THE INFLUENCE OF DEVOLUTION ON ACCESS TO PUBLIC HEALTHCARE SERVICES IN KENYA: A CASE STUDY OF KISUMU COUNTY, 2013-2018

OGOSI JAMES YUKO,
C50/74328/2014

A RESEARCH PROJECT SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF MASTER OF ARTS IN POLITICAL SCIENCE AND PUBLIC ADMINISTRATION OF THE UNIVERSITY OF NAIROBI.

JULY, 2020

DECLARATION

I, James Ogosi Yuko, declare that this is my original work and has not been submitted in any other institution.

Signature: ……... Date: ……...

James Ogosi Yuko

C50/74328/2014

This study entitled "The Influence of Devolution on Access to Public Healthcare Services in Kenya: A Case Study of Kisumu County, 2013-2018" was prepared with my guidance and has been presented to the University of Nairobi for examination with my approval as Supervisor.

Signature: ……. Date: ……

Dr. Richard Bosire

DEDICATION

This study is devoted to my son Jesse Dacha Yuko, my wife Maureen Dieto, my mother Priscah A. Yuko and my late father John E. Yuko.

ACKNOWLEDGEMENT

I thank Dr. Richard Bosire for supervising my paper. His professional guidance in this study was invaluable, and enabled me to undertake this research with success. I also acknowledge my family members for their unwavering encouragement and support throughout the period of this study.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ACRONYMS AND ABBREVIATIONS

CEC: Chief Executive Committee

CESCR: Committee on Economic, Social and Cultural Rights

CIDP: County Integrated Development Plan

COB: Controller of Budget

CODESRIA: Council for the Development of Social Science Research in Africa

CHMT: County Health Management Teams

COK: Constitution of Kenya

CRA: Commission on Revenue Allocation

DHMB: District Health Management Board

DHMT: District Health Management Teams

GDP: Gross Domestic Product

GOK: Government of Kenya

HFMC: Health Facility Management Committee

JOOTRH: Jaramogi Oginga Odinga Teaching and Referral Hospital

KEMSA: Kenya Medical Supplies Agency

KMPDU: Kenya Medical Practitioners and Dentist Union

KPMG: Klynveld Peat Marwick Goerdeler

KIPPRA: Kenya Institute of Public Policy and Research Authority

MES: Managed Equipment Service

MOH: Ministry of Health

NGOs: Non-Governmental Organizations

NHS: National Health Service

PGHs: Provincial Government Hospitals

PHMT: Provincial Health Management Teams

SDGs: Sustainable Development Goals

SARAM: Service Availability Readiness Assessment

SPSS: Software Package for Social Sciences

UNICEF: United Nations International Children's Emergency Fund

WHO: World Health Organization

ABSTRACT

This study examined the influence of devolution on access to public healthcare services in Kenya between 2013 and 2018, by taking the case of Kisumu County. Financial resources allocation to the healthcare system, people participation and decision making on healthcare matters by county government exemplified devolution, while availability and affordability of public healthcare services exemplified access. This was in view that decision making powers by county government had expanded, and a lot more resources were being disbursed to the counties for the advancement of devolved functions, including health. Also, previous related studies had left gaps; influence of citizen engagement on access to public healthcare services had not been determined. Longitudinal research design was employed to guide the inquiry. Primary data were collected using structured questionnaires, individual interviews and key informant interviews and from secondary sources. A sample of 120 patients attending public healthcare facilities were systematically selected. 27 health facility representatives, 27 healthcare workforce; doctors, nurses and clinical officers were purposively selected. Chief Officer for health, chairman sectorial committee on health services at the county, three assistant county commissioners as well as three health-related non-governmental organizations working within the selected sub-counties were purposively selected. Spearman rho, Chi-square test of independence and descriptive techniques were employed in the analysis of quantitative data, while thematic analysis was employed in the analysis of qualitative data. The study establishes that financial resources allocated to the healthcare system, although still insufficient, has continually improved. It also establishes that resources injected into the healthcare system have largely been used to build new healthcare facilities and renovate existing ones. However, a weak negative correlation between financial resources allocation to the healthcare system and affordability of healthcare services ($r = -0.260$ when $\alpha = 0.05$), indicates that the low cost of healthcare services witnessed in public healthcare facilities by patients is also influenced by other factors. The framework guiding community engagement in healthcare development is adequate, however, no serious discussions take place in public forums, and members of the public are unable to adequately push for healthcare solutions that address community concerns. In spite of county government management bringing skilled healthcare closer to the population, delays in disbursement of funds inhibits delivery of services. Also, a clear human resource management policy that guides the hiring, retention and promotion of healthcare workers remains a challenge. The study concludes that numerous problems still face devolved healthcare service delivery; improvements are realized in some areas while others lag behind. The study recommends ring-fencing of monies allocated to the health sector against utilization by other undertakings of the county administration; a comprehensive public education program be undertaken across the county to educate the public on devolution and the opportunities it presents for the public; identification of accredited companies where all county government obtain drugs to address the widespread corruption and inefficiency in procurement and distribution of drugs, and ensure consistency in the pricing and quality of drugs. In the long-term, the study proposes the formation of a health commission to supervise the administration of the healthcare system.

CHAPTER ONE
INTRODUCTION

This first chapter provides the basis for the study and presents the background and the setting required to put the research problem in proper context. It has subsections that comprises; background to the study, statement of the research problem, research questions and objectives, justification of the study, scope and limitations, definition of concepts, theoretical framework, conceptual framework, literature review, methodology, data analysis techniques, reliability, validity and ethical considerations.

1.1 Background to the Study

Devolution of the health sector was implemented in the developing countries in 1980s and 1990s to bring about reforms (Legemaate, 2002). A growing international awareness of the close link between health and human rights encouraged donor agencies to emphasize on devolution as a key mechanism for improving the performance of the health sector (World Bank, 1993). Primary healthcare was also increasingly becoming a priority, with many donor organizations; Bamako Initiative of 1978, World Health Organization and UNICEF emphasizing the delivery of the same through a devolved healthcare system (Akin et al., 2001; Wamai, 2009). Motivated by devolution's ability to consolidate democracy and enhance the administration of public services to the people (Oyugi, 2000; Azfar et al., 1999), reduce corruption (Musgrave, 1959) and regional governments ability to make suitable choices for their communities (Hayek, 1945), many countries have since opted to move the management of their healthcare systems to the local level governments (KPMG, 2015; Okech, 2016). For instance, Uganda implemented devolution in 1997 to improve service provision in the education sector, enhance access to public healthcare, advisory services in agriculture, as well as natural resources administration (Bossert & Beauvais, 2002).

In Kenya, however, the first attempts at some form of decentralization was brief. Majimboism-a coined term for regionalism, introduced in 1963, was replaced in 1964 by centrally-controlled Provincial Administration (COK (Amended), 1964). The local authority system handed over by the colonial government at independence was undermined by President Jomo Kenyatta (Cohen & Peterson, 1999). He formed a powerful centralized state with a dominant executive that exercised absolute control over the legislature, the judiciary, and the local governments (GOK, 1977). The subsequent leadership also steered the country towards

institutional domination by moving the organization and supervision of government undertakings from regional authorities to the national government ministries (Cohen & Peterson, 1999).

Regarding healthcare, the government was convinced that a healthy population is productive, and is good for economic growth, and thus adopted a "free healthcare for all" policy in 1970 to expand healthcare accessibility in the country (Kenya Health Sector Report, 2016:22). User fees were abolished in the locally managed healthcare clinics. However, according to the Health Sector report, stagnation of the economy in 1973 made it financially unattainable for public facilities to continue operating without user fees, and was put back in 1989. The government undertook reforms in 1992 and created Health Management Boards in the districts to facilitate sharing of healthcare costs between citizens and government (Wamai, 2009). Thereafter, the GOK came up with a policy plan for public health in 1994 which envisaged a healthcare system from 2010 and beyond.

The health policy plans were implemented in two stages, with devolution in mind, through five-year arrangements. The National Health Sector Strategic Plan I implemented between (1999 and 2004) and the National Health Sector Strategic Plan II between (2005 and 2010). NHSSPs reorganized public healthcare system into hierarchical structure from level one to level six. At the bottom of the hierarchy are the village dispensaries. Health centers are at level two while level three comprises sub-county hospitals. Level four comprises former district hospitals that are currently known as county hospitals. Level five consists of the county teaching and referral hospitals while level six are at the pinnacle of the pyramid, the national teaching and referral hospitals (Kenya Health Sector Report, 2016).

The 2007 post-election violence re-ignited the process to restructure governance and ended with the ratification of a new Constitution in 2010. The constitution moved the management of public healthcare services to county governments (COK, 2010: Art 6 (1).) and entrusted county governments with all the functions related to healthcare; promotion of primary care, employment and management of medical staff, management of all healthcare facilities and pharmacies in the county, ambulance services and veterinary services, licensing of public eateries, management of mortuaries, graveyards and disposal of wastes (COK, 2010: Schedule 4). County governments have an obligation to facilitate and coordinate public participation and develop consensus at every level of devolution; from county to sub-county through wards and village level when preparing healthcare policies, blueprints, budgets, and during implementation

and monitoring of healthcare service delivery [COK, Section 30 (3) (g)]. The goal is to enhance equity in access to healthcare in the marginalized regions (Constitution 2010, Art. 174) and reduce bureaucracy in the delivery of healthcare services in public hospitals (COK, 2010: Schedule 4).

The Service Availability and Readiness Assessment Mapping (SARAM) (2013) baseline conducted on the onset of devolution implementation, established that most health facilities lacked adequate equipment, had limited healthcare personnel and patients travelling long distances to access healthcare. SARAM will be used as a benchmark upon which to evaluate the changes that have taken place concerning access to healthcare services in public hospitals.

1.2 Statement of the Research Problem

Access to quality healthcare is essential in human capital development. Access to essential healthcare services improves the general well-being and productivity of a people, and is good for sustainable development (WHO & SDG, 2015). Access enables early prognosis and management of physical, psychological and societal illnesses and is therefore very vital for the overall health status of a people (Healthy people, 2000). Healthy People also finds that accessibility of healthcare guards' local people against preventable deaths and improves life expectancy.

However, throughout the developing countries, a larger proportion of the population are still faced with limited access to healthcare (Alsheimer, 2018). Many impoverished areas are unable to afford healthcare services, are remotely away from healthcare facilities, or are faced with barriers to access that do not allow them to obtain services (WHO, 2013). According to Lodenyo (2016) over half the population in sub-Sahara Africa have inadequate access to healthcare services.

In Kenya, a study by KPMG (2014) establishes that a higher proportion of Kenyans still pay their medical bills out-of-pocket, and is partly blamed on county governments budget allocations to the health sector which has been relatively low. MOH (2015) however, finds that counties have made some increases in public health spending and attributes constrain on healthcare service provision at the facilities on delays in disbursement of funds. County run healthcare facilities are also affected by critical shortage of health workforce (Kariuki, 2014). According to Magokha (2015) county governments have only been successful in attracting and retaining lower cadre staff. Magokha affirms that specialized medical personnel are avoiding

county health facilities because of poor working conditions. KMPDU (2015) points out that more doctors are migrating from the county public service to other sectors in search of better opportunities. The county public service commission has been unable to come up with proper schemes of work to guide promotions, which has led to continuous strikes by health workers. Furthermore, the new Public Procurement and Disposal Act [(Part 10, Sec. (57) (4)] that allows counties to purchase drugs and medical supplies from other sources, in addition to KEMSA, is exploited by fraudulent persons within county governments, and has led to perennial scarcity of drugs (Kariuki, 2014).

However, many of these related studies have not considered the increased decision space at the county level that has heightened fairness in the allocation of health resources (Tsofa, 2016). Also, the Kenyan devolution recognizes and protects the right of citizens to participate in all development affairs including health [COK, 2010: Art. 196 (1) (b)]. However, related studies have not analyzed the influence of peoples input in the decisions that are made on healthcare related issues. Moreover, McCollum, Sally, Lillian, Tim, Robinson, and Barasa (2018) affirms that the early stages of devolution was rapidly implemented against counties lack of requisite capacity and capability to generate own revenues.

Devolution has now been implemented for six years. It is also apparent that related studies were either done at the onset of devolution implementation, while others have not comprehensively evaluated its influence on access to public healthcare services. This research, therefore, assesses the accessibility of public healthcare services in Kisumu County since the inception of devolution.

1.3 Research Questions

This investigation will answer the below stated questions:

1. What is the effect of financial resources allocation by county government to the healthcare system on access to public healthcare services in Kisumu County?
2. What is the influence of public participation in decision making at the county level on access to public healthcare services in Kisumu County?
3. What is the influence of decision-making on healthcare matters by county government on access to public healthcare services in Kisumu County?

1.4 The Main Objective

1. To determine the influence of devolution on access to public healthcare services in Kisumu County.

1.5 Specific Objectives

The objects of the study are:

1. Determine the effect of financial resources allocation to the healthcare system by county government on access to public healthcare services in Kisumu County.
2. Determine the influence of public participation in decision making at the county level on access to public healthcare services in Kisumu County.
3. Assess the influence of decision-making on healthcare matters by county government on access to public healthcare services in Kisumu County.

1.6 The Justification of the Study

There are a number of conceptual, contextual, theoretical and methodological knowledge gaps in studies assessing the influence of devolution on public healthcare services accessibility. For instance, conceptually, the element of public participation is a significant component of the Kenyan type of devolution, which has been left out by many studies, such as the KIPPRA (2014) study. Contextually, most studies; {KPMG (2014), MOH, (2015), KMPDU (2015)} were conducted at the earlier period of devolution implementation when counties did not have adequate capacity and resources. Other related studies such as Makonjia (2016) are not guided by any theory while some studies were conducted using single instruments that are not triangulated. Also, as demonstrated in the literature review, some studies utilized access indicators that falls short of the standard benchmarks of the SDGs markers of public healthcare services accessibility. Such knowledge gaps limit the generality of prevailing research findings on the same to broader populations. By identifying and filling these knowledge gaps relating to healthcare accessibility in county public healthcare facilities, this study enhances the prevailing knowledge.

The study generates data that can be used by policy makers during planning of health development activities. For instance, data on the distribution of healthcare facilities vis-a-vis the population, can be used as a reference point upon which county assembly members decide on which localities or public facilities ought to be prioritized during the allocation of finances.

The study findings identify and recommends key operational areas in the county governance framework that require adjustments to expand accessibility of healthcare services in public healthcare facilities. This may include formation of a health commission to supervise the administration of the healthcare system, strengthening partnerships with sectors that offer services related to health in the regions that have been marginalized in the past, and implementing interventions which address risk factors to health.

1.7 The Scope and Limitations of the Study

This investigation is an assessment of the influence of devolution on access to public healthcare services conducted in the County of Kisumu, between Sept and Oct 2019. The study is confined to examination of information that addresses healthcare services accessibility in county government public healthcare facilities since the inception of devolution. The study encompasses evaluating financial resources allocation to the healthcare system by county government, public participation in the decisions concerning healthcare and their influence on access to public healthcare services. The study also interrogates county government decisions concerning healthcare and how the public hospitals utilize resources allocated to them to expand accessibility.

Oso and Onen (2008) contend that "limitations are methodological weaknesses in a study design that lower validity and reliability". The low turnout of the respondents at 80 per cent was the study's major limitation with the possibility of lowering the generality of the study findings to broader population. However, the researcher solved this limitation by spreading the sample to cover a wider distribution; the sample of patients were drawn from public healthcare facilities distributed in every ward within the selected sub-counties which improved representation. Also, the researcher was able to obtain information from all the sampled key informants, and was used in triangulating the research findings.

1.8 Definition of Concepts

Devolution

Devolution entails moving authority in financial, political and administrative management, from the central government to a popularly elected (largely autonomous) sub-national unit (Barkan, 1989, Oyugi, 2005). It is characterized by Rondineli and Cheema (1983) as a form of decentralization. According to Muigua (2018), devolution involves moving away from state-centered control and establishing local governments in which the local people and

authorities participate in the management of resources. In this study, devolution refers to the creation of county governments and allowing them to self-govern. Devolution is conceptualized as financial resources allocation to public healthcare system, participation of the public in healthcare choices, and decision-making on public healthcare matters by the county governments.

Financial resources allocation

It entails the overall distribution of funds to decentralized management areas within the government health service (WHO, 2000). It is closely related to budgeting, which is concerned with statements of specific expenditure plans within the broad allocative ceilings. In this study, financial resource allocation refers to distribution of resources by county legislative assembly to the primary and secondary public healthcare facilities to promote the delivery of healthcare services. It is measured in terms of the total expenditures on public healthcare as a proportion of the total county budget.

Public participation

It entails seeking public contribution when determining choices that affect the people (World Bank, 1996 in Brinkerhoff & Crosby, 2002). In this study public participation implies direct contribution by public (county residents) in decisions on public health planning, implementation and monitoring by way of holding public debates, writing memoranda, organizing public protests and public hearings, law suits among others.

Decision-making

It entails the specific range of choices that national governments allow subsidiary authorities to undertake in the delivery of public healthcare services (Bossert, 1998). In this study, decision making by county governments refers to the range of administrative choices that are made by county governments and how such choices relate to the performance of the health sector along observable healthcare service delivery outcomes. It includes choices on public healthcare human resources management; availability of medical workers in adequate proportions, medical supplies and equipment.

Access to public healthcare services

Access to public healthcare services is the dependent variable. It is defined as the populations' ability to afford medical treatment, and includes the availability of adequate proportions of medical staff and medical supplies (Mc Graw-Hill, 2002). In this study, access to

public healthcare services refers to affordability and availability of healthcare services; cost of essential medicines in the counties, number of healthcare facilities, healthcare equipment, and number of healthcare staff that serves the population.

1.9 Literature Review

This part presents a review of literature on the relationship between devolution-conceptualized as financial resources allocation to the healthcare system, public participation in decisions concerning healthcare and decision making on healthcare matters by county government-and access to public healthcare services. The review critically identifies and brings to fore, gaps in the empirical studies that have been conducted on the influence of devolution on access to public healthcare services across different locations in the world, and concludes with the Kenyan cases.

1.9.1 Access to Public Healthcare Services

Access is defined by WHO (2013) from an economic perspective as the people's ability to comfortably pay for medical treatment. According to WHO, access includes indirect opportunity costs such as transport expenses patients incur when they visit a facility. Access also entails having medical work force, equipment and medical supplies in adequate proportions (Mc Graw-Hill, 2002).

Gulliford, Figueroa and Morgan (2012) argue that access to public healthcare services implies not only adequacy in supply of public healthcare facilities, but, also the affordability, approachability and suitability of services. Access also signifies appropriate use of services based on necessity and encompasses four facets; 'geographical access, obtainability, monetary access and suitability' (Peters et al., 2008: 161-171). Jacobs, Por, Bridgeli and Van Damme (2011) include healthcare utilization as an alternative substitute of access to healthcare services. Access "is when healthcare facilities, goods and services are available in sufficient quantity; are physically and economically accessible to everyone; culturally and ethically acceptable; and scientifically and medically appropriate and of good quality" (General Comments No. 14, CESCR).

The GOK health Act (2017) defines access to a public healthcare service as the provision of medical care that prevents, manages or alleviates illnesses, bodily injuries and people's psychological ailments, by a healthcare practitioner through the healthcare system. In this study,

access to public healthcare services refers to affordability and readiness of healthcare services to the people.

1.9.2 Financial Resources Allocation and Access to Public Healthcare Services

As established, overreliance on user charges to finance public healthcare increases financial burdens in households without medical insurance (Xi et al., 2007). It is also argued that financial resources allocation at the local level provides financial protection to poor citizens by reducing out-of-pocket payments. Consequently, significant efforts have been made in many developing countries to allow financing of public healthcare sector be borne by sub-national governments (Glassman & Sakuna, 2014) which transfer resources directly to the healthcare facilities. Besides, the near distance of regional authorities to the citizens allow leaders to listen and match resources according to the needs of the local people (Azfar, 1999; Mwenda, 2010). Also, reduced distance improves geographical and financial accessibility which increases healthcare service utilization (GOK, 2015).

According to Khalegian (2004) the effect of financial resources allocation on health depends on the established structures, provisions for transfer as well as the competence of regional entities. As established in the Philippines, poor administrative preparations by local governments lead to shortage of personnel (Lieberman (2008). However, Glassman and Sakuna (2014) affirm that out-come based allocations need data systems that adequately link expenditures and outcomes or accomplishment. Litvack, Ahmad and Bird (1998) confirm that minimal capacity and capability of local governments to generate own revenues can fail to ensure effective delivery of services. Litvack et al. explains that regional authorities are often inhibited by limited finances they receive from the center. Frumence and Nyamhanga (2013) explains the case of Tanzania where local government authorities have limited capacity to generate own revenues, even when particular laws of devolution allow them to levy taxes. According to Frumence and Nyamanga the disbursements from the center to the periphery are often late, strict and conditional in their terms.

Empirically, across the world, related inquiries have been carried out on financial resources allocation by local governments and public healthcare services accessibility. A panel study of developed countries by Robalino, Picazo and Voetberg (2001) reveals that infant mortality rate decreases when expenditures of regional governments as a share of national government spending increase. A study by Gilson, Kilima and Tanner (1994) on primary

healthcare management by district authorities in Tanzania revealed challenges of limited resources disbursed from the center. The study highlighted antagonisms that existed due to demands from central management and local discretion which undermined the delivery of primary healthcare. In the Philippines, an early study of the same revealed inequitable distribution of resources from the center where some cities received 3.5 times more than the provinces, resulting in the inability of many local governments to effectively finance healthcare activities (Grundy, et al., 2003). In some areas, geography-related disparities in health service utilization with respect to neonatal children have exacerbated after devolution (journal of Development studies, 2014). In Nigeria, variations in the organization of healthcare services between urban community healthcare hospitals and those in rural regions increased after devolution (Gupta et al., 2003).

In Kenya, it is anticipated that county level management will reduce some of the healthcare access barriers by equitably allocating resources to the primary and secondary healthcare facilities located in areas previously marginalized ((COK, 2010: Article 174)). To achieve this, counties receive conditional grants to provide free maternal healthcare. They also receive compensation for any user fees waived and money for leasing of medical equipment. Every county receives no less than 15 per cent of the consolidated income and a 0.5 per cent equalization finance for the marginalized communities. The national government also provides conditional and unconditional grants which are targeted at level 5 hospitals (Commission on Revenue Allocation, 2014).

However, a study by KPMG (2014) establishes that many households still rely on out-of-pocket spending to obtain care. This has resulted in higher disease burden levels. The study also holds that some households have been pushed below the poverty line due to catastrophic health spending. According to Olugo (2015) a bigger percentage of the county allocations to the healthcare facilities is spent on workers' salaries and purchase of drugs. A study by UK-based Chatham House (2017) confirms that Kenya, among sub-Sahara African countries, is one of the places where even though the practice of detaining patients is illegal (COK, 2010: Article 43), hundreds of women are held because of failure to pay medical bills. However, the KPMG study focuses only on the financial aspect of healthcare access and leaves out other dimensions which are also critical; availability and adequacy of healthcare services. The study was also conducted

at an earlier time of devolution implementation process when most counties were still familiarizing themselves with devolution.

KIPPRA (2018) conducted an assessment regarding the uptake of public healthcare services under devolved government since 2013 and noted an overall improvement in healthcare service delivery. The study noted an increase in budget allocations for public health sector in both county and national governments in the financial years 2013/14 and 2015/2016. However, the study indicators employed; maternal mortality rates, pre and post-natal visits, and immunization of children, child nutrition status and life expectancy do not meet the standard benchmarks of a middle-income country as well as the SDGs indicators of healthcare services accessibility. The inquiry does not examine the role of public participation on aspects of healthcare like equitable administration of healthcare services, accountability and efficiency in service provision, which is also important in determining the state of public healthcare services accessibility.

1.9.3 Public Participation and Access to Public Healthcare Services

It entails seeking public contribution when determining choices that affect the people (World Bank, 1996 in Brinkerhoff & Crosby, 2002). Devas and Grant (2003) characterizes public participation as the practice of exercising influence and control by citizens over the choices that directly or indirectly affect them. According to Yang and Callahan (2005) public participation could be either direct engagement of citizenries in the decisions of the state or indirect involvement by elected officials as representatives of the people. Devarajan, & Widlund, (2015) emphasizes that involving stakeholders in decision making about their communities has important social, economic and political benefits. According to Muriu (2012), when the marginalized are included in decision making, pro-poor policies which ensures provision of equitable access to services emerge. At the core of public participation is the issue of accountability. Berlan and Shiffman (2012) contend that devolution tied with active people participation leads to increased citizen monitoring which most likely enhances accountability.

In the health sector, 'public participation' is used interchangeably with 'citizen participation', and 'users', or patients' involvement to refer to the direct contribution by population in the preparation, execution and appraisal of public healthcare undertakings (Matos & Serapioni, 2017). Alma-Ata declaration distinguishes public participation as a right (WHO, 1978), and a responsibility to be exercised individually or as a group in planning and

implementation of healthcare policies (Mittelmark et al., 2008:644). According to Andras and Bruce (2002; 8:291-7) public participation is a 'noble activity which aims to democratize healthcare'. However, Baur, Tineke and Guy (2010) argue that public participation has never done any good to the disadvantaged classes. Public participation is critiqued for being costly to conduct and the difficulty in achieving a consensus whenever one is held, which results in delays in service delivery (Muriu, 2012).

Public participation incorporates information and experiences among different people which enriches the quality of healthcare decisions (IEA, 2015). In the United Kingdom, information gathered through discussions and contributions from the people has been used to regulate healthcare (Doyal, 1998). Citizens have been organized to seek their opinions about the amounts of money that should be charged to different areas of the health sector, and whether certain sectors should receive limited financing and be excluded from the National Health Service budgets (Bowie et al., 1995). Clinical conditions have also been evaluated through opinion polls to set apart needs considered to be less worthy of urgent medical attention (Heginbotham, 1993). Debates have been held locally to develop a consensus on risky lifestyles that disqualifies certain individuals from enjoying the right of equal access to healthcare (Bowie et al., 1995). According to Besley and Burgess (2002) public participation on flows of public spending can improve allocative efficiency and service provision, especially in developing countries where information and data is scarce.

In Kenya, the framework for public contribution in both the national and county administration is legally safeguarded. First, the preamble of the Kenyan constitution regards public contribution as 'a state value and a tenet of governance' (Article. 10). Article 174 allows the masses to take part in exercising the powers of the government and in the determination of choices affecting them. Article 232(d) safeguards the people's entitlement to partake in the process of policy making in the civil service. Article 196 section (1) part (b) obliges county legislatures to coordinate public discussions and involve the people in parliamentary affairs and other dealings of the legislative body. Involvement of the public in financial matters is a basic tenet of budgeting; including honesty and responsibility (Article 201). These principles hold that any public expenditure must promote equity in the advancement of the country, particularly in the marginalized groups and regions. However, given the elevated levels of fraud and misappropriation of funds that characterize county governments (EACC, 2015) public

participation has not produced any significant progress in healthcare service provision (IEA, 2015)

A health assessment by KIPPRA (2017) across counties, on public participation and health confirms the existence of high level of public input in health development issues. The inquiry revealed that a greater part of the public knows the importance of active contribution in healthcare decision making. According to KIPPRA, a lion's share of Kenyans is knowledgeable of their health rights in the constitution while a considerable margin is aware that primary healthcare is a devolved function. The study also affirmed that the level of public contribution is greater amongst urban households measured up against rural households. However, the study merely states the level of public participation on health matters across counties. The study does not explain how public participation impacts access to public healthcare services or any other healthcare outcomes.

1.9.4 Decision making and Access to Public Healthcare Services

Decision making refers to the formal array of administrative choices granted by the national management to be undertaken by regional, provincial or county administrations within various functions of finance, human resources, infrastructure, medical equipment and healthcare facilities' financial independence to promote the provision of healthcare services (Bosert, 1998). According to Shroeder (2003), when the management of government functions is vested in the hands of local leaders, access and speed of service delivery improves. According to Litvack and Seddon, (1999) granting local governments' managerial authority on healthcare matters creates a conducive environment for public involvement, which reduces social disparities and exclusion in healthcare provision. Litvack and Seddon points out that decision making powers by regional units makes it easier for leaders to achieve a consensus with the public and the leaders get the opportunity to prioritize healthcare decisions that are most urgent to their community. Khaleghian (2003) points out that decision making at the local level increases immunization coverage rates for children because information and public amenities are nearer to the people.

Bossert and Beauvais (2002) however, explains that where local leaders have limited expertise and leadership capacity, their ability for effective management of public healthcare services is constrained, and leads to sub-optimal decisions. Rondinelli and McCullough (1989) argue that some decisions made by the national government usually restrict the local choices.

In Kenya, decision-making authority on healthcare matters by county governments is granted by the constitution (COK, 2010: Schedule 4). Counties, through their assembly members make decisions on healthcare matters through parliamentary legislations. The assembly members legislate on healthcare policies, plans, and distribute resources, decide on the recommended number of medical staffs, infrastructure and equipment for healthcare facilities including ambulances, construction and expansion of new facilities (COK, 2010; Okech & Lelegwe, 2016).

County governments are expected to tailor their healthcare decisions with the local needs. However, a study by CODESRIA (2017) establishes that while a bigger proportion of Kenyans rely on public primary and secondary facilities, critical medical staffs are still clustered either in the level six hospitals or in the county referral hospitals (PGHs). According to CODESRIA, Levels one, two, three and four health facilities are left without specialized personnel. MOH (2013:15) confirms that a substantial number of doctors migrate from county run healthcare facilities to other sectors in search for better opportunities. According to MOH, certain departments such as oncology department where diagnosis of cancer cases is on the rise, do not have general cancer doctor to manage cancer patients. The MOH study also reveals that there is only one pediatric nephrologist and two consultant nephrologists available in public hospitals. Counties public hospitals presents a worse case as they have been able to only attract and retain lower cadre staff (Magokha, 2015).

County governments, through the new Public Procurement and Disposal Act [(Part 10, Sec. (57) (4)] have the authority to decide on whether to purchase drugs and supplies from KEMSA or other alternative sources. However, this has created opportunities for fraud, malpractices and extortion. According to Kariuki (2014), fraudulent persons within the county governments have taken advantage of the new law to purchase drugs and supplies from unknown sources at exorbitant rates, hence, leading to shortage and poor quality of drugs.

An empirical assessment at Kilifi County by Tsofa (2016) establishes that expanded decision space at the counties has heightened fairness in the allocation of healthcare finances. The paper confirms that conditions surrounding healthcare service delivery in public healthcare facilities improved and essential services got to populations that were marginalized in the past. However, conceptually, Tsofas study does not consider the role of public participation in influencing healthcare outcomes. Besides, a report by the Nation Newspaper (2019) disproves Tsofas findings and reveals shortage of drugs in most county facilities. The Nation Newspaper

report cites Taita-Taveta as one of the counties where locals complain of being referred to private hospitals which offer services at costs they cannot afford. The report indicates that some locals cross over to neighboring Tanzania facilities, where services are available and cheaper.

In conclusion, the identified gaps for the study are as follows. First, related studies collected data using single instruments, which are not triangulated. Some studies did not consider the role of public involvement in influencing public healthcare services accessibility. Previous studies on the same focused on other aspects of healthcare outcomes like equity and accountability and left out access. Some studies did not link devolution with access to healthcare services. While significant investigations have been undertaken on the influence of devolution on healthcare service delivery; efficiency, accountability and equity, little attention has been made to determine how it affects public healthcare services accessibility. This is a discrepancy that this inquiry anticipates to fill up.

1.10 Theoretical Framework

This study uses the principal-agent theory to explain the power relationships at the county level; between county government officials, citizens and healthcare facility representatives. Principal-agent theory describes a relationship between a principal who involves an agent to carry out stated functions that are important to the principal and entails the principal giving certain managerial authority to the agent (Bosert, 1998). Principal-agent theory was first used to analyze relationships between firms and shareholders (Jensen & Mekling, 1976). In Political Science, it has been used to mirror the interactions between central governments as principals and regional governments as agents (Grifith, 1996).

The theory has two major assumptions. Firstly, that principals delegate authority to agents with precise objectives. Secondly, agents have individual interests they would want to pursue which sometimes conflict those of the principals. Agents have the advantage of pursuing their own goals at the expense of principals, because agents are well-versed with local circumstances and are aware of the pressing necessities of the local people than the principal. However, according to Davis, Donaldson, and Schoorman (1997), some agents are very loyal to the principal. Besides, some agents may also be very proud, and would want to align their goals with those of the principal.

Applied in this study, the principal-agent theory mirrors the nature of the linkages among the main players within the governance framework of the healthcare system at the County. This

is important in analyzing how county governments work in practice and promotes understanding of power relationships at the county level that could be useful in identifying problems which, when solved, lead to improvements on healthcare outcome. For instance, from citizens (Principals) to county government leaders (Agents), the significant feature of the relationship is the articulation of the health preferences and demands to political leaders or public officials, either by voting in a governor or a member of the county assembly with the preferred health manifesto, or through advocacy and public memoranda campaigns. They elect county leaders as representatives with mandate to allocate resources and make healthcare decisions on their behalf.

From County government leaders to citizens, the main relationship is responsiveness to citizen needs and preferences; disbursing the requisite amounts of money to public healthcare facilities, hiring adequate healthcare workforce and building more health facilities in remote areas. However, based on principal-agent theory assumptions, county leaders may have different objectives from those of the citizens; like wanting to accumulate power and wealth. County leaders also have better information about financial resources disbursed from national government than the citizens. Chai (1995) explains that the principal can prevail over the information asymmetry by identifying rewards that motivate agents. For instance, county officials are always afraid of elections and citizens can take advantage of this to check their performance. Citizens can organize strikes and file law suits to push for their agenda. The constitution of Kenya also provides for recall of leaders which the citizens can use to put pressure on their leaders to be responsive to their needs.

The governance linkages between county government leaders and healthcare facility representatives also signify a perfect expression of principal-agent relations. County leaders as principals stipulate objectives, processes and guidelines. They allocate resources and exercise oversight on health facility representatives who function as their agents. In return for resources, health facility representatives carry out the instructions and certain aspirations of county leaders.

Principal-agent theory is an ideal approach for this investigation over the others. Local fiscal choice approach that has been used by economists to examine choices made by regional administrations working with finances generated locally (Musgrave & Musgrave, 1989) focuses merely on the circumstances at the community level. Equally, the public administration approach, first used by Rondinelli and Cheema (1983) to analyze wide-ranging types of decentralization in developing countries, and later utilized to explain decentralization of

healthcare delivery in undeveloped countries (Mills et al., 1990) merely states the tasks that are designated to each level of government without giving much guidance on how to analyze them (Gilson et al., 1994).

Putnam (1993) applied the social capital approach in Italy to illustrate why governments that are decentralized, in some places, perform better institutionally than others. Putnam argues that localities with strongly established civic organizations, "social capital" which have existed for a long time, create trust and reciprocity among the local population. Put into operation in the health sector, Putnam implies that regions with higher levels of 'social capital' will have better performing healthcare systems than those without. However, the approach fails to explain the contexts in areas without such networks of associations and cannot suit this study.

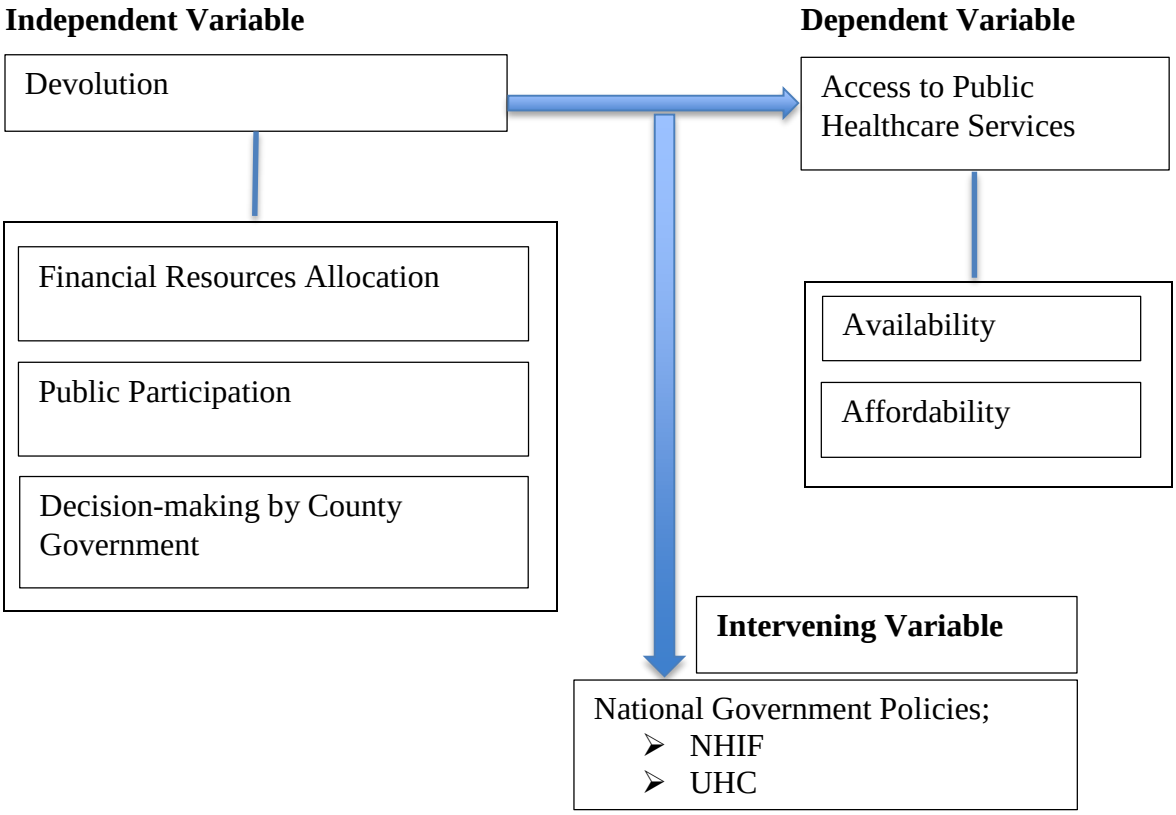
Nevertheless, principal-agent relationships are subject to challenges that include; information asymmetries, conflicts of interests' and moral hazards, that principals operating within a healthcare system have to deal with in their interactions within the county governance framework. Principal-agent theory has also been critiqued by Hedge, Scichitao and Metz (1991) for the difficulty one encounters when analyzing the vertical associations between the principal and the agent, especially when there are several principals of different managerial levels. For instance, in this study healthcare facility representatives could alternatively be viewed as agents who are accountable to the county government leaders (principal) who may have quite different objectives from the citizens who elect them (principal). Chubb (1985), however, argues that agency approach can hold many principals at either national or local levels.

1.11 Conceptual Framework

In this inquiry, the conceptual framework is founded on the objectives of the study and explains the connection between the independent variable (devolution), moderating variables (national government policies; UHC, NHIF) and the dependent variable (access to public healthcare services).

Devolution is conceptualized as financial resources allocation to the healthcare system, public participation and decision-making on healthcare matters by county government. Access to public healthcare services is conceptualized as affordability and availability of public healthcare services. The devolved healthcare functions are expected to be performed by county leaders who are elected as agents to allocate resources, organize public participation and manage the healthcare system on behalf of the citizens who are the principals.

Figure 1.1: Devolution and Access to Public Healthcare Services in Kenya



As illustrated in the framework above, the independent variable (devolution) is anticipated to influence the dependent variable (access to public healthcare services). Financial resources allocated to the healthcare facilities is anticipated to expand accessibility to healthcare; infrastructure, healthcare work force and medical supplies. More resources allocated to the healthcare facilities are also expected to lower the cost of medical treatment and incidences of excessive healthcare expenditure directly borne by patients.

Public participation in matters healthcare is expected to give a rise to the provision of equitable access to public healthcare services, especially where pro-poor policies are adopted by public authorities, where sufficient information is availed to the public and where a substantial number of public participation forums are held.

Finally, decision by county leadership to institutionalize community engagement in health development matters is anticipated to reduce social exclusion and disparities in healthcare service provision. Also, some decisions by county government, for instance, to buy medical equipment and employ more health workers are expected improve availability of public healthcare services to the public.

1.12 Hypotheses

This study tests the following hypotheses;

1. Allocation of adequate financial resources to the healthcare system by county government increases access to public healthcare services.
2. Public participation in decision making at the county level increases access to public healthcare services.
3. Decision-making on healthcare matters by county government increases access to public healthcare services.

1.13 Methodology

This section presents the research design, study area and population, sampling techniques and methods of data collection. It also discusses the techniques used to analyze data as well as the strategies employed to guarantee reliability and validity of research findings

1.13.1 Research Design

The study used a longitudinal research design. Longitudinal research design allowed examination and detailed analysis of healthcare accessibility in public hospitals in Kisumu County between 2013 through 2018 period, to provide information about changes in access to healthcare that have taken place after implementation of devolution. Also, the study employed a mixed method (Creswell, 2015); combining quantitative and qualitative data.

1.13.2 Study Area and Population

This investigation was undertaken in the County of Kisumu in Western Kenya. The County of Kisumu is one of the legally founded units of devolution (COK, 2010: Art 6 (1)) among other 47. Kisumu has 968, 909 people living in approximately 2086 km2 land area, and 567 km^2 on water (Kenya National Population and Housing Census, 2009). The County has a diverse setting, encompassing urban and rural dwellings that are divided into seven sub-counties and 35 wards. The county has 130 public healthcare facilities comprising one level five hospital, six level four, 17 level three, 34 health centers and 72 dispensaries (Master Facility List, 2015)[1].

The target population for this study comprised dwellers of Kisumu County. A sample of 178 respondents; 120 patients (60 out-patients and 60 in-patients) attending public health facilities, 25 health facility administrators, 25 health personnel; doctors, clinical officers or nurses in a facility, county chief officer for health, chairperson sectorial committee on health

[1] See Appendix 3

services, three assistant county commissioners, and three local NGOs were selected to represent the residents of the County.

Kisumu County was chosen for this investigation, because of its high maternal mortality rates where 597 mothers are dying out of every 100,000(SARAM, 2013). The infant mortality rates are also high at 95 out of 1000. The under-five mortality rates are no better at 149 per 1000 live births. Kisumu County also leads in the infectious diseases, especially HIV/AIDS and tuberculosis while malaria cases are perennial.

1.13.3 Techniques of Sampling

This investigation used two-stage stratified sampling procedure to pick out a sample for collecting data in three sub-counties out of seven, to represent Kisumu County. In the first stage, the researcher stratified the sub-counties into two urban (Kisumu central and Kisumu west) and five rural (Nyando, Nyakach, Muhoroni Kisumu East and Seme). Within this stratum, one urban sub-county was selected by picking from marked ballots. This was done to provide 50 per cent proportional representation of the urban sub-counties. There are 15 public health facilities spread in 7 wards in Kisumu central. Simple random sampling method was employed to pick two public medical facilities from Market Milimani Ward and two in Nyalenda B as demonstrated in Table 1. In both wards, the selected public facilities provide 40 per cent proportional representation which is sufficient because they are located in urban dwellings with similar setting. In the remaining five wards, each has a single healthcare facility, and was picked to improve representation of the wards.

Within the stratum that comprises rural sub-counties, a simple random sampling procedure was employed to choose two rural sub-counties which proportionately represent the rural sub-counties by 40 per cent. There are 33 public health facilities; 22 spread in four wards in Seme and 11 public health facilities spread in four wards in Kisumu East. In Seme sub-county, simple random selection procedure was utilized in picking two public medical facilities in East Seme ward, two in Central Seme, three in West Seme and 3 in North Seme ward. In all the wards, the selected facilities provide above 40% proportional representation of all facilities in those wards, and are sufficient because they are selected from areas with similar setting.

Likewise, in Kisumu East, simple random selection procedure was utilized in picking 2 public health facilities in Kajulu and 2 in Kolwa East Ward respectively. These facilities were selected from wards with similar setting, therefore, with over 40% proportional representation;

they sufficiently represent the remaining facilities. Manyatta B and Kolwa Central Wards have one healthcare facility each, and were picked to improve representation.

Simple random sampling was used to select elements from each stratum. A total of 25 healthcare facilities were selected.

In the second and final stage, from the total number of selected healthcare facilities, systematic selection procedure was utilized in selecting 120 patients (60 in-patients and 60 out-patients) who had visited the facility; Kisumu central 60 patients, Kisumu East 30 patients and Seme 30 patients as shown in Table 1. Systematic sampling allowed the researcher lower the chances of similar cases ending up into the sample. It also made it possible to generate smaller samples which were easy to construct and understand.

Table 1.1: The Number of Patients Selected

Sub-County	Population Per Sub-County	Number Of Public Health Facilities Per Sub-County	Wards Per Sub-County	Number Of Public Health Facilities Per Ward	Health Facilities Selected	Number Of Patients Visiting Facility Per Day	Number Of Selected Patients Per Facility	Number Of Patients In Totality
Kisumu Central	213,450	15	Shauri Moyo	1	1	36	6	60
			Market Milimani	5	2			
			Migosi	1	1			
			Nyalenda B	3	2			
			Kondele	1	1			
			Railways	1	1			
			Nyalenda A	1	1			
			Shauri Moyo Kaloleni	2	1			
				15	**10**			
Kisumu East	189, 730	11	Kajulu	4	2	32	5	30
			Kolwa East	5	2			
			Manyatta B	1	1			
			Kolwa Central	1	1			
				11	**6**			
Seme	124,052	22	Central Seme	5	2	21	3	30
			West Seme	7	3			
			East Seme	4	2			
			North Seme	6	3			
				22	10			
Total	528,052	48		48	25	89	14	120

A total of 25 health facility administrators (one from each facility), 25 healthcare personnel (one from each facility); doctors,' clinical officers or nurses were purposively selected. Also, the County chief officer for health, chairperson sectorial committee on health services at the county, three assistant county commissioners (one from every sub-county), and three health related non-governmental organizations (one from each sub-county) working within Kisumu County were purposively selected. They were purposively selected because of their special knowledge on the subject matter under study.

Table 1.2. The List of Public Healthcare Facilities Selected

Kisumu Central	Facility Name	Facility level	Facility type	Ward
1.	Jaramogi Oginga Odinga Teaching & Referral Hospital	Level 5	Secondary Healthcare Facility	Shauri Moyo
2.	Victoria Sub-District Hospital	Level 4	Primary Healthcare Facility	Market Milimani
3.	Migosi Sub-County Hospital	Level 4	Primary Healthcare Facility	Migosi
4	Dunga GOK Dispensary	Level 2	Dispensary	Nyalenda B
6.	Administration Polivce	Level 3	Health Centre	Nyalenda B
7.	Kosawo Dispensary	Level 2	Dispensary	Kondele
8.	Mosque Dispensary	Level 2	Dispensary	Railways
9.	Kowino Dispensary	Level 2	Dispensary	Nyalenda A
10.	St Lydia Okore Dispensary	Level 2	Dispensary	Kaloleni
Kisumu East	**Facility Name**	**Facility level**	**Facility type**	**Ward**
1.	Gita Sub-County Hospital	Level 4	Primary Healthcare Facility	Kajulu
2.	Kibos Sugar Research Centre	Level 2	Dispensary	Kajulu
3.	GK Prisons	Level		Kolwa East
4.	Angola Community Dispensary	Level 2	Dispensary	Kolwa East
5.	Kuoyo Health Center	Level 3	Health Centre	Manyatta B
6.	Nyalunya Health Centre	Level 3	Health Centre	Kolwa Central
Seme	**Facility Name**	**Facility level**	**Facility type**	**Ward**
1.	Kombewa County Referral	Level 4	Primary Healthcare Facility	Central Seme
2.	Lolwe Dispensary	Level 2	Dispensary	Central Seme
3.	Manyuanda Sub-county Hospital	Level 4	Primary Healthcare Facility	West Seme
4.	Oriang' Alwala Dispensary	Level 2	Dispensary	West Seme
5.	Asat Beach Dispensary	Level 2	Dispensary	West Seme
6.	Miranga Sub-County Hospital	Level 4	Primary Healthcare Facility	East Seme
7.	Langi Kawino Dispensary	Level 2	Dispensary	East Seme
8.	Nduru Kadero Dispensary	Level 2	Dispensary	North Seme
9.	Oriang' Kanyadwera Dispensary	Level 2	Dispensary	North Seme
10.	Ratta Health Centre	Level 3	Health Centre	North Seme

1.13.4 Data Collection

This study utilized both primary and secondary data. Primary data was obtained through structured questionnaires administered on 120 patients (60 out-patients and 60 in-patients) in public healthcare amenities in the three sub-counties of Kisumu. Structured questions were used to generate uniform responses that provide greater reliability (Bryman, 2012).

The researcher also conducted individual interviews to elicit and record responses from 25 health facility administrators and 25 healthcare personnel. Individual interviews enabled the interviewer to paraphrase questions that interviewees found difficult to understand.

The researcher interviewed key informants; Chief Officer for health at the County, chairperson sectorial committee on health services, three assistant county commissioners, and three health related NGOs' in Kisumu County. The key informant interviews enabled the researcher to obtain specialized knowledge concerning the dynamics of county funded healthcare system.

Finally, Secondary data was obtained from county annual development plans, Kenya health strategic plans, county official records; progress reports, finance commission annual reports, controller of budget reports, previous studies and articles by WHO, World Bank and any other, relating to access to healthcare services and devolution. Published policy papers, journal articles, books and other relating written documents were also reviewed.

1.14 Data Analysis Techniques

This investigation generated quantitative and qualitative data. Quantitative data generated from administering structured questionnaires was entered on SPSS and analyzed using descriptive statistics; measures of central tendencies and measures of dispersion. The structured questions that sought information on financial resources allocation to the healthcare system and affordability of public healthcare services generated quantitative data, and was analyzed using Spearman rho to determine whether there is a correlation between the two. Phi and Crammers V was employed to verify the strength of the relationship. Qualitative data obtained from conducting individual interviews and key informant interviews was analyzed using thematic analysis, and entailed identifying and sorting out themes and indicators with common relationships and listing them together to establish recurring patterns.

1.15 Reliability

In the natural sciences, data is perceived to be 'reliable' if other scientists using the same methods of inquiry on the same substance generate the same results. By replicating an experiment, it is possible to check for inaccuracies in observation and measurement (Haralambos & Holborn, 2000). Reliability, thus, is the extent to which findings of a study can be accurately interpreted and generalized to other populations.

In this study, quantitative techniques that provide greater reliability were employed. The researcher used structured questionnaires to obtain data which is consistent and uniform; easily stated in numerical form which can be repeated and the results checked.

1.16 Validity

Validity is the extent to which research instruments measure what they are designed to measure (Osborn & Haralambos, 2000). Data is, therefore, 'valid' if it presents an accurate depiction of what is being investigated. This study adapted a technique from Oso and Onen (2008) to establish validity, where research instruments were given to an expert to assess their relevance against the objectives. The expert ranked each item on a Likert scale: very relevant (4), quite relevant (3), somewhat relevant (2) and not relevant (1). The researcher adopted only those instruments graded very relevant for the study.

1.17 Ethical Considerations

Protecting and keeping the information obtained from the respondents was the major ethical challenge of this study. This is because, the process of obtaining valid and reliable data involved accessing specific information of the respondents; patients in hospitals. This challenge was mitigated by leaving the patients names out of the questionnaires. Personal information about them was kept confidential. The researcher also obtained consent from the participants before administering questionnaires.

The researcher sought and received ethical approval from NACOSTI[2], the license to conduct research in public healthcare facilities. The researcher was also permitted to conduct research in public hospitals by the county director of medical services.[3]

[2] See Appendix 7
[3] See Appendix 8

CHAPTER TWO

THE HISTORICAL AND CONTEXTUAL BACKGROUND TO THE STUDY

2.0 Introduction

This chapter presents the historical overview of devolution of the health sector and its influence on access to public healthcare services. It concludes by discussing the Kenyan context of the same.

2.1 Devolution of the Healthcare System and Accessibility to Public Healthcare Services

Devolution has been characterized by Rondineli and Cheema (1983) as a form of decentralization, which entails moving authority in financial, political and administrative management, from the central government (Barkan, 1989), to a popularly elected (largely autonomous) sub-national unit (Oyugi, 2005). According to Akin, Hutchinson and Strumpf (2001) devolution first gained prominence in developing countries due to the failures in economic growth which was heavily associated with centralized government planning. Some countries thought devolution would be the best strategy of consolidating democracy and enhancing the provision of public services to the people (Oyugi, 2005; Azfar et al., 1999). However, there are those who criticized devolution for its propensity to increase inequities in service provision between the well-off areas and poor regions (Collins & Green, 1994)

In the health sector, a much broader decentralization framework was first mentioned during the Alma Ata Declaration in 1978, where "health for all by year 2000" was pushed for, and the importance of involving the public in managing their health affairs emphasized (Owino, 1999; Tsofa, 2017). This was preceded by an earlier Bamako initiative's "health for all", promulgated in Mali in 1977, which advocated for the sale of essential drugs at the village level to generate money for financing primary healthcare. International organizations; the World Bank and other structural adjustment policies had also initiated health policy changes. They advised the developing countries to implement devolution as the most suitable strategy that could help them reform their health sector (World Bank, 1993).

Alongside the push for decentralization of healthcare system, was the increasing emphasis on delivery of healthcare at the primary level (Wamai, 2009). There was a wide belief that decentralizing national resources and allowing communities have greater influence over their healthcare services would empower the previously marginalized and enhance equity (WHO/UNICEF, 1978). Decentralization was, therefore, packaged as a 'good governance';

intervention for improving equity and efficiency in resource allocation and management of the health sector (Collins, 1989). An emphasis on community participation was made to allow resource management decisions to be made nearer to the target communities (Rondinelli, 1981). Thus, many developing countries that wanted to reform their healthcare system, implemented decentralization in 1980 and early 1990s (Legemate, 2002)

However, in spite of the growing popularity of decentralization as a way to confronting poor governance, irrespective of the decentralization approach adopted, the experiences of decentralization of the healthcare sector in most developing countries have been diverse. (Mills, 1990; Bossert, 2002). For instance, while decentralization in Zambia allowed districts to make decisions on user fees, which enhanced their ability to collect funds at the local level (Bossert, 2003), in Uganda, local leaders' overall discretion over priority setting in the health sector increased tremendously, and was associated with the reduction in allocations for primary healthcare from the national government. (Jeppson, 2001). According to Gupta (2003) the provision of healthcare services varied between urban public healthcare facilities and those in rural regions in Nigeria.

2.2 The Kenyan Context

In Kenya, different decentralization policies and strategies have been adopted over time, including the health sector. Upon Kenya receiving independent status, the government immediately acknowledged that health sector plays a significant role in the development of society and the economy of a nation and enrolled on a broader policy reform designed to heighten access to quality and lower cost healthcare services for all Kenyans. In the *Sessional paper no.10 of 1965, on African Socialism and its application to Kenya*, a healthcare reform agenda aimed at eliminating diseases, eradicating poverty and illiteracy was enunciated (Wamai, 2004). To implement the reforms, the government established a framework that focused on the provision of primary healthcare and training of various groups of skilled healthcare work force (GOK, 2010).

Until 1980, healthcare blueprints were stipulated in the development plans of the state- which were five-year arrangements outlining government intentions and strategies. In the first development plan, the management of the delivery of healthcare services was centralized in the Ministry of health (Mwabu, 1995). However, just like in many other developing countries, the failure of centralization to spur continuous economic growth and eliminate regional disparities

(Mwabu, 1995), together with the health policy changes at the international level, heavily influenced the government to introduce decentralization policy. Oyugi (2005) explains that the decentralization policy adopted in Kenya involved deco-centration; where decision making was moved to subordinate managerial levels.

In 1983, the District Focus for Rural Development was created to strengthen healthcare management at the district level. In 1986, influenced by WHO policy of healthcare service administration at the primary level, a national plan for the implementation of primary healthcare was published in Kenya, with the immediate effect being the reorganization of healthcare system to emphasize decentralization and community participation (Oyaya and Rafikin, 2003). With the ushering in of consumer charges in public healthcare facilities in 1989, the government formed the District Health Management Boards and District Health Management Teams to oversee the management of user fees (Mwabu, 1995). According to the United Nations Development Program (2002) increase in population, a deteriorating economy and other social and party-political factors in 1990 plunged the country into a crisis which culminated into the withdrawal of 'free healthcare provision for all' commitment by the government.

In 1990s, with DFRD in place, the decentralized healthcare system constituted 71 districts overseen by the District Health Management Boards (DHMBs). They oversaw the administration of the subordinate levels of healthcare system; district hospitals, health centers and dispensaries. They also represented communities during health planning, coordination and execution of health developments at the districts level (GOK, 1999).

Healthcare services were integrated down the hierarchy of health system structure; from the national level to the provincial and district levels. At the apex was the Provincial Health Management Team (PHMT) who operated at the province, and supervised and administered the districts and sub-districts. The District Health Management Team (DHMT) and District Health Management Board supervised healthcare facilities in rural areas; sub-district hospitals, health centers, and dispensaries. Public health services were managed by the Public Health Unit of the district hospitals. Therapeutic services were delivered by district hospitals and mission hospitals. At the sub-district level, both preventive measures and therapeutic services were delivered by the health centers as well as dispensaries and outreach services to the communities. Basic preventive and restorative services for small illnesses were dealt with at the village and family level.

However, waning health sector spending, ineffective use of funds, central decision

making, obsolete health regulations, inadequate competent management staff at the district level, rising healthcare burden and rapid growth in population propelled the government to develop a new framework in 1994; the Kenya Health Policy Framework, to respond to the challenges facing the health sector (Oyaya and Rafikin, 2003). The policy outlined long-lasting plans and the future agenda for the health sector in Kenya.

2.2.1 Health Sector Strategic Plan I (1999-2004)

The recommendations from the Kenya Health Policy Framework culminated into the development of the first National Health Sector Strategic Plan (NHSSP-I) for the period 1999-2004. It considered the past health sector challenges and involved key stakeholders; professional associations, public sector, NGOs, faith-based groups, communities, as well as educational and research bodies in the planning process (Oyaya and Rafikin, 2003).

The NHSSP-I focused on improving healthcare service delivery through devolving healthcare administration and decision making to the district and providing affordable, accessible and quality healthcare to all. However, the lack of a statutory framework to back decentralization; insufficient discussions between ministry of health staff and other key stakeholders concerned with the administration of health care services; powerless management systems; limited financing and little answerability in use of resources, inhibited the NHSSP-I (1999-2004) from transforming the health sector. Indicators of healthcare access; use of healthcare services in public facilities continued to plummet. The death rates of infants and children below five years rose and the support of the public sector to healthcare system dropped.

2.2.2 Health Sector Strategic Plan II (NHSSP-II): 2005-2010

NHSSP-II come about as a revised version of the NHSSP-I, endeavored to better the delivery of healthcare services and expand access to as many people as possible (MOH, 2004). With devolution as the guiding strategy, the Health Sector Strategic Plan II reorganized the delivery of healthcare services into the following levels. At the bottom-most level was the community level-also called level I. It organized village health committees in each community so as to allow families and persons to take part in matters concerning their health. The second and third tier comprised levels 2 and 3; dispensaries, health centers, and maternity/nursing homes where the Kenya Essential Package for Health (KEPH) activities related to precautionary and proactive care, and other various therapeutic services were dealt with. The fourth, fifth and sixth tier comprised levels 4, 5 and 6; primary, secondary and tertiary hospitals which undertook

primarily therapeutic and restorative activities.

In 2009, the government, introduced another decentralization initiative; the Health Sector Services Fund (HSSF), where recurrent costs for primary level healthcare facilities are financed by monies received through direct transfers from the national coffers to the bank accounts of the healthcare facilities, without going through the conventional official procedure (Waweru, 2015).

In 2010, a new constitution was put in place, which unveiled a devolved government system with 47 quasi-independent counties. The push for devolution was to a large extent motivated by broader nationwide party-political developments which aimed to institutionalize equity in the allocation of resources amongst regions and communities and involvement of the people in the administration of public resources (Wamai, 2004). It moved the management of healthcare services to the counties (COK, Schedule 4) and legally safeguards the right of access to health services. For instance, Article 43 protects the right to reproductive healthcare, while children's entitlement to basic sustenance, housing and healthcare is guaranteed in Article 53. Article 56 requires the government to initiate favorable measures to ensure underprivileged and previously excluded groups get fair access to public health services, water and infrastructure (COK, 2010).

The constitution has also separated healthcare tasks for the county and those for the national governments (Cok, 2010; Fourth Schedule). All issues touching on primary care; employment and management of medical staff, management of all healthcare facilities and pharmacies in the county, ambulance services and veterinary services, licensing of public eateries, management of mortuaries, graveyards and disposal of wastes (COK, 2010: Schedule 4) are the primary responsibility of counties, while health policy, technical support to counties and administration of national referral healthcare facilities is the preserve of national government.

2.2.3 The Process of Financial Resources Allocation to the Healthcare System by County Government

The process of allocating financial resources to the healthcare system in a county is a bureaucratic process that involves the county legislative assembly and the county executive arm. In the organogram of the county system, Article 179 of the constitution explains the executive arm as comprising an elected governor and his deputy as well as members of the County Executive Committee (CECs) who are 10 in number. The CECs are appointed by the governor to lead different county departments.

The legislature comprises County Assembly Members (MCAs) who, politically, represents wards in the county. The members that are nominated represent select categorizes of people and also form part of the assembly (Art, 177).

The articulation of policies, including those of health is undertaken by the executive branch of the county government under the supervision of the CECs. Beneath the CEC in each department is a Chief Officer who is appointed by the governor as the general accounting and administrative officer (CoG Act, 2012). To implement any activity, every department in the county must first develop a strategic plan. Public inputs are incorporated into the strategic plans for the entire year which are then synchronized to form Annual Work Plan (AWP). In the health department, the annual work plans commence in September and includes a performance appraisal of the preceding year's Annual Work Plans. It also incorporates the healthcare priorities for the subsequent year. The Chief Officer for health, together with the County Health Management Team (CHMT) oversee all the planning, development of annual work plans, and budgeting for health.

Guided by the AWPs, each department develops its budget. The AWPs from different departments together with their corresponding annual county budgets are combined to form the County Integrated Development Plan (CIDP). A funds bidding process is organized yearly where funds is distributed to all the departments. The office of the CEC for finance which oversees the preparation, budgeting and the general management of public finances approves the consolidated budget and submits it to the county assembly by the close of April every year. The county assembly invites suggestions and proposals from the people as well as other interested parties. The budget is approved by close of June, each year. When endorsed, the budget is made public by the county department of finance as required by law.

Upon gazzetement of the County Budget Estimates, all county departments including health are able to know the projected county revenue collection which comprises shares from national treasury and funds mobilized locally. It also includes a summary of the portions for all departments. All county finances obtained from the national government and locally generated revenues are held in a consolidated County Income account. Any inflows or outflows from this account requires the authorization of the Controller of Budget (COB) who sits at the national treasury and ensures that county governments abide by the stated financial regulations.

In conclusion, it is apparent that health sector decentralization has widely been implemented in developing countries as part of broader economic and governmental reforms. In Kenya, the establishment of District Health Management Teams in 1980s were part of decentralization efforts aimed at bringing public services nearer to the communities and allowing people to contribute in healthcare development activities. It was also aimed at enhancing access to healthcare services in public healthcare facilities.

The 2010 devolution framework was a culmination of previous political developments as well as challenges that continued to bedevil the health sector, despite earlier decentralization attempts. It transfers functions and financing to the counties and shifts key decisions making from national to county governments, opening opportunity for people engagement. Devolved management objective is to enhance equity in access to healthcare in the marginalized regions (Art. 174) and reduce bureaucracy in the provision of healthcare services in public healthcare facilities (COK, 2010: Schedule 4).

CHAPTER THREE

DATA PRESENTATION, ANALYSIS AND INTERPRETATION

3.0 Introduction

This chapter presents, analyses and interprets research data based on the objectives of the study.

3.1 Response Rate

The response rate was 80 per cent. Only 96 patients out of a sample of 120 were interviewed. The researcher was unable to attain 100 per cent response rate because of a medical workers strike which had been ongoing for three months, and had led to partial operations in public healthcare facilities.

3.2 Demographic Information

The researcher also wanted to ascertain the age, gender and education level of the respondents for demographic analysis.

3.2.1 Age of Respondents

The respondents' ages were sought in order to determine whether the information provided emanated from adult respondents.

Table 3.1: Age Distribution of the Respondents

Age Distribution

Age Valid N	Frequency	Percent	Valid Percent	Cumulative Percent
18-25	29	30.2	30.2	30.2
26-30	21	21.8	21.8	21.8
31-35	16	16.7	16.7	16.7
36-40	7	7.3	7.3	7.3
41-45	6	6.3	6.3	6.3
46-50	8	8.3	8.3	8.3
51-55	4	4.2	4.2	4.2
56-60	5	5.2	5.2	5.2
Total	96	100	100	100

Source: Research Data

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Age	96	18	58	32.92	10.807
Valid N	96				

Source: Research Data

From the analysis of the data in table 3.1, the researcher establishes that all respondents were adults of ages between 18 and 58. The mean age was 32.

3.2.2 Gender of the Respondents

The gender identity of the respondents was enquired about to ascertain the number of male and female respondents that took part in the study. Results were processed and is presented in table 3.2.

Table 3.2: Gender of the Respondents

Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	45	46.9	46.9	46.9
	Female	51	53.1	53.1	100.0
	Total	96	100.0	100.0	

Source: Research Data

Based on the data in table 3.2, more female respondents took part in the study as compared to the male counterparts. This is because a sizable proportion of the women interviewed had taken their children to the hospitals.

3.2.3 Level of Education of Respondents

The level of learning of the respondents was sought to determine the number of respondents capable of reading and understanding the research questions. Results was analyzed and is presented in table 3.3.

Table 3.3: Level of Education of Respondents

Level of Education

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Primary	33	34.4	34.4	34.4
	Secondary	42	43.8	43.8	78.1
	Diploma	12	12.5	12.5	90.6
	University	9	9.4	9.4	100.0
	Total	96	100.0	100.0	

Based on data in table 3.3, 66 per cent of the respondents had secondary schooling and beyond. This demonstrates that respondents had the capability to read and comprehend the questions with minimum clarification. However, 34 per cent of the residents had primary level education and needed further clarification of the research questions.

3.3 General Information

The researcher also analyzed some of the general information related to access to healthcare services in public health facilities in Kisumu County.

3.3.1 Gender Difference by Level of Facility

The researcher sought to determine the gender differences in preference for different levels of facility by gender.

Table 3.4: Gender Differences by Level of Facility

Gender * Level of Facility Cross tabulation							
		Type Of Facility					Total
		Dispensary	Health Centre	Sub-County Hospital	County Referral Hospital	Private HealthCare Facility	
Gender	Male	12_{a}	$7_{a, b}$	10_{a}	8_{b}	$8_{a, b}$	45
	Female	6_{a}	$7_{a, b}$	6_{a}	20_{b}	$12_{a, b}$	51
Total		18	14	16	28	20	96

Based on cross tabulation of data in table 3.4, the researcher establishes that more male respondents chose to visit dispensary than female counterparts. On the other hand, more female respondents chose to visit county referral hospital and private healthcare facility than male members. The researcher further analyzed the data using Chi-square to determine if the gender difference by level of facility is significant.

Table 3.5: Chi-square Analysis of Gender Difference by Level of Facility

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	8.601[a]	4	.072
Likelihood Ratio	8.793	4	.066
Linear-by-Linear Association	4.968	1	.026
N of Valid Cases	96		
a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 6.56.			

Based on Chi-square analysis of the data in table 3.5, it is established that at $\alpha = 0.05$, the gender differences by level of facility is statistically insignificant (P=0.072). This implies that there is more or less the same number of male and female members of the public who visit different levels of facility.

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Nominal by Nominal	Phi	.299			.072
	Cramer's V	.299			.072
Ordinal by Ordinal	Kendall's tau-b	.203	.089	2.272	.023
	Spearman Correlation	.226	.100	2.252	.027[c]
Interval by Interval	Pearson's R	.229	.099	2.278	.025[c]
N of Valid Cases		96			

Further analysis of the data in table 3.5 using Phi and Cramer's V shows the strength of insignificance (P=2.99).

3.3.2 How Residents Pay for Medical Services

The researcher asked respondents to indicate how they pay for their medical treatment. The data is presented in table 3.6

Table 3.6: How Residents Pay for Medical Services

How Do You Pay For Medical Services Frequencies

		Responses		Percent of Cases
		N	Percent	
How Do You Pay	Out of Pocket	86	45.0%	89.6%
	NHIF	34	17.8%	35.4%
	Medical Insurance	15	7.9%	15.6%
	UHC	56	29.3%	58.3%
Total		191	100.0%	199.0%

Source: Research Data

Based on the analysis of data on table 3.6, the researcher establishes that 45 per cent of the respondents pay for medical treatment out of pocket. 29 per cent of the respondents are enrolled in the Universal Health coverage and receive free medical treatment, while only 18 per

cent have NHIF cover. This implies that there are still more members of the public who pay for medical treatment out of pocket. This also confirms the assertion by Lodenyo (2016) that there is a high burden of disease in Kenya, because a majority of the population pay for medical treatment out of pocket.

3.4 Financial Resources Allocation and Access to Public Healthcare Services in Kisumu County

Under this objective, the researcher sought to establish whether financial resources allocated to the healthcare system have effect on access to public healthcare services.

3.4.1 Adequacy of Financial Resources Allocation

The researcher interviewed healthcare facility representatives to determine whether resources that healthcare facilities received from the County Government were adequate. Data on adequacy of financial resources allocated to the healthcare system is presented in table 3.7. Below

Table 3.7: Adequacy of Financial Resources Allocated to the Healthcare System

Financial Resources Allocation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	48	50.0	50.0	50.0
	No	48	50.0	50.0	100.0
	Total	96	100.0	100.0	

Source: Research Data

Based on the data in table 3.7, respondents had a divided opinion (50% agreed, 50 % disagreed) on the adequacy of funds allocated to the healthcare system. This implies that members of the public were divided in opinion concerning the adequacy of financial resources disbursed to the healthcare system. This can be attributed to the limited information concerning monies that county governments receive from the central government. Based on principal agent theory, County government leaders wield more information concerning monies they receive from the national government. However, information about resources distribution to the healthcare sector is never shared with the public. In most cases, budget information is gazetted and does not reach a large section of the population in rural areas. Also, fewer members of the public have technical capacity to interrogate the budget. The division in opinion among members of the public concerning adequacy of financial resources allocation to the healthcare system can, thus,

be attributed to their lack of information concerning county government budget and the amount of money disbursed to the healthcare facilities.

3.4.2 Healthcare Expenditure against Total County expenditure

An examination of healthcare expenditure against the total county government expenses established that healthcare spending has increased every year above the 15 per cent benchmark set out during the Abuja declaration. However, further scrutiny established that more than 60 per cent of the health budget has been consistently spent on recurrent expenses; payment of workers' salaries and county operations, while merely 27.6 per cent has been spent on preventative and curative services (CIDP, 2019).

Table 3.11 presents a summary of the 2017/2018 health sector expenditure by category.

Table 3.11: Summary of the 2017/2018 Kisumu County Health Sector Spending by Category

Category	Amount	Per Cent (%)
General Administration, Planning and Support Services	2,008,567,390	63.8
Public Health and Sanitation Services	270,227,506	8.6
Curative and Preventative Health Services	867,032,160	27.6
Total	3,145,827,056	100

Source: Kisumu County (CIDP, 2018)

The study established that the trend had been repeated in previous years where, as a share of the total county budget, monies allocated to the healthcare system constituted 24.5 per cent in the year 2015/2016; 60 per cent of that amount was spent on workers' salaries, 29.6 per cent on operations and management and 10 per cent on development (CIDP, 2015).

In 2016/2017, 25 per cent of the total county budget was disbursed to health sector; 59 per cent was spent on personnel salaries, 30 per cent on operations and management and 10 per cent on development (CIDP, 2016). The funds allocated for development were largely utilized to expand dispensaries and healthcare centers, and construct mortuaries and maternity wards. of hospitals.

3.4.3 County Governance Framework

An examination of the governance framework established inconsistencies in the office of the Chief Officer for health at the county. The study finds that the Chief Officer for health at the county has been replaced three times since 2016. All the monetary requirements for regular overheads had to be taken for approval at the (CEC) for finance's office, which occasioned

delays in financial disbursement hence constraining the delivery of healthcare services in public healthcare facilities. Because of a lack of steady leadership in the department of health, it was established that certain categories within the county health department have been overlooked and funds meant for them diverted to other areas of interest to the CEC finance.

The study also established that during annual resource bidding process, funds are sometimes allocated not based on the Annual Work Plans generated by various departments, but on personal interests. In most cases, it was established that the Governors interest precedes the Annual Work Plans. The study established that the county government revenue account has been overdrawn on several occasions and some of the monies are alleged to have been channeled to the construction of governor's residence.

3.4.4 Affordability of public healthcare services

The researcher further sought to establish whether healthcare services were affordable in public healthcare facilities. Patients attending public healthcare facilities were asked to indicate their view on the statement "Healthcare services are affordable in public healthcare facilities in Kisumu County". The data was tabulated and presented in table 3.7 below.

Table 3.7: Affordability of public healthcare services in Kisumu County.

Low Cost of Services/ Affordability

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	11	11.5	11.5	11.5
	Disagree	19	19.8	19.8	31.3
	Neutral	10	10.4	10.4	41.7
	Agree	24	25.0	25.0	66.7
	Strongly agree	32	33.3	33.3	100.0
	Total	96	100.0	100.0	

Research Data

The results show that the majority 56 per cent of the respondents agree that healthcare services are affordable in public healthcare facilities, while 31 per cent of the patients disagree and 10 per cent did not know. The data is further analyzed using Chi square test of independence to ascertain if there is any difference between the number of patients who agree and those who disagree that healthcare services are affordable in public healthcare facilities.

Table 3.8: Independent Sample Test of the Difference in Opinion on whether Public Healthcare Services Are Affordable

One-Sample Test

	Test Value = 0					
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Low cost of Services	24.051	95	.000	3.490	3.20	3.78

Based on the analysis, at $\alpha = 0.05$, the difference in opinion between those who agree and those that disagree is statistically significant (P=0.00). This can be deduced that more members of the public are of the opinion that healthcare services are affordable in public healthcare facilities in Kisumu County. Data on financial resources allocation to the healthcare system was correlated with information on affordability of public healthcare services to determine whether there is a relationship. The analysis is presented in table 3.9 below.

Table 3.9: Correlation between Financial Resources Allocation and Affordability of Public Healthcare Services

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Nominal by Nominal	Phi	.423			.002
	Cramer's V	.423			.002
Interval by Interval	Pearson's R	-.243	.101	-2.430	.017[c]
Ordinal by Ordinal	Spearman Correlation	-.260	.100	-2.608	.011[c]
N of Valid Cases		96			

Based on the analysis of data on table 3.9, there is a weak negative relationship between financial resources allocation to the healthcare system and affordability of public healthcare services. r = -0.260 when α =0.05. It implies that lower costs of healthcare services in public healthcare facilities is influenced by other factors or variables. Some of these factors may include the Universal Health Coverage (UHC) program that is currently piloted in Kisumu County among other four counties and delivers free healthcare for the registered residents. Also, based on data in table 3.6, 17.8 per cent of the residents have National Hospital Insurance Fund (NHIF) cover, while 7.9 per cent have individual medical covers, which also contributes to the reasonable financial access witnessed in public healthcare facilities.

3.5 Public Participation and Access to Public Healthcare Services in Kisumu County

Under this objective, the study sought to examine the influence of public participation on access to public healthcare services. The study operationalized public participation as public engagement by patients, users, care givers, residents and healthcare workers' unions in the activities of needs identification, priority setting, planning, budgeting, and appraising of healthcare development projects. Patients were asked to indicate their views based on the statement "members of the public regularly participate in healthcare development forums" The data is presented in table 3.12

Table 3.12: Public Participation in Healthcare Development Activities

Participation in Health Development Activities

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	21	21.9	21.9	21.9
	Disagree	13	13.5	13.5	35.4
	Neutral	14	14.6	14.6	50.0
	Agree	21	21.9	21.9	71.9
	Strongly agree	27	28.1	28.1	100.0
	Total	96	100.0	100.0	

Source: Research Data

Based on the data in table 3.12, 48 per cent of the respondents agreed that members of the public regularly engage in healthcare development activities, against 35.4 per cent who disagreed. 14.6 per cent of the respondents had a neutral opinion. This implies that more

members of the public are of the opinion that people regularly engage in healthcare development activities. However, it was also established that active discussion within these forums to identify priorities with greatest impact to community members is minimal. The study established that "Often, people have little or no time to scrutinize the documents provided". The study established that the county government of Kisumu has a public participation Act (2015) with an elaborated framework for the creation of the office that deals with public matters. The office is expected to coordinate and ensure expedient access to information, data, documents and other information relevant to or related to health policy design, implementation and oversight. However, the study revealed that the laws on public engagement remain on paper. Public participation forums are usually held as a formality and only serve as a procedural requirement that has to be performed by county government officials before they proceed to the next level.

The Kisumu County Public Participation Act (2015) requires observance of timeliness and stipulates that public venues be determined and communicated at least two weeks in advance to ensure that people have ample time to prepare themselves to participate. It was, however, established that short notices about public forums are usually advertised in the national newspapers and electronic media and reach only a small portion of the population. It was also established that members of the public only attend forums convened by members of the county assembly when they are facilitated or compensated for their attendance. It is also revealed that county officials normally circulate a few copies of the budget to be shared among the participants, denying most people the opportunity to contribute in the planning and budget-making process. This study establishes that the county government usually presents scanty information in the key health budget documents. As such, it has been difficult for the public to meaningfully scrutinize the budget lines against their immediate healthcare development needs.

However, in Kisumu County, public engagement in health development forums has been fruitful in stopping the allocation of money to a "Health center in Migosi ward" which, from 2013, has been fraudulently receiving the same to undertake a project which is already complete.

3.6 Decision making by County government and Access to Public Healthcare Services in Kisumu County

The study sought to examine whether the management of healthcare system is better in the hands of county government than when it was the domain of national government. It

specifically focuses on the availability of healthcare workers, medical equipment and essential drugs in public health facilities.

3.6.1 Availability of Healthcare Workers

On availability of healthcare workers, this study sought to establish, from patients attending public healthcare facilities, their views on the statement "Healthcare workers are readily available in public healthcare facilities". The responses are presented in table 3.13.

Table 3.13: Availability of Healthcare Workers

Medical Workers Readily Available

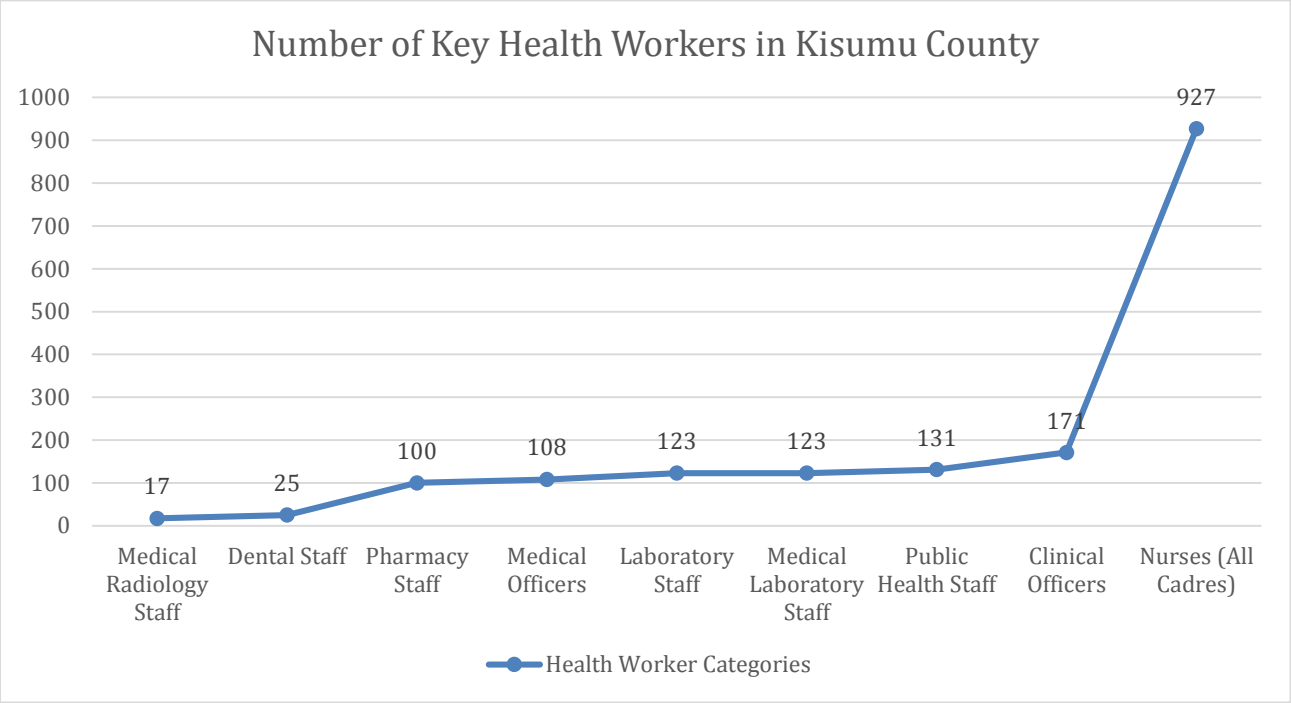
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	32	33.3	33.3	33.3
	Disagree	28	29.2	29.2	62.5
	Neutral	3	3.1	3.1	65.6
	Agree	18	18.8	18.8	84.4
	Strongly agree	15	15.6	15.6	100.0
	Total	96	100.0	100.0	

Source: Research Data

From the data above, 63 per cent of the respondents disagree that medical workers are readily available in public healthcare facilities. This implies that more members of the public are of the opinion that medical workers are not readily available in public healthcare facilities. The respondents who disagree may have been influenced by the medical workers strike that had been going on in Kisumu County for three months. Especially, because a study by Intra-Health (2017) establishes that the current number of key healthcare staff in public healthcare facilities in the entire Kisumu County comprises 17 medical radiology staff, 25 dental staff, 100 pharmacy staff, 108 medical officers, 123 medical laboratory staff, 131 public health staff, 171 clinical officers and 927 nurses, which is a remarkable improvement from 2013 when there were only 19 doctors, 70 nurses and 18 clinical officers per 100,000 people (SARAM, 2013).

Figure 3.1 illustrates the current number of key health workers in public healthcare facilities in Kisumu County.

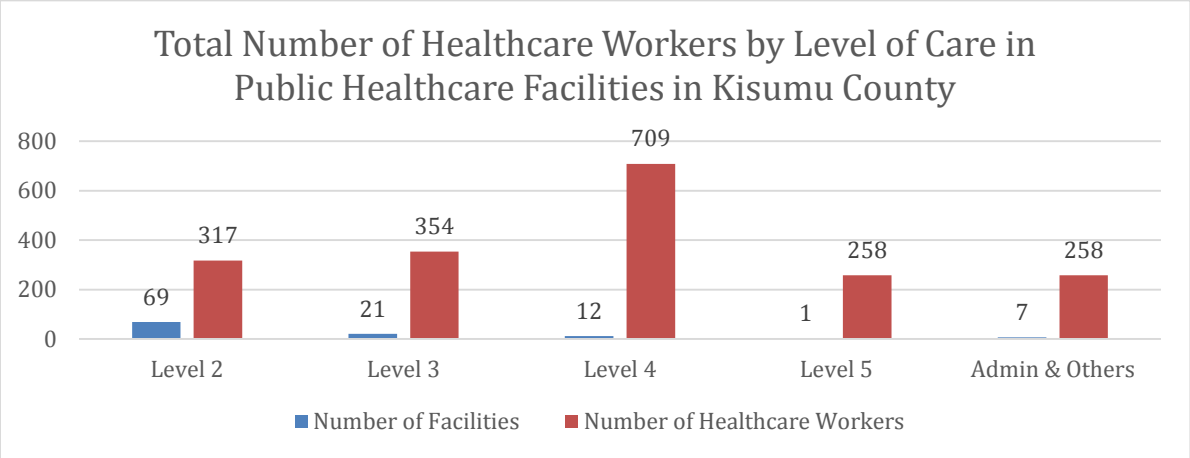
<u>Figure 3.1:</u> Current Number of Health Workers in Public Healthcare Facilities in Kisumu County



Source: Intra-Health Kisumu

In terms of distribution by level of care, there is a total of 317 healthcare officials distributed in 69 dispensaries and 354 health officials spread in 21 sub-county hospitals. There are 709 health officials working in 12 county hospitals. There is one County teaching and referral hospital that has a total of 258 medical personnel (Intra-Health, 2017). The distribution of health workers by level of care in public healthcare facilities is described in figure 3.2 below.

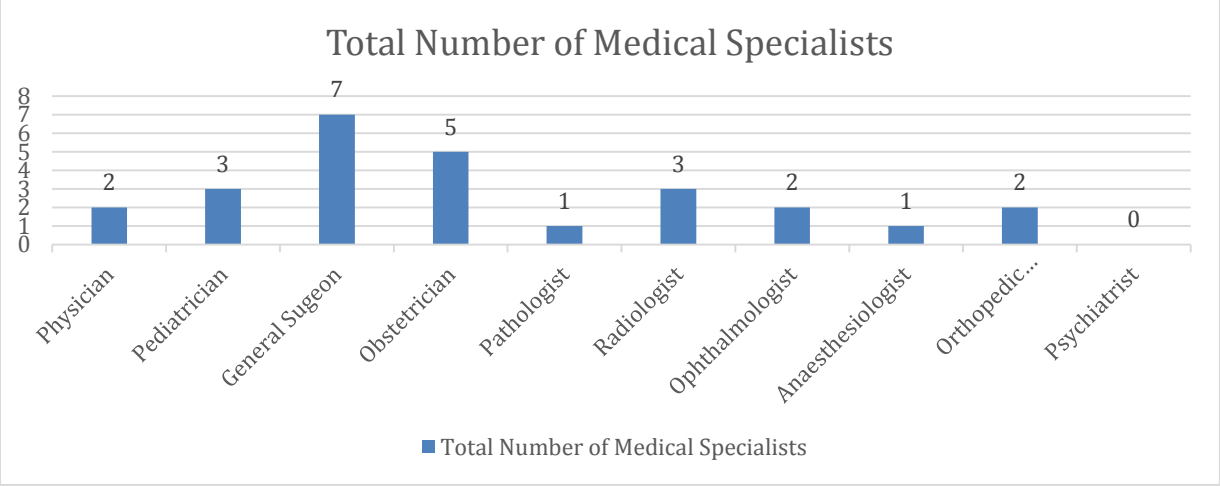
Figure 3.2: The Distribution of Healthcare Workers by Level of Care in Public Healthcare Facilities in Kisumu County



Source: Intra-Health Kisumu

The study established that Kisumu County currently has a total of 131 healthcare facilities; dispensaries, health centers, sub-county hospitals, county hospitals and county teaching and referral hospital (Master Facility List, 2015). A remarkable improvement from 2013 when there were a total of 92 facilities (SARAM, 2013). Also, the level 4 and 5 county public hospitals that provide curative healthcare services have a total of 27 specialized healthcare personnel (Intra Health, 2017). This is also an improvement from 2013 when Kenya had an average of one doctor, 12 nurses and midwives per 10,000 people (KIPPRA (2012). It was, however, established that certain departments do not have any medical specialist; Psychiatry, while others have only one specialist in the entire county as illustrated in figure 3.3 below.

Figure 3.3: Total Number of Medical Specialists in Public Hospitals in Kisumu County



Source: Intra-Health Kisumu

In spite of the current improvements, limited finances allocated to Kisumu County by national treasury, has made it difficult to employ the requisite number of health workers, that is 23 doctors, nurses and midwives per 10,000 people as stipulated by WHO (2013).

3.6.2 Availability of Medical Equipment

Concerning availability of medical equipment, this study sought to establish the readiness of medical equipment in public healthcare facilities. Patients attending public healthcare facilities in Kisumu County were asked to react to the statement "medical equipment is readily available in public healthcare facilities". The responses are presented in table 3.14

Table 3.14: Availability of Medical Equipment

Sufficient Medical Equipment

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	8	8.3	8.3	8.3
	Disagree	10	10.4	10.4	18.8
	Neutral	2	2.1	2.1	20.8
	Agree	24	25.0	25.0	45.8
	Strongly agree	52	54.2	54.2	100.0
	Total	96	100.0	100.0	

Source: Research Data

Based on the data on table 3.14, 76 per cent of the respondents agreed that medical equipment is adequately available in public hospitals. This indicates that a majority of members of the public agree that under county government management, medical equipment is readily available. This could be as a consequence of the Managed Equipment Scheme (MES) (2015), a joint venture between National and County government for equipping select public hospital with modern medical equipment.

Under the program, two hospitals in each county benefits from an equipment upgrade and includes cutting edge machines for dialysis, Intensive Care Unit (ICUs), theatre and X-rays and other imaging machines. It is the responsibility of county government to select the respective healthcare facilities. According to a report by Nation Newspaper (2018) 96 hospitals have received surgical and radiology equipment, 39 have dialysis machines installed while nine have new ICU facilities. According to the Nation Newspaper report, the number of county public hospitals that are now offering dialysis has shot up to 49 from five in three years. ICUs and High

Dependency Units (HDU) beds in county public hospitals have increased to 116 and 63 from 50 and 30 respectively in the corresponding period. With these services now available in county hospitals, the burden of specialized medical healthcare has been significantly reduced. However, the program has been criticized for failing to acknowledge the diversity of medical priorities and needs of each county. In Kisumu County, Kombewa county hospital did not have a radiologist to operate the radiology equipment.

3.6.3 Availability of Essential Drugs

Concerning availability of drugs, this study sought to establish, from patients seeking medical treatment in public hospitals, their view on the availability of essential drugs in public healthcare facilities. Their responses are tabulated below:

Table 3.15: Availability of Essential Drugs in Public Healthcare Facilities in Kisumu County

Availability of Essential Drugs

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	22	22.9	22.9	22.9
	Disagree	10	10.4	10.4	33.3
	Neutral	7	7.3	7.3	40.6
	Agree	36	37.5	37.5	78.1
	Strongly agree	21	21.9	21.9	100.0
	Total	96	100.0	100.0	

Source: Research Data

From the data in table 3.15, a total of 57 per cent agree that essential drugs are readily available in public healthcare facilities, 33 per cent disagree while 7 per cent did not know. This implies that a majority of members of the public concur that under devolved healthcare management, essential drugs are readily available in public healthcare facilities. The researcher further conducted an independent sample test to determine if the difference in opinion on availability of drugs in public healthcare facilities is significant.

Table 3.16: Independent Sample Test of the Difference in Opinion on Availability of Essential Drugs in Public Healthcare Facilities

One-Sample Test

	Test Value = 0					
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Participation in Budgeting for Healthcare	21.316	95	.000	3.250	2.95	3.55

The difference between those who agree and the ones who disagree that essential drugs are readily available in public healthcare facilities is significant. At α=0.05, the value of (P=0.00). This signifies that more members of the public agree that essential drugs are readily available in public healthcare facilities. It is also a confirmation of Tsofa's (2017) study which establishes that availability of essential drugs has improved in Kilifi County since implementation of devolution. However, it was further established that consistent availability of drugs in public healthcare facilities is sometimes inhibited by county government delays in allocation of finances to the healthcare facilities. That when hospitals run out of stock of drugs, it usually takes long before money is disbursed to the health facilities to refill, and patients are forced to buy drugs from private facilities. For instance, the study established that Kombewa County hospital had very limited supply of essential drugs, and patients with special conditions were sent to buy drugs outside the hospital. At Kisumu County hospital, medical suppliers had refused to conduct business with the facility because of unpaid bills. This was because county governments had taken long before paying the suppliers. It was also established that whenever county government disbursed money to the healthcare facility accounts, the funds were usually insufficient and could not cater for all the demands of healthcare services delivery. As such, public healthcare facilities have been unable to consistently stock essential drugs and pharmaceutical supplies

The study also establishes that a new system of procuring drugs is in place, known as the 'pull system' which allows each facility to place an order for drugs depending on the needs of that facility and the disease burden of the catchment area that the facility serves (GOK Health

Act, 2017). The study also reveals that the new system has become ineffective because county governments have repeatedly treated the monies collected from healthcare facilities as one of their sources of revenue. The investigation established that in spite of health department receiving inadequate funds, the monies collected from public health facilities has been used to finance other projects within the county.

CHAPTER FOUR

DISCUSSION, SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

4.0 Introduction

This chapter presents a discussion of the study findings, summary, conclusions and recommendations.

4.1 Discussion of Findings

This section discusses the findings of the study based on the three stated objectives.

4.1.1 Financial Resources Allocation and Access to Public Healthcare Services

As explained by Elliss and Hartley (2005) lack of resources in health sector has serious consequences for the quality of care and for the work environment of health staff. To provide financial protection to poor citizens, it is important to allocate adequate resources to the healthcare system to reduce out-of-pocket payments by patients who seek treatment in public facilities. Litvack et al. (1998) explains that the amount of resources that regional authorities receive from the center, is often inadequate. In this study, the first objective was to determine the influence of financial resources allocation to the healthcare system on access to public healthcare services in Kisumu County. Data analysis and interpretation reveals a number of findings under this objective. It reveals that 50% members of the public are of the opinion that funds allocated to the healthcare system is adequate. It reveals that healthcare expenditure against the total county government expenses has increased every year above the 15 per cent benchmark set out during the Abuja declaration. It also reveals that more than 60 per cent of the health budget has been consistently spent on recurrent expenses; payment of workers' salaries and county operations, while merely 27.6 per cent has been spent on preventative and curative services (CIDP, 2019).

The study establishes that the trend had been repeated in previous years where, as a share of the total county budget, monies allocated to the healthcare system constituted 24.5 per cent; 60 per cent of that amount was spent on workers' salaries, 29.6 per cent on operations and management and 10 per cent on development (CIDP, 2015). The funds allocated for development have largely been utilized to expand dispensaries and healthcare centers, and construct mortuaries and maternity wards.

The study also reveals that the County governance framework has inconsistencies in leadership, especially at the health department where the Chief Officer for health has been replaced three times since 2016. All the monetary requirements for regular overheads are taken for approval at the (CEC) for finance's office, which causes delays in financial disbursement hence constraining the delivery of healthcare services in public healthcare facilities. Because of a lack of steady leadership in the department of health, the study establishes that certain categories within the county health department have been overlooked and funds meant for them diverted to other areas of interest to the CEC finance. The study establishes that during annual resource bidding process, funds are sometimes allocated not based on the Annual Work Plans generated by various departments, but on personal interests. In most cases, the Governors interest precedes the Annual Work Plans. The study establishes that the county government revenue account has been overdrawn on several occasions and some of the monies are alleged to have been channeled to the construction of governor's residence. This has been done at the expense of doctors' salaries which has often been delayed, causing disruption in the delivery of healthcare services in public hospitals.

Finally, the study reveals that the dwindling resources for the health sector is excess abated by the financial regulations (2012) that impede public healthcare facilities from spending monies they collect. According to Tsofa (2017) before devolution, public hospitals prepared budgets with the help of hospital management committees and sent all the monies they collected to the provincial director of medical services (PDMS) every three months for approval. Tsofa explains that government's allocations would be combined with the hospitals collections and sent back to the hospital accounts. A special kitty called Facility Improvement Fund was also set up where the government sent all money intended for the development of hospitals.

In the current system, the study establishes that public hospitals mobilize funds and are banked in the revenue account for the county. The county government is expected to pay the banked money back to the hospitals with an added amount, however, it is established that this has not been the case in Kisumu County where less resources than what hospitals bank has been reimbursed to the hospital accounts, inhibiting hospitals from buying sufficient supplies. The above findings confirm the Ministry of Health (2017) assertion that considerable increases in allocations have been made to the health sector. It confirms KPMG (2014) study which established that insufficient resources were being disbursed to the healthcare system and many

households still rely on out-of-pocket spending to obtain medical treatment. It also confirms Olugo (2015) assertion that despite counties receiving more than 25 per cent of the total budget, less than 5 per cent of that amount has been earmarked for health. However, the division in opinion among members of the public concerning adequacy of financial resources allocation to the healthcare system can, thus, be attributed to their lack of information concerning county government budget and the amount of money disbursed to the healthcare facilities. County government leaders take advantage of the information asymmetry to conceal information about the monies they receive from the national government and information about resources distribution to the healthcare sector is never shared with the public. In most cases, budget information is gazetted and does not reach a large section of the population in rural areas. Also, fewer members of the public have technical capacity to interrogate the budget.

As depicted in the principal-agent theory, county government leaders are agents with individual interests they would want to pursue which sometimes conflict those of the principals (Bossert, 1998). County leaders usually have more information concerning county financial status, and take advantage of the information asymmetry to pursue their own goals at the expense of the people.

4.1.2 Public Participation and Access to Public Healthcare Services

Public participation has been known to enhance the provision of equitable access to services especially when pro-poor policies are incorporated and the marginalized included in decision making (Muriu, 2012). Therefore, the second objective of this study sought to determine the influence of Public participation on access to public healthcare services in Kisumu County. Based on data analysis and interpretation, more members of the public (48 per cent) are of the opinion that the public regularly engage in healthcare development activities, against 35.4 per cent who disagree. 14.6 per cent of the respondents have a neutral opinion. It is revealed that through public forums, the public successfully appealed to the county government to stop allocating money to a “Health center in Migosi ward” to undertake a project which is already been complete

However, this study also reveals that public participation has not contributed significantly in identifying public healthcare priorities with greatest impact to community since no active discussion takes place within a majority of the public forums. The study establishes that “Often, people have little or no time to scrutinize the documents provided”. The study also establishes

that the county government of Kisumu has a public participation Act (2015) with an elaborated framework for the creation of the office that deals with public matters. The office is expected to coordinate and ensure expedient access to information, data, documents and other information relevant to or related to health policy design, implementation and oversight. However, the study reveals that the laws on public engagement remain on paper. Public participation forums are usually held as a formality and only serve as a procedural requirement performed by county government officials before proceeding to the next level.

Principal-agent theory emphasizes the fundamental role of information and monitoring; in enabling the principals assess whether agents are implementing the principal's goals. However, this investigation reveals that county officials normally circulate a few copies of the budget to be shared among the participants, denying people the opportunity to contribute in the planning and budget making process. The investigation establishes that county government usually present inadequate information in the key health budget documents. As such, it has been difficult for the public to meaningfully scrutinize the budget lines against their immediate healthcare development needs. According to Bossert (1998) agents control information to enable them hold onto power. The county government officials as agents are accused of releasing scanty information to the members of the public to protect themselves and have comparative advantage over the principal during negotiations. Agents release information only when it is in their best interest. Bossert recommends the establishment of routine information systems in central ministries through which agents must report to control the information asymmetry.

The Kisumu County Public Participation Act requires observance of timeliness and stipulates that public venues be determined and communicated at least two weeks in advance to ensure that people have ample time to prepare themselves to participate. The study, however, establishes that short notices about public forums are usually advertised in the national newspapers and electronic media and reach only a small portion of the population. It also establishes that members of the public only attend forums convened by members of the county assembly when they are facilitated; compensated for their attendance to participate.

4.1.3 Decision-Making by County Government and Access to Public Healthcare Services

Aiken (2013) explains that healthcare facilities with higher proportion of medical attendants to patients often have lower death rates. Low wages have also been known to lead to workers seeking additional employment outside government run facilities (Gupta, 2003). In

Kenya, poor pay and long working hours due to fewer doctors and nurses are some of the issues that have always surrounded medical staffing (MOH, 2013). Thus, the third objective of this study sought to examine whether the management of public healthcare is better in the hands of county government than when it was a responsibility of the national government. Issues sounding availability of healthcare workers in county run public healthcare facilities were examined. After analyzing and interpreting data, it is established that more members of the public (63 per cent) are of the opinion that medical workers are not readily available in public healthcare facilities. However, the division in opinion may have been influenced by the medical workers strike that had been going on in Kisumu County for three months. Especially, because the study establishes that the current number of key healthcare staff in public healthcare facilities in the entire Kisumu County comprises 17 medical radiology staff, 25 dental staff, 100 pharmacy staff, 108 medical officers, 123 medical laboratory staff, 131 public health staff, 171 clinical officers and 927 nurses (Intra-Health, 2017). This is a remarkable improvement from 2013 when there were only 19 doctors, 70 nurses and 18 clinical officers per 100,000 people (SARAM, 2013).

In terms of distribution by level of care, it was established that there is a total of 317 healthcare officials distributed in 69 dispensaries and 354 health officials spread in 21 sub-county hospitals. There are 709 health officials working in 12 county hospitals. There is only one County teaching and referral hospital that has a total of 258 medical personnel (Intra-Health, 2017).

Concerning availability of medical facilities, this study establishes that the county of Kisumu currently has a total of 131 healthcare facilities; dispensaries, health centers, sub-county hospitals, county hospitals and county teaching and referral hospital (Master Facility List, 2015). A remarkable improvement from 2013 when there were a total of 92 facilities (SARAM, 2013). Also, the level 4 and 5 county public hospitals that provide curative healthcare services have a total of 27 specialized healthcare personnel (Intra Health, 2017). This is also an improvement from 2013 when Kenya had an average of one doctor, 12 nurses and midwives per 10,000 people (KIPPRA (2012). However, certain departments still do not have any medical specialist; Psychiatry, while others have only one specialist in the entire county. Besides, the requisite number of health workers is 23 doctors, nurses and midwives per 10,000 people WHO (2013). Therefore, the county government still falls short of this.

On medical equipment, World Bank (2005a) explains that medical equipment constitutes 30 per cent of global health spending and therefore forms a major part of the budget of whoever is paying for medical treatment. In this study 76 per cent of the respondents agreed that medical equipment is adequately available in public hospitals. This indicates that a majority of members of the public agree that under county government management, medical equipment is readily available. This could be as a consequence of the Managed Equipment Scheme (MES) (2015), a joint venture between National and County government for equipping select public hospital with modern medical equipment. Under the program, two hospitals in each county benefits from an equipment upgrade and includes cutting edge machines for dialysis, Intensive Care Unit (ICUs), theatre and X-rays and other imaging machines. It is the responsibility of county government to select the respective healthcare facilities. According to a report by Nation Newspaper (2018) 96 hospitals have received surgical and radiology equipment, 39 have dialysis machines installed while nine have new ICU facilities including Kisumu County.

According to the Nation Newspaper report, the number of county public hospitals that are now offering dialysis has shot up to 49 from five in three years. ICUs and High Dependency Units (HDU) beds in county public hospitals have increased to 116 and 63 from 50 and 30 respectively in the corresponding period. With these services now available in county hospitals, the burden of specialized medical healthcare has been significantly reduced. However, the program has been criticized for failing to acknowledge the diversity of medical priorities and needs of each county. In Kisumu County, Kombewa county hospital does not have a radiologist to operate the radiology equipment.

Concerning essential drugs, World Bank (2005a) explains that lack of drugs in healthcare facilities discourages utilization of public healthcare services. In Kenya, MOH (2015) establishes that KEMSA has been experiencing numerous obstacles in procurement of drugs; lack of track lists in the procurement department, flaunting of procurement rules by county officials and widespread fraud leading to unavailability of drugs in county hospitals. In this study 57 per cent agree that essential drugs are readily available in public healthcare facilities, 33 per cent disagree while 7 per cent did not know. This implies that a majority of members of the public concur that under devolved healthcare management, essential drugs are readily available in public healthcare facilities.

The study further establishes that consistent availability of drugs in public healthcare facilities is sometimes inhibited by county government delays in allocation of finances to the healthcare facilities. That when hospitals run out of stock of drugs, it usually takes long before money is disbursed to the health facilities to refill, and patients are forced to buy drugs from private facilities. Kombewa County hospital had very limited supply of essential drugs, and patients with special conditions were sent to buy drugs outside the hospital. At Kisumu County hospital, medical suppliers had refused to conduct business with the facility because of unpaid bills. This was because county governments had taken long before paying the suppliers. It is also established that whenever county government disburse money to the healthcare facility accounts, the funds are usually insufficient and cannot cater for all the demands of healthcare services delivery. As such, public healthcare facilities have been unable to consistently stock essential drugs and pharmaceutical supplies.

The study establishes that before devolution, a system of procuring drugs known as the 'push system' was employed in public hospitals where medications and other health supplies were agreed upon from a central point (KEMSA) and delivered to the facilities (Tsofa, 2017). This has been replaced with a new system known as the 'pull system', which allows each facility to place an order for drugs depending on the needs of that facility and the disease burden of the catchment area that the facility serves (GOK Health Act, 2017). The study establishes that the new system has become ineffective because county government has repeatedly treated the monies collected from healthcare facilities as one of its sources of revenue. The investigation establishes that in spite of health department receiving inadequate funds, the monies collected from public health facilities has been used to finance other projects within the county.

4.2 Summary

This study investigated the influence of devolution on access to public healthcare services in Kenya. This was in relation to the failure of earlier studies to consider the influence of increased decision space at the county level that has heightened fairness in the distribution of resources to the healthcare system on access to public healthcare services. Also, related studies had failed to analyze the influence of peoples input in the decisions on healthcare on access to healthcare services. Most studies were done at the early stages of the implementation of devolution when counties lacked the requisite capacity and capability to generate own revenues.

4.2.1 Financial Resources Allocation and Access to Public Healthcare Services

The study establishes that in spite of county government continually increasing the healthcare budgetary allocation to levels above the 15 per cent benchmark stipulated by the Abuja declaration, the allocations to public healthcare facilities are insufficient and explains the many unmet demands of the health sector. Most of the allocations to the healthcare system have been used to construct more dispensaries and health centers. Mortuaries and maternity wards have also been constructed. Hospitals such as Lumumba and Kombewa have been expanded and upgraded to level 5 to serve more patients in need of curative and specialized care. However, late disbursement of funds from the county headquarters remains the main challenge to efficient healthcare service delivery. A weak negative correlation between financial resources allocation to the healthcare system and affordability of healthcare services ($r = -0.260$ when $\alpha = 0.05$), confirms that affordability of healthcare services witnessed in public healthcare facilities by patients (56%) is influenced by other factors.

4.2.2 Public Participation and Access to Public Healthcare Services

The study also establishes that public engagement in healthcare decision-making is above average, at 59 per cent. The county government of Kisumu has a public participation framework (2012) in place and holds forums for discussing health development activities at least two times in a year. At the facility level, the Health Facility Management Committee (HFMC) holds community dialogues upon which they discuss facility plans and budget for the year. Participating in budget discussion enabled members of the public to discover fraud in the allocation of resources. Members of the public have been able to identify a health center in Migosi ward that has fraudulently been receiving funds to undertake a project that is already complete. However, inadequate information dissemination on healthcare budgets has made it difficult for the members of the public to scrutinize the same and push for healthcare solutions that benefit the community members. Public forums are publicized through short notices given in the newspapers. The adverts on national newspapers and electronic media reaches an insignificant fraction of the residents.

4.2.3 Decision making by County government and Access to Public Healthcare Services

Despite the hiring of more healthcare workers by the county public service commission, decision-making is no better under county government management. In fact, the study establishes that more members of the public (60 per cent) are of the opinion that health workers

are not readily available in public healthcare facilities. As established by (KMPDU, 2015) this study confirms that the majority of doctors have left county run public hospitals due to lack of policy direction on human resources. Healthcare workers complain of a lack of clear mechanism for hiring and transfers. The study ascertained that remuneration and salary delays are among other concerns that doctors continue to raise. This also confirms (HERAF, 2015) assertion that retention of health workers, guidelines for promotion and opportunities for continued medical education are the major reason for health worker's desertion of county public hospitals. These affect work morale and output.

As concerns medical equipment, there are ongoing investments in many public hospitals (Nation Newspaper, 2018). A majority of the members of the public also agree (76 per cent) that with county government management of the healthcare system, adequate medical equipment is readily available in public healthcare facilities. However, a number of the medical equipment lie idle without specialized personnel to operate them. On availability of drugs, more members of the public agree (57 per cent) that under county government management of the healthcare system, the essential drugs have been readily available in public healthcare facilities. However, sourcing of essential medications and other non-drugs supplies is riddled with corruption and financial limitations. Patients are, therefore, forced to pay directly from pocket resulting in inappropriate medicine use; many experience drug resistance and others under dose.

4.3 Conclusion

As depicted in Principal-Agent theory, County leaders as agents of the people, allocate resources to the healthcare system, organize public participation on healthcare development activities and manage healthcare workers. This investigation, therefore, concludes by accepting the first hypotheses that "Allocation of adequate resources by county government to the healthcare system increases access to public healthcare services in Kisumu County". This is because significant gains have been realized in many categories; more healthcare facilities have been built in remote areas where none existed before, existing ones renovated and new medical equipment purchased under the Managed Equipment Scheme (MES) using resources allocated directly to the healthcare facilities. However, delays in disbursement of funds from the county government is still a major challenge. Besides, while the healthcare system is still constrained by limited resources they receive, the little money that hospitals collect is often treated as a source of revenue by the county government, and is often used to fund projects in other departments.

Concerning public participation, the study rejects the hypotheses that "Public participation in healthcare decision making at the county level increases access to public healthcare services in Kisumu County". This is because, in spite of more members of the public taking part in healthcare development activities, which has helped unearth corruption in the allocation of funds to healthcare facilities, limited discussions on public healthcare priorities with greatest impact to community members take place within these forums. Also, inadequate information presented in the key health budget documents provided by county leadership makes it difficult for the public to meaningfully scrutinize the budget lines against their immediate healthcare development needs. Moreover, members of the public only attend forums convened by the county assembly when they are facilitated; compensated for their attendance to participate

Concerning decision-making on healthcare matters by county government, the study rejects the hypotheses that "Decision making on healthcare matters by county government increases access to public healthcare services in Kisumu County". This is because, in spite of skilled healthcare workers having been brought closer to the population, the majority of health staff have run away from the county run public healthcare facilities. Many healthcare workers complain of poor working conditions; staff compensation mechanisms, salary delays, promotions, transfer of workers and lack of support for continued education among others. Also, in spite of the investments made in many public hospitals concerning medical equipment, a number of them lie idle without specialized personnel to operate them. Besides, the procurement and distribution of essential medications and other non-drugs supplies is riddled with corruption.

4.4 Recommendations

The main argument in this study is that despite yearly financial increases to the health department at the county, the full realization of benefits of public healthcare service delivery is still inhibited by marginal amounts disbursed directly to the healthcare facilities. While a bigger proportion of the health budget is consumed by recurrent expenses, the monies collected by hospitals are also taken away by county administration and diverted to other departments. The study also confirms that public engagement framework, although in place and operational, is still hampered by apathy and scanty information provided by the county government to public. This study also shows that the healthcare sector, under county government management, continues to face several challenges. This study, thus, proposes the following:

1. To ensure continuity of access to public healthcare services, monies collected by healthcare facilities should be safeguarded against utilization by other undertakings of the county administration. Such hospital collections should be used in financing healthcare development activities whenever county government delay to disburse resources to the healthcare facilities. Besides, County government should also consider looking for other alternative financiers to supplement public healthcare financing.
2. To deal with people's apathy towards public engagement in healthcare development activities, the county government should conduct civic education to sensitize the masses on the significance of public participation in devolved management and the opportunities it presents for the people.
3. To deal with the unending widespread fraud in relation to drugs, accredited drug companies should be identified where all county governments procure drugs. This will ensure consistency in the pricing and quality of drugs.
4. Overall, the management of the healthcare system should be supervised by a health commission to ensure effective management of human and financial resources. As one of the minimum qualifications, members of that commission should have a health related qualification.

4.5 Areas for Further Research

The study proposes the following areas for further investigation:

1. A research on the influence of devolution on procurement and distribution of drugs in county public healthcare facilities.
2. A study on the influence of devolved management on quality of specialized healthcare.

REFERENCES

Aiken, L.H. and McHugh (2003) New Evidence on the Impact of Safe Nurse Staffing Interventions. Center for Health Outcomes and Policy Research: University of Pennsylvania School of Nursing

Akin, J., Hutchinson, P., Strumpf, K, (2001) Decentralization and Government Provision of Public Goods: The Public Health Sector in Uganda. Carolina Population Center University of North Carolina at Chapel Hill, Working Paper Pp. 01-35.

Alsheimer, Q., (2018) Surveying Access to Healthcare in Kisumu and Siaya Counties, Kenya. Independent Study Project (ISP) Collections. 2816. https://digitalcollections.sit.edu/isp_collection/2816. Accessed 29th April 2019.

Andras, P., & Bruce, CC. (2002) Democratic deficit and communication hyper-inflation in healthcare systems. J Evan Clin Pract.

Azfar, O., Kahkonen, S., Lanyi, A., Meagher, P., & Rutherford, D. (1999). "Decentralization, Governance and Public Services: The Impact of Institutional Arrangements," *Centre for Institutional Reform and the Informal Sector*, Working Paper No. 255, University of Maryland.

Barkan, Joel, & Chege, M. (1989) Decentralizing the state: District Focus and the Politics of Reallocation in Kenya. *Journal of Modern African Studies* 27 (3): 431-53 [Google Scholar].

Barnes, M., Chris, S., Hanne, B., Robert, D., Stephen, J., Lyn., W. (2008) Designing citizen centered governance. Birmingham: Joseph Rowntree Foundation.

Baur, VE., Tineke, AA., Guy, AMW. (2010) Participation of marginalized groups in evaluation: mission impossible? Eval Programme Plan.

Berlan, D., & Shiffman, J. (2012) Holding health providers in developing countries accountable to consumers: A synthesis of relevant scholarship. *Health Policy and Planning* 27:271-280.

Bessley, T. & Burgess (2002) The Political Economy of Government Responsiveness: Theory and Evidence from India. *Quarterly Journal of Economics* 177: 1415-1451.

Bossert, T. (1998). Analyzing the decentralization of health systems in developing countries: decision space, innovation, and performance. *Social Science and Medicine Vol.* 47: 1513-27.

Bossert, T., & Beauvais, JC. (2002) Decentralization of health systems in Ghana, Uganda, Zambia and the Philippines: A comparative analysis of decision space. *Health Policy and Planning; 17 (1): 14-31*. Oxford University Press.

Bosire, C. (2013) Devolution for development, conflict resolution, and limiting central power: An analysis of the Constitution of Kenya 2010.

Bowie, C., Richardson, A., Sykes, W. (1995) Consulting the Public about health service priorities. *BMF*

Brinkerhoff, D., W., & Crosby, B, (2002) Managing policy reforms: concepts and tools for decision-makers in developing and transitioning countries. Bloomfield, CT: Kumarian Press.

Bryman, A., (2012) Social Research Methods (4th Ed.). New York: Oxford University Press Inc.

Chai, Y., M. (1995). The interaction effect of information asymmetry and decentralization on managers' job satisfaction: a research note. Human Relations 48(6).

Chubb, J., E. (1985). The political economy of federalism. American Political Science Review.

Collins, C & Green, A. (1994) Decentralization and primary health care: some negative implications in developing countries. *International Journal of Health.* 24 (3):459-75.

Council for the Development of Social Science Research in Africa, (2017) Challenges of the Devolved Health Sector in Kenya. Teething Problems or Systematic Contradictions. CODESRIA: *Africa Development* Vol. 42, No 1, Pp 55-77

Cohen, J.M., & Peterson, S.B., (1999) Administrative Decentralization: *Strategies for Developing Countries*. Sterling: Kumarian Press.

Commission on Revenue Allocation (CRA), (2013). Available on: http//www.crakenya.org/cra-chairman-launches-marginalization-policy/ Accessed 20 March, 2019.

CESCR. Committee on Economic, Social and Cultural Rights. General Comment No 14 (2000) Paras. 2, 8, 11, 16,21,23,34 and 36.

Creswell, J.W., (2015) *Basic features of mixed methods research: A concise introduction to mixed methods research*. Thousand Oaks, CA: SAGE Publications.

Davarajan, S., & Wilbund, I, (2015) The politics of Service Delivery in Democracies: Better Access for the poor. Stockholm. EGDI Secretariat.

Davis, J.H., Donaldson, L., and Schoorman, F.D. (1997) Toward a stewardship theory of management. *Academy of Management Review*, 22, 20-47.

Devas, N., & Grant, U. (2003) Local Government Decision-Making-Citizen Participation and Local Accountability: Some Evidence from Kenya and Uganda. *Public Administration and Development*, 23 307-316 (Online) Accessed 31 May 2019.

Doyal, L. (1998) Public participation and the moral quality of healthcare rationing. Available at http://qualitysafety.bmj.com. (Accessed on 31 May 2019.)

Frumence, H., & Nyamanga (2013) Challenges to the implementation of health sector decentralization in Tanzania; Experiences from Kongwa district council. Global Health Action 6: 209-83.

Gilson, L., Kilima, P., and Tanner, M. (1994). Local government decentralization and the health sector in Tanzania. Public Administration and Development 14, 451-477.

GOK, (2010) The Constitution of Kenya. Nairobi: Government Printers.

GOK, (2008) Kenya National Health Sector Strategic Plan (KHSSP) II. Nairobi: Government Printers.

GOK, (2015) Kenya Health Bill 2015. Nairobi: Government Printers.

GOK (2017) Health Act 2017. Nairobi Government Printers:

Glassman, A., & Sakuma, Y. (2014) Intergovernmental Fiscal Transfers for Health: Overview Framework and Lessons Learned. Center for Global Development.

Griffith, J. A. G. (1966). Central Departments and Local Authorities. Toronto: University of Toronto Press.

Grundy, J., Healy, V., Gorgolon, L., Sandig, E., (2003) Overview of devolution of health services in the Philipines. *Rural and Remote Health* l. *Vol.* 3 (220). http//www.rrh.org.au. [PubMed].

Gulliford, M., Figueroa-Munoz, J., Morgan, M., et. al., (2002) What does 'Access to Health Care' Mean? *Journal of Rural Health* 10 (2):98-108.

Gupta, M.D. (2003) Decentralized Delivery of Primary Health Services in Nigeria. *Africa Region Human Development Working Paper Series.* Washington DC, The World Bank.

Haralambos, M., and Holborn, N. (2000). Sociology: Themes and Perspectives (5th Ed.) Harper Collins Publishers Limited.

Hayek, F. (1945) The Use of Knowledge in Society. American Economic Review. XXXV (4): 519-530.

Heginbotham, C., (1993) Healthcare priority setting: A survey of doctors, managers, and the general public. In: *Rationing in action*. London: BMJ Publishing.

Healthy People.gov. (2012) Access to Health Services. Available at http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=1 (Accessed May 31, 2019).

Hedge, D. M., Scicchitao, M.J., and Metz, P. (1991). The principal agent model and regulatory federalism. Western Political Quarterly 44(4), 1055-1080.

HERAF, Report (2015) Annual Devolution Healthcare Services in Kenya

IEA (2015) Review of status of public participation, and County Information Dissemination Frameworks: A Case Study of Isiolo, Kisumu, Makueni and Turkana Counties. Institute of Economic Affairs. Nairobi, Kenya.

Jacobs, B., Por, IR., Bidgeli, M., Annear, PL., Van Damme, W (2011) Addressing access barriers to health services: an analytical framework for selecting appropriate interventions in low-income Asian countries. *Health Policy and Planning* (19) (2):69-79

Jensen, M.C., and Meckling, H.W. (1976) Theory of the firm: Managerial Behavior, Agency Costs and University Structure. *Journal of Financial Economics* (3): 305-360.

Jeppsson, A. (2001) Financial priorities under decentralization in Uganda. *Health Policy Plan.*16 (2): 187-92.

Khalegian, P. (2000) Decentralization and Public Services: The Case of Immunization; World Bank Policy Research Working Paper No 2989. Washington DC.

Khalegian, P. (2004) Decentralization and public services: the case of immunization. *Social Science & Medicine* 59 (1): 163-183.

KPMG Africa (2014) Devolution of Healthcare Services in Kenya: Lessons Learnt from Other Countries. Available at: https://www.kpmg.com/Africa/en/IssuesAndInsights/Articles-Publications/Documents/Devolution%20of%20HC%20Services%20in%20Kenya.pdf. [Downloaded: 27 November, 2018]

Kariuki, P., (2014) Corruption Devolved to the Counties, Daily Nation, 4th April. Nairobi.

Kiamabati, H., Kiio, C., & Towett, J., (2013) World Health Organization (WHO). Understanding the Labour Market of Human Resources for Health in Kenya.

Kothari, C. R., (2004) Research Methodology: Methods and Techniques (Revised 2nd Ed.) New Delhi: New Age International.

Legemaate (2002) Decentralizing Health Services: A global Perspective.

Lieberman, S., (2014) Decentralization and Health in the Philippines and Indonesia-an Interim Report. Washington DC, The World Bank.

Litvack, J., Ahmad, J., & Bird, R.M., (1998) Rethinking decentralization in developing countries. Washington D.C.: The World Bank.

Lodenyo, M.M., Otsyula, B.K., Downing, R., Yakubu, K., Miima, M., & Ifeyinwa, O. (2016) Factors affecting time of access of in-patient care at Webuye District Hospital, Kenya. Africa Journal of Primary Health Care & Family Medicine, 8(1), el-e9.doi:10.4102/phcfm. v8il.898. Accessed on 29th April, 2019.

McCollum, R., Sally, T., Lillian, O., Tim, M., Robinson, K., Barasa, E. (2018) Priority Setting for health in the context of devolution in Kenya: Implications for local equity and community-based primary care. *Health Policy Planning, Vol. 33, Issue 6. Pp. 729-742*

McGraw-Hill Concise Dictionary of Modern Medicine (2002) Definition of Healthcare Access. The McGraw-Hill Companies.

Magokha, T., (2015) Blame Game as Kenya's Health Crisis Hurts. Standard, Nairobi. http//www.standardmedia.co.ke…/blame

Mills, A., et al., eds. (1990) Health System Decentralization: Concepts, Issues and Country Experience. World Health Organization. Geneva.

Ministry of Health (2015) Master List of Facilities.

Mittelmark, M., Kickbusch, I., Rootman, I., Scriven, A., Tones, K. (2008) Health Promotion. In: Kirch., W, ed. Encyclopedia of Public health. London: Elsevier.

Musgrave, R., A. (1959). The theory of public finance: A study in public economy. New York: McGraw-Hill.

Musgrave, R., A., & Musgrave, P., B. (1989). Public Finance in Theory and Practice. New York: McGraw-Hill.

MOH, (2014) Human Resources for Health Norms and Standards Guidelines for the Health Sector: Nairobi, Kenya.

MOH, (2015) Kenya Demographic and Health Survey (KDHS), key Health Indicators.

MOH, (2017) Accelerating attainment of Universal Health Coverage, Health Infrastructure, Norms and Standards: Nairobi, Kenya.

Muigua, K., (2018) Devolution and Natural Resource Management in Kenya. Nairobi. University of Nairobi

Muriu, A. R., (2012) Decentralization, Citizen Participation and Local Public Service Delivery.

Mwabu, G., (1995) Healthcare Reform in Kenya: A Review of the Process. *Health Policy 32:245-255.*

Mwenda, A., (2010). Introduction. In: Mwenda, A., 2010. Devolution in Kenya: Prospects, Challenges and Future. Nairobi: Institute of Economic Affairs. IEA Research Paper Series No. 24, Pp 8-13 (Online) Available

Nation Team, (2019 March 30). Poor services and lack of drugs the ruin of public hospitals. Saturday Nation, Pp.4.

Nyikuri, MM., Tsofa, B., Okoth et al., (2014) "We are toothless and hanging, but optimistic": Sub-county managers' experiences of rapid devolution in coastal Kenya. *International Journal for Equity in Health 16:113.* Available at, http://equityhealthj.biomedcentral.com/articles/10.1186/s12939-017-0607-x [Pubmed] Accessed on 20th July 2019.

Okech, C.T., (2014) Systematic review of Kenya's programmatic progress towards universal coverage and its effects on health equity: International Journal of Business and Social Science, 5 (7).

Okech, C.T., & Lilegwe, L.S., (2016) Devolution and Universal health coverage in Kenya: situational analysis of health financing, infrastructure & personnel. *International journal of Economics, Commerce and Management,* Vol. IV, Issue 5.

Oloo, O. M., (2014) Devolving Corruption? Kenya's Transition to Devolution, Experiences and Lessons from the decade of Constituency Development Fund in Kenya,' *Paper Presented at Workshop on Devolution and Local Development in Kenya*, Nairobi. p. 5.

Oso, W.Y., & Onen, D. (2008). A General Guide to Writing Research Proposal and Report: A handbook for beginning Researchers (2nd Ed.). Makerere University Printer.

Oyaya, CO., & Rafikin, S., B. (2003) Health Sector Reforms in Kenya: An Examination of District Level Planning. *Health Policy 64:113-127.*

Oyugi, W. O., (2005) The Search for an Appropriate Decentralization Design in Kenya: Historical and Comparative Perspectives. In the Anatomy of Bomas: Selected Analyses

of the 2004 Draft Constitution of Kenya, edited by Kindiki, Kithure and Ambani, Osogo, 57-107. Nairobi: Claripress [Google Scholar].

Peters, DH., Garg, A., Bloom, G., Walker, DG., Brieger, WR., Rahman, MH (2008) Poverty and access to healthcare in developing countries. *Annals of the New York Academy of Science* Vol. 1136: 161-71

Potter, J., (2001) Devolution & globalization implications for local decision makers. Paris. Organization for Economic Cooperation & Development (OECD).

Putnam, R., D. (1993). Making Democracy Work: Civic traditions in modern Italy. New Jersey: Princeton University Press.

Reinikka, R., & Svenson, J. (2005) Fighting Corruption to Improve Schooling: Evidence from a Newspaper Campaign in Uganda. *Journal of the European Economic Association* 3 (2-3): 259-267.

Republic of Kenya (1977). Local Government Act (Cap. 265) of 1977.

Robalino, D.A, Picazo, O.F., Voetberg, A. (2001) Does Fiscal Decentralization Improve Health Out-comes? Evidence from a Cross-Country Analysis. *World Bank Policy Research Working Paper*.

Rodden, J., (2003) Reviving Leviathan: Fiscal Federalism and the Growth of Government. *International Organization* 57, Pp. 695-729.

Rondinelli, D., & Cheema, G., S. (1983) Implementing decentralization policies: an introduction. In Decentralization and Development: Policy Implementation in Developing Countries, ed. G.S. Cheema and Rondinelli, Pp. 9-34. Sage, Beverly Hills.

Serapioni, M., Matos, AR., (2017) The challenge of citizen's participation in health systems in Southern Europe: A literature review

The Kenya Institute for Public Policy Research and Analysis (KIPPRA) (2017) Promoting Public Participation for Improved Health Outcomes. KIPPRA Policy Brief, No 5/2017-2018

The Kenya National Population and Housing Census Report (2009) Kenya National Bureau of Statistics: Nairobi, Kenya.

The Kenya Service Availability and Readiness Assessment (SARAM) (2013). Ministry of Health.

Kisumu County Gazette Supplement Acts (2015) Kisumu County Public Participation Act No. 11. National Council for Law Reporting Library: Nairobi.

Tsofa, B., (2016) Examining the effects of political decentralization in Kenya on health sector planning and budgeting: a case study of Kilifi County, in Global Health Department, Faculty of Public Health. University of London: London School of Hygiene and Tropical Medicine. [Google Scholar].

Tsofa, B., (2017) Devolution and its effects on health workforce and commodities management-early implementation experiences in Kilifi County, Kenya. *International journal for equity in health Vol. 16 (1), 169.*

United Nations Development Program (UNDP), Kenya (2002). Kenya Human Development Report 2001: Addressing Social and Economic Disparities. Nairobi: UNDP.

Wamai, R. G., (2009) The Health System in Kenya: Analysis of the situation and enduring challenges. *JMAJ, Vol*. 52, No 2, Pp. 138.

Waweru, E., et al., (2015) Tracking Implementation and Unintended Consequences: a process evaluation of an innovative peripheral health facility financing mechanisms in Kenya. *Health Policy and Planning.*

World Bank. (1993) World Development Report: Investing in Health. New York: Oxford University Press.

World Bank (2005a) Doing Business in 2005: Removing Obstacles to Growth. Washington, D.C: World Bank.

World Health Organization (1978) Alma Ata 1978. In Primary Health Care: report of the Conference. Geneva.

World Health Organization (2013) Universal Health Coverage and Universal Access. Bulletin of (WHO) 91, 546-546A.

Yang, K., & Callahan, K. (2005) Assessing Citizen Involvement Efforts by Local Governments. *Public Performance and Management Review Vol. 29 (2).*

APPENDICES

Appendix 1. Operationalization Table

Indicators	Data Needs	Technique	Data Source	Instrument	Measurement
Sex/Marital status/Disability status/Age	Socio-demographic information	Quantitative	Patients	structured questionnaire	Nominal/interval ratio
Education status	Patients	Quantitative	Patients	structured questionnaire	Ordinal
Household Income	Level of household income	quantitative	Patients	Structured questionnaire	Interval/Ratio
Access to healthcare services; Affordability	Incidences of catastrophic health spending due to OOP	Qualitative	Key Informants; health workers	Interview guide	Nominal
Financial resources allocation	Healthcare expenditures	Quantitative	Patients/Key informants	Structured questionnaire/ Interview guide	Interval/Ratio
Public participation	Institutional framework governing public participation	Qualitative	Patients/Health workforce/ Key informants	Questionnaire / Interview guide	Nominal
Decision making by county government	Decision space on human resource management / Purchase of drugs etc.	Qualitative	Key Informants/ Healthcare workforce;	Interview guide	Nominal

Appendix 2: Questionnaire for Patients

Introduction

My name is James Ogosi Yuko, a Masters Student at the University of Nairobi, Department of Political Science & Public Administration, undertaking a study on 'The Influence of Devolution on Access to Public Healthcare Services in Kisumu County, 2013-2018'. The aim of this study is to understand the influence of devolution on public healthcare service delivery Kisumu County.

I request for information from you, in this regard, to enable me write a report for my master of arts degree. Your information shall be kept anonymous and will not be disclosed to anybody else, and will only be used for the stated purposes. The findings from this study could help improve the healthcare services in Kisumu County. I thank you for your cooperation and contribution.

A. Demographic Information

I. Age: (Yrs.)

II. Gender

1. Male 2. Female

III. Marital status

1. Single 2. Married 3. Divorced 4. Widowed

IV. Disability?

2. Yes 2. No

V.What is your level of education?

1. Primary 2. Secondary 3. Diploma 4. University 5. Masters 6. Doctorate 7. No Education

VI. How do you earn a living?

1. Business 2. Agriculture 3. Livestock Keeping 4. Others (Please Specify)

B. Access to healthcare services

I. When you or someone in your family falls ill, where do you seek healthcare?

1. Public Healthcare Facility 2. Private Healthcare Facility 3. Traditional Healer 4. Other (Please explain)

II. What is the level of the facility at which you prefer to seek care?

1. Dispensary 2. Health Centre 3. Sub-county hospital 4 County Referral hospital 5 other (Please explain).

III. Why do you chose to seek care at this facility? Choose all that apply.

1. Near 2. Offers quality service 3. Affordable 4. All healthcare services are available
3. Facility delivers services promptly 6. Other (Please explain).

IV. How do you pay for your medical bills at your preferred facility?

1.Out of pocket 2. NHIF 3. Medical Insurance 4. Other (Please explain)

IV. When you visit a public healthcare facility, how much do you pay directly out-of-pocket?

1.0 Kshs. to Ksh. 2,500 2. Kshs. 2,500 to Kshs. 5,000 3. Kshs. 5,000 to Kshs. 10,000

1.Kshs. 10,000 to Kshs. 20,000 5. Kshs. 20,000 to Kshs. 35,000 6. Above Kshs. 35,000

Financial Resources Allocation

I. Do you think county government has been allocating enough resources to the health sector?

1. Yes 2. No

II. Enough resources have been allocated to the healthcare system by county government.

1. Strongly Disagree 2. Disagree 3. Neutral 4. Agree 5. Strongly agree

Decision making by county governments on healthcare matters

For the following question, indicate the response that best relates to the statement.

I. Decision making by county governments has made medical staff, doctors and nurses readily available at my preferred facility.

1. Strongly Disagree 2. Disagree 3. Neutral 4. Agree 5. Strongly agree

II. The essential drugs and treatments are readily available at my preferred facility.

1. Strongly Disagree 2. Disagree 3. Neutral 4. Agree 5. Strongly agree

III. My preferred facility has sufficient medical equipment to perform all medical laboratory tests.

1. Strongly Disagree 2. Disagree 3. Neutral 4. Agree 5. Strongly agree

Distance to a facility

I. How far away is a healthcare facility from your home?

1. 0-2km 2. 3-5 km 3. Above 5km

II. What mode of transport do you use to get to a healthcare facility?

1. Ambulance 2. Public Transport 3. On foot 4. Private Car 5. Motorcycle 6. Other (Please Specify.

C. Public Participation

I. Does your county government organize public forums to discuss healthcare development matters with members of the public? 1 Yes 2. No

2. What is usually your source of information about events in your county concerning healthcare activities? 1. Newspaper 2. Radio 3. Friends/ Relatives 4. Location Chief 5. Ward Representative 6. Local NGO's 7. County Government

3. To what extent do you agree with the following statements?

I. Because of people engaging in healthcare development forums, healthcare service delivery has improved in our community public hospital. 1.Strongly Disagree 2. Disagree 3. Neutral 4. Agree 5. Strongly agree

II. Because of people participating in planning and budgeting for healthcare development activities, essential healthcare services that address our community needs are now available in our community public hospital. 1. Strongly Disagree 2. Disagree 3. Neutral 4. Agree 5. Strongly agree.

III. Because of people participating in the implementation and monitoring of healthcare development activities, the levels of corruption in public hospitals have gone down. 1. Strongly Disagree 2. Disagree 3. Neutral 4. Agree 5. Strongly agree

Appendix 3: Questionnaire for Health Workers

Introduction

My name is James Ogosi Yuko, a Masters Student at the University of Nairobi, Department of Political Science & Public Administration, undertaking a study on 'The Influence of Devolution on Access to Public Healthcare Services in Kisumu County, 2013-2018'. The aim of this study is to understand the influence of devolution on public healthcare service delivery in Kisumu County.

I request for information from you, in this regard, to enable me write a report for my master of arts degree. Your information shall be kept anonymous and will not be disclosed to anybody else, and will only be used for the stated purposes. The findings from this study could help improve the healthcare services in Kisumu County. I thank you for your cooperation and contribution.

A. Financial Resources Allocation

1.Do you consider the county financial allocations to your healthcare facility sufficient?

2.Are there other sources that finance public healthcare in your facility?

3. Do you think financial resources allocated directly to your health facility has reduced the cost of medical treatment for members of the public?

C. Decision making by county governments

1. Do you consider healthcare management under county government better?
2. Is your facility consistently supplied with medical drugs?
3. What is the current number of healthcare workers in this facility?
4. Are there any shortages of healthcare workers experienced in this facility?
5. Does your facility have adequate medical equipment to conduct medical tests?

Appendix 4: Key Informant Interview Schedule for Chief Officer for Health and Chairman Sectorial Committee on Health Services at the County

Introduction

My name is James Ogosi Yuko, a Masters Student at the University of Nairobi, Department of Political Science & Public Administration, undertaking a study on 'The Influence of Devolution on Access to Public Healthcare Services in Kisumu County, 2013-2018'. The aim of this study is to understand the influence of devolution on public healthcare service delivery in Kisumu County.

I request for information from you, in this regard, to enable me write a report for my master of arts degree. Your information shall be kept anonymous and will not be disclosed to anybody else, and will only be used for the stated purposes. The findings from this study could help improve the healthcare services in Kisumu County. I thank you for your cooperation and contribution.

A. Financial Resources allocation

I. What is your take on the issue of healthcare financing at the county?

II. As a proportion of the total county health expenditures, how much is allocated to healthcare?

III. Do you think county financial allocations to the healthcare system has increased access to healthcare services accessibility in public hospitals?

IV. Do you consider financial resources allocated to the healthcare system sufficient?

V. Are there other sources that finance public healthcare at the county?

B. Public Participation

I. What has been the nature of public involvement on healthcare matters in Kisumu County

II. What can you say about timely organization of public forums in healthcare matters in the county?

III. Has public involvement influenced healthcare services accessibility in Kisumu County, in view of the following parameters of devolved healthcare service delivery?

1. Equitable access to healthcare services
2. Reduction of corruption
3. Accountability

C. Decision making by county governments

I. Since the county government took over the management of the health sector, what improvements are there in relation to medical equipment, healthcare workers and essential drugs?

II. Are monies allocated to healthcare facilities adequate to carter for all the county public healthcare services requirements?

III. What is the total number of public healthcare workers at the county?

IV. In relation to the population of the county that healthcare facilities serve, what is the proportion of health workforce?

IV. Do you expend finances to the healthcare facilities on time?

Appendix 5: Key Informant Interview Schedule for Assistant County Commissioners and NGO's in Kisumu County

Introduction

My name is James Ogosi Yuko, a Masters Student at the University of Nairobi, Department of Political Science & Public Administration, undertaking a study on 'The Influence of Devolution on Access to Public Healthcare Services in Kisumu County, 2013-2018'. The aim of this study is to understand the influence of devolution on public healthcare service delivery in Kisumu County.

I request for information from you, in this regard, to enable me write a report for my master of arts degree. Your information shall be kept anonymous and will not be disclosed to anybody else, and will only be used for the stated purposes. The findings from this study could help improve the healthcare services in Kisumu County. I thank you for your cooperation and contribution.

B.Public Participation

I. Are you aware of incidences where county government has organized participation forums for members of the public to discuss healthcare matters?

II. What has been the nature of public participation on healthcare matters in Kisumu County?

III. Has public contribution influenced healthcare services accessibility in Kisumu County, in view of the following parameters of devolved healthcare service delivery?

1. Equitable access to healthcare service
2. Reduction of corruption
3. Accountability

Appendix: 6 University of Nairobi Research Authorization Letter

University of Nairobi
COLLEGE OF HUMANITIES AND SOCIAL SCIENCES
Department of Political Science & Public Administration

Telephone: 318262 Ext.28171
Telegrams:"Varsity" Nairobi
Fax: 254 (020) 245566
Email: dept-pspa@uonbi.ac.ke

P.O Box 30197
Nairobi, Kenya.

4 October, 2019

TO WHOM IT MAY CONCERN

Dear Sir/Madam

SUBJECT: AUTHORIZATION TO CONDUCT FIELD RESEARCH (JAMES OGOSI YUKO-C50/74328/2014)

This is to confirm that Mr. James Ogosi Yuko of Registration Number C50/74328/2014) is a bonafide student in the Department of Political Science and Public Administration. He is registered and is pursuing a Master of Arts Degree Science and Public Administration.

Mr. Yuko has successfully completed his coursework and is hereby authorized to undertake field research. His research topic is titled, **"The influence of Devolution on access to Healthcare services in Public Hospitals in Kenya: A Case study of Kisumu County"**

It is against this background that the Department of Political Science and Public Administration request your support and access to relevant information that could enable the candidate to collect data for his research.

Mr. Yuko will be expected to abide and comply with your regulations research. The information collected will be purely used for academic purposes.

In case of further clarification, feel free to contact the undersigned.

Thanking you most sincerely for support.

Prof. Fred Jonyo (Ph.D)
Chairman, Department of Political Science and Public Administration

DEPARTMENT OF POLITICAL SCIENCE
CHAIRMAN
PUBLIC ADMINISTRATION

APPENDIX 7: NACOSTI Research License

REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Ref No: **518031**

Date of Issue: **16/October/2019**

RESEARCH LICENSE

This is to Certify that Mr.. James Yuko of University of Nairobi, has been licensed to conduct research in Kisumu on the topic: The Influence of Devolution on Access to Healthcare Services in Public Hospitals in Kenya: A Case Study of Kisumu County, 2013-2018 for the period ending : 16/October/2020.

License No: **NACOSTI/P/19/2088**

518031

Applicant Identification Number

Director General
NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Verification QR Code

NOTE: This is a computer generated License. To verify the authenticity of this document, Scan the QR Code using QR scanner application.

THE SCIENCE, TECHNOLOGY AND INNOVATION ACT, 2013

The Grant of Research Licenses is Guided by the Science, Technology and Innovation (Research Licensing) Regulations, 2014

CONDITIONS

1. The License is valid for the proposed research, location and specified period
2. The License any rights thereunder are non-transferable
3. The Licensee shall inform the relevant County Director of Education, County Commissioner and County Governor before commencement of the research
4. Excavation, filming and collection of specimens are subject to further necessary clearence from relevant Government Agencies
5. The License does not give authority to tranfer research materials
6. NACOSTI may monitor and evaluate the licensed research project
7. The Licensee shall submit one hard copy and upload a soft copy of their final report (thesis) within one of completion of the research
8. NACOSTI reserves the right to modify the conditions of the License including cancellation without prior notice

National Commission for Science, Technology and Innovation
off Waiyaki Way, Upper Kabete,
P. O. Box 30623, 00100 Nairobi, KENYA
Land line: 020 4007000, 020 2241349, 020 3310571, 020 8001077
Mobile: 0713 788 787 / 0735 404 245
E-mail: dg@nacosti.go.ke / registry@nacosti.go.ke
Website: www.nacosti.go.ke

Appendix 8: Kisumu County Letter of Authorization to Conduct Research

COUNTY GOVERNMENT OF KISUMU

Telegrams: "PRO.(MED)"
Tel: 254-057-2020105
Fax: 254-057-2023176
E-mail: kisumucdh@gmail.com

County Director of Health,
Kisumu.
P. O. Box 721-40100,
KISUMU.

DEPARTMENT OF HEALTH

REF: GN.133.VOL. III/908

Date: 17/10/2019

To DRT.

SCMOHs: Kisumu East, Central and Seme

RE: APPROVALTO CONDUCT RESEARCH – JAMES OGOSI YUKO – C50/74328/2014 ON "THE INFLUENCE OF DEVOLUTION ON ACCESS TO HEALTHCARE SERVICES IN PUBLIC HSPITALS IN KENYA: A CASE STUDY OF KISUMU"

The County Department of Health has reviewed the proposal to conduct the above study and supports it's implementation.

The department has granted the researcher permission for one year effective 17th October, 2019 to conduct the research and share the findings with this office in both hard & soft copy upon completion of the study.

COUNTY DIRECTOR OF HEALTH KISUMU

for

Dr. Onyango D. O.
County Director of Health
Kisumu County

From the County Director of Health office

Appendix 9: Kisumu East Sub-County Letter of Approval to Conduct Research

COUNTY GOVERNMENT OF KISUMU

Telegrams: "Health" Kisumu
Tel: 0720966233/0789559423
Email: MOH ksmeast@yahoo.com

MINISTRY OF HEALTH

Medical Officer of Health
Kisumu East Sub-County
P. O. Box 105-40100
KISUMU

When replying please quote

Date 14TH OCTOBER 2019

REF.NO: ST-GN/1/VOL.1/111

JAMES OGOSI YUKO

THE UNIVESITY OF NAIROBI
P.O BOX 30197
NAIROBI.

RE: RESEARCH AUTHORIZATION

Following your application to carry out research on ***'The Influence of Devolution on Access to Healthcare Services in Kenya: A case Study of Kisumu County, 2013-2018,'*** I am pleased to inform you that you have been authorized to undertake research in **Kisumu East Sub-County** for the period ending 31st October 2019.

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

MOH KISUMU EAST SUB COUNTY P. BOX 150 - 40100 KISUMU

WILSON ACHOLA

FOR: MEDICAL OFFICER OF HEALTH

KISUMU EAST SUB-COUNTY

Appendix 10. List of the Total Number of Public Healthcare Facilities in Kisumu County

	Facility Name	Facility Level	Facility Type	Sub-County	Ward
1.	Masogo Sub-County Hospital	Level 4	Primary Healthcare Facility	Muhoroni	Masogo/Nyang'oma
2.	Nyang'oma Sub-county Hospital	Level 4	Primary Healthcare Facility	Muhoroni	Masogo/Nyang'oma
3.	Miranga Dispensary	Level 2	Dispensary	Muhoroni	Masogo/Nyang'oma
4.	Nyakunguru Dispensary	Level 2	Dispensary	Muhoroni	Masogo/Nyang'oma
5.	Milenye Health Centre	Level 3	Health Centre	Muhoroni	Masogo/Nyang'oma
6.	Nyakunguru Dispensary	Level 2	Dispensary	Muhoroni	Masogo/Nyang'oma
7.	Chemelil GOK Dispensary	Level 2	Dispensary	Muhoroni	Masogo/Nyang'oma
8.	Migere Health Centre	Level 3	Health Centre	Muhoroni	Masogo/Nyang'oma
9.	Makindu Dispensary	Level 2	Dispensary	Muhoroni	Masogo/Nyang'oma
10	Nyangore Dispensary	Level 2	Dispensary	Muhoroni	Chemelil
11.	Nyangore Dispensary	Level 2	Dispensary	Muhoroni	Chemelil
12.	Nyangore Dispensary	Level 2	Dispensary	Muhoroni	Chemelil
13.	Mashambani Health Centre	Level 3	Health Centre	Muhoroni	Chemelil
14.	Tamu Health Centre	Level 3	Health Centre	Muhoroni	Chemelil
15.	Kibigori Health Centre	Level 3	Health Centre	Muhoroni	Chemelil
16.	Ogen Dispensary	Level 2	Dispensary	Muhoroni	Chemelil
17.	Miwani Health Centre	Level 3	Health Centre	Muhoroni	Miwani
18.	Muhoroni County Hospital	Level 4	Primary Healthcare Facility	Muhoroni	Koru
19.	Jaber Dispensary	Level 2	Dispensary	Muhoroni	Koru
20.	Jaber Dispensary	Level 2	Dispensary	Muhoroni	Koru
21.	Koru Dispensary	Level 2	Dispensary	Muhoroni	Koru
22.	Mnara Dispensary	Level 2	Dispensary	Muhoroni	Koru
23.	Kandege Dispensary	Level 2	Dispensary	Muhoroni	Koru
24.	Kasongo Dispensary	Level 2	Dispensary	Muhoroni	Ombeyi
25.	Ramula Dispensary	Level 2	Dispensary	Muhoroni	Ombeyi
26.	Obumba Dispensary	Level 2	Dispensary	Muhoroni	Ombeyi
	Facility Name	**Facility Level**	**Facility Type**	**Sub-County**	**Ward**
1.	Jaramogi Oginga Odinga Teaching & Referral Hospital	Level 5	Secondary Healthcare Facility	Kisumu Central	Shauri Moyo
2.	Lumumba Sub-county Hospitals	Level 4	Primary Healthcare	Kisumu Central	Shauri Moyo Kaloleni

			Facility		
3.	St. Lydia Okore Dispensary	Level 2	Dispensary	Kisumu Central	Shauri Moyo Kaloleni
4.	Kisumu County Hospital	Level 4	Primary Healthcare Facility	Kisumu Central	Market Milimani
5.	Victoria Sub-District Hospital	Level 4	Primary Healthcare Facility	Kisumu Central	Market Milimani
6.	Police Lines Dispensary	Level 2	Dispensary	Kisumu Central	Market Milimani
7.	Beyond Zero Medical Clinic	Level 2	Dispensary	Kisumu Central	Market Milimani
8.	Railways Dispensary	Level 2	Dispensary	Kisumu Central	Market Milimani
9.	Migosi Sub-County Hospital	Level 4	Primary Healthcare Facility	Kisumu Central	Migosi
10.	Kowino Dispensary	Level 2	Dispensary	Kisumu Central	Nyalenda A
11.	Dunga GOK Dispensary	Level 2	Dispensary	Kisumu Central	Nyalenda B
12.	Administration Police Dispensary	Level 2	Dispensary	Kisumu Central	Nyalenda B
13.	Nyalenda Health Centre	Level 3	Health Centre	Kisumu Central	Nyalenda B
14.	Mosque Dispensary	Level 2	Dispensary	Kisumu Central	Railways
15.	Kosawo Dispensary	Level 2	Dispensary	Kisumu Central	Kondele
	Facility Name	**Facility Level**	**Facility Type**	**Sub-County**	**Ward**
1.	Usoma Health Centre	Level 3	Health Centre	Kisumu West	Central Kisumu
2.	Kisumu International Airport Dispensary	Level 2	Dispensary	Kisumu West	Central Kisumu
3.	St. Mark's Lela Health Centre	Level 3	Health Centre	Kisumu West	Central Kisumu
4.	Kodiaga Prison Health Centre	Level 3	Health Centre	Kisumu West	Central Kisumu
5.	Airport Health Centre	Level 3	Health Centre	Kisumu West	Central Kisumu
6.	Usoma Health Centre	Level 3	Health Centre	Kisumu West	Central Kisumu
7.	Nyahera Sub-County Hospital	Level 4	Primary Healthcare Facility	Kisumu West	Kisumu North
8.	Dago Kokore	Level 3	Health Centre	Kisumu West	Kisumu North
9.	Chulaimbo County Hospital	Level 4	Primary Healthcare Facility	Kisumu West	North West Kisumu
10.	Aboge	Level 3	Health Centre	Kisumu West	North West Kisumu
11.	Mbaka Oromo Health Centre	Level 3	Health Centre	Kisumu West	North West Kisumu
12.	Siriba Dispensary	Level 2	Dispensary	Kisumu West	North West Kisumu

13.	Sunga Dispensary	Level 2	Dispensary	Kisumu West	North West Kisumu
14.	Ober Kamoth Sub-County Hospital	Level 4	Primary care hospital	Kisumu West	South West Kisumu
15.	Ojola Sub-County Hospital	Level 4	Primary care hospitals	Kisumu West	South West Kisumu
16.	Rota Health Centre	Level 3	Health Centre	Kisumu West	South West Kisumu
17.	Mainga Health Centre	Level 3	Health Centre	Kisumu West	West Kisumu
18.	Lwala Kadawa Health Centre	Level 3	Health Centre	Kisumu West	West Kisumu
19.	Riat Dispensary	Level 2	Dispensary	Kisumu West	West Kisumu
	Facility Name	**Facility Level**	**Facility Type**	**Sub-County**	**Ward**
1.	Ahero County Hospital	Level 4	Primary Healthcare Facility	Nyando	Ahero
2.	Kanyagwal Dispensary	Level 2	Dispensary	Nyando	Ahero
3.	Bunde Health Centre	Level 2	Dispensary	Nyando	Ahero
4.	Oren Health Centre	Level 3	Health Centre	Nyando	Awasi/Onjiko
5.	Holo Dispensary	Level 2	Dispensary	Nyando	Awasi/Onjiko
6.	Wanganga Health Centre	Level 3	Health Centre	Nyando	Awasi/Onjiko
7.	Katolo-Manyatta Dispensary	Level 2	Dispensary	Nyando	East Kano/Wawidhi
8.	Magina Health Center	Level 3	Health Centre	Nyando	East Kano/Wawidhi
9.	Nyangande Sub-County Hospital	Level 4	Primary Healthcare Facility	Nyando	Kabonyo/Kanyagwai
10.	Kadhiambo dispensary	Level 2	Dispensary	Nyando	Kabonyo/Kanyagwai
11.	Komwaga Health Center	Level 3	Health Centre	Nyando	Kabonyo/Kanyagwai
12.	Koduol Reru Dispensary	Level 2	Dispensary	Nyando	Kabonyo/Kanyagwai
13.	Rabuor Sub-county Hospital	Level 4	Primary Healthcare Facility	Nyando	Kobura
14.	Okana Dispensary	Level 2	Dispensary	Nyando	Kobura
15.	Absalom Wangulu Dispensary	Level 2	Dispensary	Nyando	Kobura
16.	Hongo Ogosa Health Centre	Level 3	Health Centre	Nyando	Kobura
17.	Kinasia Health Centre	Level 3	Health Centre	Nyando	East Kano/Wawidhi
18.	Nyakongo health Centre	Level 3	Health Centre	Nyando	East Kano/Wawidhi
	Facility Name	**Facility Level**	**Facility Type**	**Sub-County**	**Ward**
1.	Nyakach County Hospital	Level 4	Primary Healthcare Facility	Nyakach	Central Nyakach

2.	Sondu Sub-County Hospital	Level 4	Primary Healthcare Facility	Nyakach	Central Nyakach
3.	Bonde Dispensary	Level 2	Dispensary	Nyakach	Central Nyakach
4.	Onyuongo Dispensary	Level 2	Dispensary	Nyakach	Central Nyakach
5.	Nyabola CDF Dispensary	Level 2	Dispensary	Nyakach	Central Nyakach
6.	Pedo Dispensary	Level 2	Dispensary	Nyakach	Central Nyakach
7.	Katito Sub-County Hospital	Level 4	Primary Healthcare Facility	Nyakach	North Nyakach
8.	Cherwa Dispensary	Level 2	Dispensary	Nyakach	North Nyakach
9.	Kibogo Dispensary	Level 2	Dispensary	Nyakach	North Nyakach
10.	Lisana Dispensary	Level 2	Dispensary	Nyakach	North Nyakach
11.	Rae Dispensary	Level 2	Dispensary	Nyakach	North Nyakach
12.	Sigoti Health Centre	Level 3	Health Centre	Nyakach	South East Nyakach
13.	Radienya Dispensary	Level 2	Dispensary	Nyakach	South East Nyakach
14.	Nyamarimba Sub-County Hospital	Level 4	Primary Healthcare Facility	Nyakach	South West Nyakach
15.	Oboch Dispensary	Level 2	Dispensary	Nyakach	South West Nyakach
16.	Kodingo Health Centre	Level 3	Health Centre	Nyakach	West Nyakach
17.	Sango Rota Health centre	Level 3	Health Centre	Nyakach	West Nyakach
18.	Anding'o Opanga Dispensary	Level 2	Dispensary	Nyakach	West Nyakach
19.	Sangoro Dispensary	Level 2	Dispensary	Nyakach	West Nyakach
	Facility Name	**Facility Level**	**Facility Type**	**Sub-County**	**Ward**
1.	Gita Sub-County Hospital	Level 4	Primary Healthcare Facility	Kisumu East	Kajulu
2.	Got Nyabondo Health Centre	Level 3	Health Centre	Kisumu East	Kajulu
3.	Simba Opepo Health Centre	Level 3	Health Centre	Kisumu East	Kajulu
4.	Kibos Sugar Research Dispensary	Level 2	Dispensary	Kisumu East	Kajulu
5.	Nyalunya Health Centre	Level 3	Health Centre	Kisumu East	Kolwa Central
6.	Angola Community Dispensary	Level 2	Dispensary	Kisumu East	Kolwa East
7.	Orongo Dispensary	Level 2	Dispensary	Kisumu East	Kolwa East
8.	Chiga Dispensary	Level 2	Dispensary	Kisumu East	Kolwa East
9.	GK Prisons Dispensary	Level 2	Dispensary	Kisumu East	Kolwa East
10	Kotunga Dispensary	Level 2	Dispensary	Kisumu East	Kolwa East

11.	Kuoyo Health Center	Level 3	Health Centre	Kisumu East	Manyatta B
	Facility Name	**Facility Level**	**Facility Type**	**Sub-County**	**Ward**
1.	Kombewa County Referral Hospital	Level 4	Primary Healthcare Facility	Seme	Central Seme
2.	Lolwe Dispensary	Level 2	Dispensary	Seme	Central Seme
3.	Kolenyo Dispensary	Level 2	Dispensary	Seme	Central Seme
4.	Bodi Health Centre	Level 3	Health Centre	Seme	Central Seme
5.	Miranga Sub-County Hospital	Level 4	Primary Healthcare Facility	Seme	East Seme
6.	Langi Kawino Dispensary	Level 2	Dispensary	Seme	East Seme
7.	Onyinjo Dispensary	Level 2	Dispensary	Seme	East Seme
8.	Kuoyo Kaila Dispensary	Level 2	Dispensary	Seme	East Seme
9.	Rodi Dispensary	Level 2	Dispensary	Seme	East Seme
10	Nduru Kadero Dispensary	Level 2	Dispensary	Seme	North Seme
11	Oriang' Kanyadwera Dispensary	Level 2	Dispensary	Seme	North Seme
12.	Bongu Konyango Dispensary	Level 2	Dispensary	Seme	North Seme
13.	Korwenje Dispensary	Level 2	Dispensary	Seme	North Seme
14.	Ratta Health Centre	Level 3	Health Centre	Seme	North Seme
15.	Otieno Owala Dispensary	Level 2	Dispensary	Seme	North Seme
16.	Manyuanda Sub-county Hospital	Level 4	Primary Healthcare Facility	Seme	West Seme
17.	Opapla Dispensary	Level 2	Dispensary	Seme	West Seme
18.	Oriang' Alwala Dispensary	Level 2	Dispensary	Seme	West Seme
19.	Dago Jonyo Dispensary	Level 2	Dispensary	Seme	West Seme
20.	Asat Beach Dispensary	Level 2	Dispensary	Seme	West Seme
21.	Arito Langi Dispensary	Level 2	Dispensary	Seme	West Seme
22.	Osewre Dispensary	Level 2	Dispensary	Seme	West Seme