total	107	100.0

From Table 4.26, big junk of the population 63 (58.9%) found waiting time very long, 25 (23.4%) long and 19 (17.8%) short while none found the waiting time to be short. The very long waiting time is an indicator that all is not all right as there could be hidden causes behind the scene.

The ultimate aim of cost sharing program was to facilitate a clean environment in the government hospitals. The perceived status of cleanliness was rated and the findings shown in Table 4.27

Table 4.27: Perceived state of cleanliness of the selected health facilities

Category	Number of respondents	Percentage %
Very dirty	0	0
Dirty	11	10.3
Clean	70	65.4
Very clean	26	24.3
Total	107	100.0

From the observations, the health facilities were generally clean with 70 (65.4%), 26 (24.3%) very clean, 11 (10.3%) dirty and 0% very dirty.

The respondents' perceptions towards attitude of the hospital workers are shown below.

Table 4.28: Attitude of the hospital staff.

Category	Number of respondents	Percentage %
Not concerned	32	29.9
Rude	27	25.2
Helpful	27	25.2
Friendly	21	19.6
Total	107	100.0

Table 4.28 shows that 27 (25.2%) of the staff were rude, 32 (29.9%) showed no concern to service seekers 27 (25.2%) quite helpful while only 21 (19.6%) were friendly.

Staff attitude is quite wanting and needs to be looked into for better implementation of the program. Table 4.29 shows the level of satisfaction in service delivery in the hospitals.

Table 4.29: Assessment of level of satisfaction in service delivery

Category	Number of respondents	Percentage %
Below my expectations	54	50.5
Met my expectations	39	36.4
Beyond my expectations	14	13.1
Total	107	100.0

The observation by the respondents in relation to service delivery was not quite pleasing as 54 (50.5%) of the respondents felt that the services were below their

expectations 39 (36.4%) had their expectations met and 14 (13.1%) had services offered beyond their expectations. This affirms that despite the implementation of cost sharing program, service delivery is yet to improve.

From the analysis of the above data, it is clear that over half of the population 55 (51.4%) could not tell what cost sharing entails, 61 (57%) had no information about the program and those informed got the information from friends and relatives. The expectations of the public as pertains to the program were not met as the service charges were expensive 45 (42.1%) waiting time very long 63 (58.9%), staff was rude and less concerned 32 (29.9%) and customer satisfaction towards service delivery was below expectation at 54 (50.5%).

CHAPTER FIVE

SUMMARY OF FINDINGS, DISCUSSIONS, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This final chapter contains a presentation of the summary of findings, discussions, conclusion, recommendations and suggestions for further research.

5.2 Summary of finding

The study sought to identify the factors influencing implementation of cost sharing program in public health facilities in Machakos County and came up with the following findings.

On the first objective, which sought to establish how competence of the employees' influences implementation of cost sharing Programme, certain indicators were used to assess the employee's competence. These indicators included knowledge about cost sharing, trainings and updates under taken, level of involvement, competence levels and state of working environment just to mention but a few. In fact most surprising is the high rate of no knowledge about the program which was at 80 out of 96 (83.3%), 82 (85.1%) of the employees had not undergone any cost sharing related trainings and updates and 72 (75%) declared that they were not competent enough.

The commodities that were needed to ensure the program runs well were also a challenge.39 (40.6%) and 28 (29.2%) of the health workers appreciated the challenge of commodities at a small degree and a moderate degree respectively. On the contrary the managers who were just too few to have any impact on the program seemed to be competent with 11 (68.8%) having moderate knowledge about the program. 8 (50%) of the managers however had no trainings or updates on the same. 2 (12.4%) and 3 (18.8%) of the managers were competent enough to implement cost-sharing Programme to a great and to a very great degree respectively. This is unlike the case of health workers who were at 3 (3.1%) rating to a great degree. The state of working environment seemed to favor the managers at a moderate degree of 10 (62.5%). From

the above findings, it is clear that for the implementation of cost sharing program to be effective, both managers and health workers need to be competent. The second objective, which sought to assess how internal controls influence implementation of cost sharing program, gave the following results.

All the managers were aware of the internal control measures put in place but 90 (93.8%) of the health workers were not aware of the control systems. 8 (50%) of the managers rate the effectiveness of the internal controls at very high and 5 (31.2%) at fair. This is contrary to the health workers who rate the same at 22(22.9%) fair and 59 (61.5%) low effectiveness. Another indicator, which was of concern in the internal controls, is the rating of effectiveness of management in ensuring that the control measures work. The findings were quite pathetic as 4 (25%) of the managers felt that the management was slightly effective, 10 (62.5%) effective and 2 (12.5%) were highly effective. The health workers rating however contradicted that of the managers as 21 (21.9%) rated the managers as slightly effective and 50 (52.1%) non-effective. Fraud and corruption mostly comes in when the existing internal control measures are weak. In this particular study, the issue of fraud detection was considered and the findings were as follows. The managers supported the controls and rated fraud detection levels as at high as 10 (62.4%. The health workers on the other hand had low effectiveness rating of as high as 64 (66.7%). These findings show that the above indicators related to internal control systems have a lot of influence in the implementation of cost sharing program.

According to this study, the third objective, which intended to assess the extent to which attitude for employees' influences implementation of cost sharing gave the following findings as per indicators, assessed. 52 (54.2%) of the health workers did not find cost sharing important and 30(33.3%) found its importance to a small degree. On the other hand, 4 (25%) found the program important to a great degree and 12 (75%) to a very great degree. Without training, information or knowledge of cost sharing, it was obvious that 25 (26%), 42 (43.6%) and 42 (14.6%) of the health workers understood why the program is there at the levels of moderate degree, to a

small degree and not at all respectively. The managers understood why the program exists at a rate of 15 (93.8%) to a great degree and 1(6.2%) to a very great degree. It is surprising to find that most of the health workers rated motivation levels not at all at 49 (51%), to a small degree 31(32.3%) and 13 (13.6%) to a moderate degree. 7 (43.8%) of the managers rated motivation levels at a moderate degree but with 3 (18.7%) and 2 (12.5%) at a great degree and a very great degree respectively.

Another indicator of attitude in this case was the appreciation of how funds were collected and utilized. 69 (71.8%) of the health workers did not appreciate the vice at all and 18(18.8%) to a small degree. In this case 6 (37.5%) of the managers rated the indicator to a great degree and 3 (18.8%) to a very great degree. This indicator however had mixed reactions among the managers. 2 (12.5 %) rated the indicator to a small degree and 5 (31.3%) to a moderate degree. The indicators tell us that attitude which can be as a result of certain unmet needs or dissatisfaction with the systems in place can have a lot of influence in implementation of any program.

The fourth objective sought to establish how Public awareness influences the implementation of cost sharing program. The main informants in this objective were the health care seekers. Several indicators were used to assess what they knew about the program and their expectations as related to the general outcomes or gains of the cost-sharing program. 55 (51.4%) of the respondents knew cost sharing entails free services and 6 (5.6%) had no idea about costs sharing. 61(57% of the respondents had no information on cost sharing and those with the information 30 (28%) got the information from friends and relatives.

The service charges that cut across the hospitals were expensive at 45 (42.1%) and reasonable rate at 29 (27.1%). 63 (58.9%) of the patients found the waiting time quite long while the hospitals were clean at 70 (65.4%) but at 11 (10.3%) dirty rating. 32 (29.9%) of the staff were not concerned with the welfare of the patients, while 27 (25.2%) were rude and 21 (19.6%) friendly. It is unfortunate that 54 (50.5%) of the respondents' felt that service delivery was below their expectations with only 14

(13.1%) appreciating beyond my expectations rating. The findings show how public awareness influences the implementation of cost sharing.

5.3 Discussion of findings.

The study findings showed that competence of employees is quite key for implementation of any project or program. According to Robinson (2010), trainings, theoretical knowledge, cognitive skills, experience and willingness to work as per agreed standards, rules and procedures contribute to one's competence. The study showed that very few managers 6 (37.5%) had undergone trainings related to cost sharing. Some of departmental heads 82 (85.1%) that were considered to be managers were also implementers but unfortunately had not undergone any training.

Most of the implementers 80 (83.3%) did not even understand the program. Thus it is quite difficult and challenging to implement what one does not know or understand. Studies by Robinson (2007) have reported that a high performing and effective health care system is important for the viability of communities and improvement in human health around the world. Organizations and their employees have to meet the worldwide requirements and standards so as to gain competitive advantage in the global market. Competency development has become a crucial strategic management tool in today's work environment. Therefore as said earlier, for any project / program to succeed all people involved need to be brought on board and be updated as need arises. Wallace (2009) notes that successful and well performing institutions / organizations ensure that their employees are well equipped with information, required skills, knowledge, appreciation and recognition.

Good management of internal control systems in any organization is the backbone of efficiency and effectiveness in utilization of funds. Integrity, transparency and accountability of finances are key in any institution. Control measures put in place need to be realized and understood by all employees and be supervised for effectiveness to avoid misuse and fraud. There is danger when most of the implementers 59 (61.5%) lowly rate the effectiveness of the control systems put in

place. The low effectiveness rating 64 (66.7%) on low fraud detection is an issue of concern. This shows that the internal controls put in place are weak and chances of misuses and manipulation are high thus leaving a leeway for corruption and other fraud related activities. Kenyatta National Hospital internal audit reports NOs. KNH/1A/57/51 and KNH/FIN/35 evidence cases where senior officers fraud the hospital of 51 million Kenya shillings. However according to Devos and Soens (2008) internal control measures discourage corruption and also deter fraudulent activities. Internal controls provide essential checks and procedures that help organizations meet their legal duties, manage finances, risks and ensure quality financial reporting.

Greg and Geoffrey (2010) highlight the importance of the right attitude. Unless people have the right attitude, no amount of training will improve performance. Attitude, which cannot be taught, is presented by beliefs, feelings and behavioral intentions towards a person, object or event. From the study findings, most the health workers 52 (54.2%) did not value the importance of cost sharing, 42 (43.6%) to a small degree understand why it is in place, 49 (51%) don't support it, and 69 (71.8%) did not appreciate the way in which the funds are collected and utilized.

This shows a relatively negative attitude towards the program. Greg and Geoffrey (2010) recognize the need to develop employees' positive attitude, which can never be substituted by any amount of training. There is need for managers to effectively deal with the underlying causes of discontent among employees so as to raise the morale of the entire work place. With this kind of attitude from the people who are involved in the implementation of cost sharing program, then nothing much is expected even if the program stays in place for the next one hundred years. A positive attitude needs to be instilled in the employees. Attitudes determine how employees will perceive their environment, commit themselves to intended actions and ultimately behave.

Public awareness plays a crucial role in implementation of any project. The users need to know what is expected of them and what they expect from the program. However in the case of this study it is quite clear that the service users 61 (57%) are not informed about cost sharing. 30 (28%) had informal information through relatives and friends. The information may not be true thus misleading. This is an indication that social sensitization is missing. Sayers, (2006) supports lack of awareness due to inaccurate or lack of sufficient information. Thus with this deficit they tend not to support the program whole-heartedly. Wyart and Tallon, (2009) describe high public awareness occurring when a significant proportion of the society express that the issue at hand is of great importance to all. On the other hand, low public awareness is found when majority of the people do not know about the issue at hand or they care less about it. In-fact despite the relatively lower charges for services than in the private facilities, the patients tend to seek for services from the latter. Wyart et al, (2009) express the advantages of public awareness, which include strengthening of attitudes, values and action, all aimed at promoting sustainable development.

5.4 Conclusion of the Study

Based on the results of this study, the researcher was able to draw the following conclusions:-Implementation of programs to a great extent will require competent employees. Competence entails the right person for the job and right qualifications. In addition to the personal competence other external factors may hinder the achievement of intended results.

These external factors include necessary trainings, updates, motivation, and recognition and conducive working environment. There should understanding and appreciation together with provision of required working tools. Accountability, integrity and transparency are vital in the prosperity of any successful organization. Corruption tends to de-motivate those who work for the good of the organization and with time, the output is compromised. Implementation o f cost sharing program achievements has been a dream as corruption crept in due to weak control systems put in place. Managers at some time could not even tell how much money was waived as

the records were poorly kept. Managers are not effective in ensuring control measures put in place are used as expected and this has left the door wide open for corrupt and fraudulent deals.

Altitude, which is as a result of visible or invisible feelings or perceptions, is a silent killer in implementation of projects. Altitude cannot be seen and thus hard to deal with it. However, for the employees to have the right altitude towards implementation of cost sharing, they need to be informed about the program, know what it entails, be motivated through appreciation, and have a stake in utilization of the funds especially in making the working conditions favorable.

As the saying goes information is power a well-informed public will be empowered thus able to make informed decisions and choices. The service providers together with the service seekers, (clients and patients) and the general population need to know about cost sharing program. With the right information in place the chances of a successful program are high as the people involved in sorting out their own issues will be participate and support the program and thus a high probability of sustainable development of the same.

5.5. Recommendations of the study

The researcher makes the following recommendations from the study findings.

The issue of employee competence needs to be addressed urgently in order to ensure cost-sharing program is successfully implemented. All stakeholders need to be well informed to ensure sustainability. The employees' roles, duties and responsibilities need to be clearly defined. The issue of staff shortage should also be looked into to ensure the right people do the right job.

Efforts need to be put in place to ensure that accountability is key in implementation of cost sharing program. There is urgent need to strengthen the existing financing mechanisms and mobilize additional financial resources to bridge the existing financial gaps. Officers implicated with corruption and fraud, need to be strictly penalized or sacked.

Social, physical, emotional, environmental and financial needs of the employees should be considered when implementing programs. Thus continuous updates and trainings should be carried out if and when need arises. This will keep the employees at par with the changing times and technology.

The government needs to put in place measures that accommodate long-term awareness raising campaigns, which become part and parcel of normal life of the public. It is only through involving the public in solving their own issues that there will be fostering of personal responsibility, greater motivation and commitment towards sustainable development.

With the devolved government in place, the county governments need to review the policies on cost sharing program and amendments made and more so on matters of service charges.

5.6 Suggestions for further research

The study recommends for further research on efficiency in collection and use of cost sharing funds.

Further research can also be carried out on the effectiveness and efficiency of waiver and exemption systems used to ensure access to health care by vulnerable groups.

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APPENDICES

Appendix 1

LETTER OF TRANSMITAL

Mary Njeri Kiala

P O Box 482

MATUU

To the Participant

Dear Sir/ Madam

RE: ACADEMIC RESEARCH PROJECT FOR A MASTERS DEGREE PROGRAM.

I am a student at the University of Nairobi (UON) pursuing a master's degree course in project planning and management. I am required to conduct and submit a research report on "Factors influencing cost sharing program in public health facilities in Machakos County,Kenya.

I am inviting you to participate in this research study by completing the attached questionnaire. Kindly note that these information you give is to be used in this study for academic purposes only and such it well be treated with utmost confidentiality and will not be shared with unauthorized persons. Your cooperation and honesty in filling this questionnaire will be highly appreciated.

Thank you for your time.

Yours faithfully,

MARY KIALA

CELL PHONE 0725972648

EMAIL: mary_kiala@yahoo.com

Appendix 2

RESPONDENT QUESTIONNAIRE

Thank you for taking time to answer this questionnaire. It seeks to identify the factors influencing cost sharing program in public health facilities in Machakos County. The information gathered from the field during this research is surely for academic purposes and will not be shared with any unauthorized persons. Although your participation is voluntary, it is important for the purpose of this study that all questions be answered. (Please tick in the box against your response to the options provided. For questions without options, fill in your answer on the space provided).

Section A: Back Ground Information

1. Gender
   - a) Male ( )
   - b) Female ( )
2. Name of the hospital...
3. Years worked in the hospital
   - a) Below one year ( )
   - b) 1 – 3 years ( )
   - c) 4 – 6 years ( )
   - d) More than 6 years ( )
4. What is your level of education?
   - a) University ( )
   - b) Tertiary ( )
   - c) Secondary ( )
   - d) Primary ( )
5. What is the functional position in the institution?
   - a) Manager ( )
   - b) Health worker ( )
6. What role do you play in cost sharing program?
   - a) Supervisor ( )
   - b) Implementer ( )
   - c) Any other, specify ....

Section B: Competence of Employees

Please rate each item below and indicate your selection by circling the appropriate number that represent your reaction to the statement where: 1 = No at all, 2 = To a small degree, 3 = To a moderate degree, 4 = To a great degree, 5 = To a very great degree.

	Statement	1	2	3	4	5
1	I know about cost sharing program	1	2	3	4	5
2	I strive to ensure cost sharing is successful	1	2	3	4	5
3	I have undergone several trainings and updates on cost sharing program	1	2	3	4	5
4	I feel part and parcel of the people involved in achievement of the program	1	2	3	4	5
5	I am competent enough in relation to cost sharing program	1	2	3	4	5
6	The environment in terms of availability of recording tools, drugs, laboratory reagents and motivation among others is conducive	1	2	3	4	5

Section C: Internal Control systems.

1. Are you aware of the control measures used in the cost-sharing program?
   a) Yes ( )
   b) No ( )
   c) If yes,
   list them down;...
2. How would you rate the influence of internal controls on the effectiveness in collection and utilization of cost sharing funds in the facility?
   a) Very high ( )
   b) High ( )
   c) Fair ( )
   d) Low ( )

3. How effective has the management in the hospital been in ensuring that internal controls are well implemented for proper collection and utilization of cost sharing revenues?
    a) Highly effective ( )
    b) Effective ( )
    c) Slightly effective ( )
    d) Non effective ( )
4. How would you rate the impact of internal controls in fraud detection?
    a) Very high ( )
    b) High ( )
    c) Fair ( )
    d) Low ( )

Section D: Attitude of employees.

Please rate each item on a scale from 1 to 5 where;

1 = Not at all

2 = To a small degree

3 = To a moderate degree

4 = To a great degree

5 = To a very great degree

	Statement	**1**	**2**	**3**	**4**	**5**
1	I feel cost sharing is important					
2	I understand why cost sharing is there					
3	I am motivated to support cost sharing program					
4	I appreciate the way cost sharing funds are collected and utilized					

Appendix 3

KEY INFORMANT INTERVIEW SCHEDULE (PATIENTS/CLIENTS)

Thank you for taking your time to answer this questionnaire. It seeks to identity factors influencing implementation of cost sharing program in public health facilities in Machakos County. The information gathered is for academic purpose thus will not be shared with unauthorized persons and will be treated with a lot of confidentiality. Please tick against your response to the options provided.

For questions without options, fill in your answer on the space provided)

1. Gender
   a) Male ( )
   b) Female ( )
2. Name of the hospital attended:...

3. What do you think cost sharing is?...
   a) Free services
   b) Service fees partly paid by the government
   c) All service fees are paid by the patient
   d) None of the above.
4. Have you ever been informed about cost sharing program?
   a) Yes
   b) No
5. If yes where did you get the information from?
   a) From the hospital staff
   b) Chiefs baraza
   c) Medical brochure
   d) Media
   e) News papers

6. How are the charges for the services offered?
   a) Cheap ( )
   b) Reasonable ( )
   c) Expensive ( )

7. How is waiting time in the departments attended?

a) Very long (more than 1hour) ( )

b) Long (30 mins to 1 hour) ( )

c) Short (10 to 30 mins) ( )

d) Very short (0 to 10 mins) ( )

8. How do you rate cleanliness in this hospital?

a) Very dirty ( )

b) Dirty ( )

c) Clean ( )

d) Very clean ( )

9. What is your view of the staff altitude?

a) Not concerned ( )

b) Rude ( )

c) Helpful (

d) Friendly ( )

10. Generally how are the services in the hospital?

a) Below my expectations ( )

b) Met my expectations ( )

c) Beyond my expectations ( )

Appendix 4

Determining Sample Size from a Given Population

N	S	N	S
10	10	220	140
15	14	230	144
20	19	240	148
25	24	250	152
30	28	260	155
35	32	270	159
40	36	280	162
45	40	290	165
50	44	300	169
55	48	320	175
60	52	340	181
65	56	360	186
70	59	380	191
75	63	400	196
80	66	420	201
85	70	440	205
90	73	460	210
95	76	480	214
100	80	500	217
110	86	550	226
120	92	600	234
130	97	650	242
140	103	700	248
150	108	750	254
160	113	800	260
170	118	850	265
180	123	900	269
190	127	950	274
200	132	1000	278
210	136	1100	285

Author Daryle W. Morgan and Robert V. Krejcie

Appendix 5

CONDITIONS

1. You must report to the County Commissioner and the County Education Officer of the area before embarking on your research. Failure to do that may lead to the cancellation of your permit
2. Government Officers will not be interviewed without prior appointment.
3. No questionnaire will be used unless it has been approved.
4. Excavation, filming and collection of biological specimens are subject to further permission from the relevant Government Ministries.
5. You are required to submit at least two(2) hard copies and one(1) soft copy of your final report.
6. The Government of Kenya reserves the right to modify the conditions of this permit including its cancellation without notice

REPUBLIC OF KENYA

NACOSTI

National Commission for Science, Technology and Innovation

RESEARCH CLEARANCE PERMIT

Serial No. A 2164

CONDITIONS: see back page

THIS IS TO CERTIFY THAT:
MS. KIALA MARY NJERI
of UNIVERSITY OF NAIROBI, 0-90119 Matuu,has been permitted to conduct research in *Machakos County*

on the topic: *FACTORS INFLUENCING IMPLEMENTATION OF COST SHARING PROGRAM: A CASE OF PUBLIC HEALTH FACILITIES, MACHAKOS COUNTY KENYA*

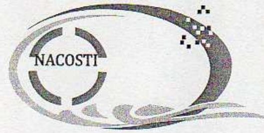
for the period ending:
31st August,2014

Permit No : NACOSTI/P/14/8806/2220
Date Of Issue : 4th July,2014
Fee Recieved :Ksh 1,000

Applicant's Signature

Secretary
National Commission for Science, Technology & Innovation

Appendix 6



NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

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Ref: No.

NACOSTI/P/14/8806/2220

Date:

4th July, 2014

Kiala Mary Njeri
University of Nairobi
P.O. Box 30197-00100
NAIROBI.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ***"Factors influencing implementation of cost sharing program: A case of public health facilities:-Machakos County-Kenya,"*** I am pleased to inform you that you have been authorized to undertake research in **Machakos County** for a period ending **31st August, 2014.**

You are advised to report to **the County Commissioner, the County Director of Education and the County Coordinator of Health, Machakos County** before embarking on the research project.

On completion of the research, you are expected to submit **two hard copies and one soft copy in pdf** of the research report/thesis to our office.

SAID HUSSEIN
FOR: SECRETARY/CEO

Copy to:

The County Commissioner
The County Director of Education
The County Coordinator of Health
Machakos County.