

**EFFECTS OF DECENTRALIZATION ON THE
DELIVERY OF HEALTH CARE SERVICES:**

**A survey of the perceptions of hospital staff and patients
at selected Provincial Government Hospitals, Kenya. //**

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DECLARATION

This management project report is my original work and has not been presented for a degree in any other university.

Signed Rhodie Date 6-11-2003

This project report has been submitted for examination with my approval as University supervisor.

Signed P. K'Obonyo Date 06/11/03

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DEDICATION

This paper is dedicated to my husband, Francis Eric Wasuna, for his inspiration and encouragement during my entire MBA course and to our children, Tony, Nina, Brian and Nikky who urged me to “read on”.

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My gratitude goes to several people who, through their inspiration, encouragement and concern, contributed to my successful completion of the MBA Course.

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Finally, I would like to thank the Research Assistants for their effort in collecting the data, and also the respondents without whose participation the project would not have been complete.

ABSTRACT

This research set out to find out effects of decentralization on the delivery of health care services in Kenya, as perceived by patients and hospital staff in selected provincial general hospitals. The important aspects considered were: The effect of decentralization on the proportion of direct and referral patients, how frequently are cases that can effectively be handled at the district hospitals referred to the provincial government hospitals and if these practices have affected efficiency of service delivery at the provincial general hospitals.

To achieve the objectives, primary data was collected using two separate structured questionnaires, one for staff and the other for patients.

The population of study comprised staff at senior, middle and lower levels of management; staff in middle management formed majority of the sample (91.5%). Understandably, majority of the staff who deal directly with patients at treatment level are in the middle management level. The findings of this study indicate that: Generally, the number of cases referred to the provincial general hospitals from the district hospitals have decreased, there are some cases referred to the PGH which can effectively be handled at the district hospitals, and efficiency of service delivery is perceived by both staff and patients to have improved at the provincial general hospitals. It has also been shown that majority of patients who seek treatment at the provincial general hospitals have not been referred from the district or lower level health facilities. This implies that such people find services at the lower health facilities not acceptable. The major reasons for referrals as cited by respondents are lack of specialized staff and equipment at the district hospitals; hence some cases that can be dealt with at that

level are referred to the PGHs. Although, the majority of the patients involved in the study rated services received as satisfactory, a significant proportion of the patients was dissatisfied with the services.

This led to the conclusion that efficiency at the provincial general hospitals is affected by cases of patients referred to this level that could be dealt with at the district hospitals if the latter had adequate specialized facilities and staff.

It can therefore be derived that, equipping district hospitals and health centres with adequate facilities and specialized personnel will help improve services at that level. Consequently, this will win the confidence of the public to use these facilities as their first level of contact, freeing the Provincial hospitals to be used strictly for referral purposes. This will in turn enhance the efficiency and the effectiveness of the provincial hospitals. However, it is important to note that the level of efficiency of the provincial government hospitals may also be affected by other factors that were not included in this study. Based on the findings of the study, recommendations are made on what needs to be done to improve efficiency and for future research.

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ABBREVIATIONS

HIS	HEALTH INFORMATION SERVICES
MOH	MINISTRY OF HEALTH
HMB	HOSPITALS MANAGEMENT BOARD
PMO	PROVINCIAL MEDICAL OFFICE /OFFICER
PHMT	PROVINCIAL HEALTH MANAGEMENT TEAM
HMT	HOSPITAL MANAGEMENT TEAM
DMOH	DISTRICT MEDICAL OFFICER OF HEALTH
DHMT	DISTRICT HEALTH MANAGEMENT TEAM
CHWs	COMMUNITY HEALTH WORKERS
PGH	PROVINCIAL GOVERNMENT HOSPITAL
NGOs	NON-GOVERNMENTAL ORGANIZATIONS
OP	OUT PATIENT
IP	IN PATIENT

CHAPTER I: INTRODUCTION

1.1 Background

The concept of Decentralization is broad and encompasses the transfer of responsibility for planning, management, resources generation, and allocation away from the central government and its agencies (Rondinelli et.al, 1983). The concept could take various forms (Mills 1990b). Administrative responsibilities can be redistributed within the central government (de-concentration). Decision-making and management authority for specific functions can be delegated to semi-autonomous organizations (delegation). Authority can also be transferred to autonomous and independent units at the lower levels with supervisory powers and financial role retained by the central government (devolution). Functions can be transferred from the central government to non-governmental institutions (privatization).

Health Sector reform has been the subject of increasing attention over the past decade, with considerable pressure being exerted on developing countries to restructure and reform their health systems. This has prompted the need to change health system organization and management, which involves among other processes, decentralization.

1.1.1 Desired Effects of Decentralization

Decentralization has been promoted by bodies such as the World Bank (1993a) as a means of improving the efficiency, management and responsiveness of government health services. Moreover, it seems to be increasingly linked with the transfer of assets from the public to the private sector and the use of market mechanisms, such as the internal market and the purchaser –provider split, to allocate resources (Collins 1989).

Many countries are adopting decentralization policies for the health sector with high expectations of the benefits to follow. However, it is important to note that the impetus for decentralization come from different directions.

Some analysts see decentralization as a tool for implementing Primary Health Care Policies (Green 1992). Thus the objective here is to empower the local communities, improving multi-sectoral co-ordination of activities at the local level, stimulating participatory planning that is more responsive to local demands and strengthening community participation (Taal 1993).

1.1.2 Organization of the Kenyan Health Care Delivery Systems

a) Players in Health Care Delivery Services

The Kenyan Health Sector Comprises of the public health system in which the major players are the Ministry of Health and the Ministry of Local Government, and other players being NGOs, Mission and the Private Sector. The public health system accounts for 51% of the total as shown in table 1 below:

Table 1: Distribution of Facilities by type and Provider October, in 1998.

Facility Type	GOK		NGO		PRIVATE		TOTAL
	NO	%	NO	%	NO	%	NO
Hospital	109	50	67	30.7	42	19.3	268
Health Centre	460	80	100	17.4	15	2.6	655
Dispensary	1537	60.9	595	23.6	391	15.5	2523
Nursing & Maternity Home	0	0.0	11	5.8	180	94.2	191
Health Clinics/ Medical Centres	43	6.10	72	10.2	592	83.7	707
Total	2149	51.0	845	20.1	1220	29.0	4214

Source: HIS, MOH, 1999

The overall mandate for health services promotion is vested with the Ministry of Health under the Public Health Act, CAP 242 of the Laws of Kenya and under various subsidiary legislation dealing with specific areas of health services promotion (The National Health Sector Strategic Plan 1999-2004)

b) Structure of the Kenyan Government Health Care Delivery System

The Structure of the Government Health Care Delivery System is hierarchical in nature. The dispensaries and health centres provide the bulk of services and form the first level contact with the community. The provincial and district hospitals provide both referral and outpatient services in addition to the requisite technical backstopping to the facilities at the periphery. Kenyatta National Hospital is at the Apex as the key Referral and Teaching Facility. Moi Teaching Hospital also serves as a referral hospital. Table 2 below shows the hierarchical levels and key actors.

Table 2: Health Care Delivery Levels, Facilities and Key Actors

LEVEL	KEY ACTORS	FACILITY
National	MOH Headquarters Kenyatta National Hospital Moi Teaching & Referral Hospital	Kenyatta National Hospital Moi Teaching & Referral Hospital
Province	HMB, PMO, PHMT, HMT	Provincial Hospital
District	DMOH, DHMT, DHMB & HMB	District Hospitals
Division	Clinical Officers, Rural Health Facility Clinicians	Health Centres
Location/Sub-Location	Nurse/ Rural Health Facility Clinicians	Dispensaries
Community	Village Health Committees) TBAs, Community Health Workers (CHWs)	Community Based Health Care Community Pharmacies
Household	Family Members	Family Care

Source MOH: Kenya Health Policy Framework Paper, 1994

Until December 1996, the previous centralized organizational structure of the Ministry was broad at the top and narrow at the base. The departments and divisions had ill-defined responsibilities and reporting relationships (Liambila 2002). This arrangement made the delivery of health services weak at the District and Community levels.

Under decentralization the proposed structure of the Ministry of Health, which was launched two and a half years ago, was specifically designed to meet the needs of a decentralized health care system as it recognizes the new corporate rules played by the Province, District and the Community health care delivery. In addition, it will facilitate the operationalization of the reform agenda (Kenya's Health Policy Framework 1994).

The new structure of the MOH spells out roles and responsibilities of various levels as:

Headquarters:

- Policy, strategic planning, resource mobilization and allocation
- Human Resource development, procurement of equipment, registration and control of pharmaceuticals.
- Support periphery in better financial and accounting systems.

The Province:

- Supervision, monitoring, and coordination of District level activities, i.e. Superintending role

- Inspectorate and audit as well as training activities.

The District: (Operational level)

- Health Service delivery at District and Community levels.
- Key activities include planning, supervision, monitoring, training, resource allocation, and inter-sectoral 'collaboration and coordination' as well as implementing curative, preventive, promotive and rehabilitative health care.

As outlined in the National Health Sector Strategic Plan for 1994-2004, under decentralization, the community will be actively involved in health care delivery. It is also envisaged that as specialization increases with level, lower levels act as filtering facilities. Effectiveness and efficiency at lower levels should ease clinical workload at the provincial level which will in turn function as a referral tier and will be freed to play a bigger role to handle broader issues that are beyond the district level.

Key to the success of decentralization are certain conditions which include establishing relevant policies. Proponents of decentralization made various assumptions, one of them being that institutional capacity exists to implement the reform. A reality check by Thomason (1997) concluded and proposed among other things, that there is need for further research in developing more sophisticated techniques to predict the effect of health sector reform proposals, and mechanisms for monitoring the effect of the reforms processes.

1.1.2 Decentralization Defined

Decentralization can be defined as:

'The degree of authority delegated by upper management to lower levels' (Rue and Byars 1997: Management Skills and Application, pg 231).

Decentralization is one of the principles of F W Tylor's scientific theory of management, and can also be referred to as:

The transfer of authority, dispersal of power, public planning management and decision making from the national levels to sub-national levels, or more generally from higher to lower levels of government (Mills 1990b).

Decentralization allows for more flexibility and quicker action especially at the lower levels of an organization or government. It also relieves executives or higher level management to be actively involved in strategic decision making and planning processes. It has advantages and disadvantages, the major disadvantage being potential loss of power and duplication of effort (Rue and Byars 1997). It is argued that there is no prescribed appropriate degree of decentralization, hence the need for periodic evaluation of a particular situation in light of the advantages and disadvantages of greater decentralization.

In the private sector scenario, major diversified firms have decentralized into business units with profit responsibility embracing the principle of autonomy (Porter 1985). According to Porter, the concept of decentralization has revolutionized the way diversified firms are managed, bringing with it a wide range of practices and management expectations. Many firms have successfully made the transition to decentralization. However, as pointed out by Porter, decentralization in diversified firms is still a necessity, but must be overlaid with mechanisms to achieve the important interrelationships. The different forms of decentralization affect decision making differently.

1.2 Statement of the problem

One of the objectives of Decentralization of Health Care Delivery System in Kenya is to improve efficiency and thus accessibility of health service delivery at District and lower levels of the public health sector. However, inefficiency remains one of the major concerns to increasing access to health care (Wasunna 1997). This necessitates the need for continuous evaluation of the implementation process in the decentralized health care delivery system.

As decentralization is implemented, strengthening the district and lower levels of health care delivery system should result in restructuring at all levels. Provincial hospitals should handle more referral than direct outpatient clinical cases. This will free provincial level staff to deal with broader issues that are beyond any one district level. Patient proportion and the profile

of staff cadre should reflect changes in organizational structure and management, which facilitate implementation of decentralization.

Although, there have been studies done to determine effects of decentralization at district and lower levels, so far none has been done at provincial level. This constitutes a gap in knowledge that needs to be filled through a study.

The purpose of this study is to survey the perceptions of hospital staff and patients in Provincial Government Hospitals by attempting to answer the following questions:

- Does the proportion of referral patients reflect the role of Provincial Hospitals as referral facilities?
- How frequently are medical cases that can effectively be handled at the District Hospitals referred to the Provincial Hospitals?
- What is the level of efficiency in health care service delivery at the provincial government hospitals, as perceived by both the staff and patients

1.3 Objectives of the Study

1. To establish the proportion of direct and referral patients at the Provincial Government Hospitals.
2. To determine how frequently medical cases that can be effectively dealt with at the district government hospitals are referred to the provincial government hospitals.
3. To determine the level of perceived efficiency of health care service delivery at the Provincial Government Hospitals.

1.4 The Importance of the Study

This study is expected to benefit various groups of people or organizations. Amongst the beneficiaries are Decision-Makers and Managers in the Health Ministries and Public Health Facilities. Other beneficiaries will be Policy Makers, Donors and Academicians. The study will help policy makers in evaluation of Health Sector Reforms in order to come up with policies appropriate for revamping the Public Health Care Delivery, while academicians/researchers may wish to pursue further studies in this area.

Development Partners such as Donors, NGOs and other stakeholders in Health Care Delivery Sector will find this study useful. Donors require constant evaluation of the reform processes being implemented by recipient countries. As indicated by Langan (1993) donors are engaged in their own political battles. In a paper presented at a conference in Durham, New Hampshire, United States of America (USA), she argued that it is difficult for donors to maintain funding for programmes that have long implementation periods without some interim measures of progress. Goals must be clarified and progress measured. The purpose of this study is to assess the effectiveness of decentralization of the Health Care Delivery System in Kenya.

CHAPTER II: LITERATURE REVIEW

2.1 Country Experiences

As a principle of organizing function in management, decentralization has been successfully applied to both public and private organizations. However, if not properly instituted, it has limitations. It is not always easy to design decentralized health sector reforms that achieve the desired effects (Sikosana, et al., 1996). The argument is that successful implementation of decentralization will depend on many factors that are of political and economic nature. Key issues involved in decentralization include Policy, Balancing Inter-Regional Equity, Capacity Building and Evaluation and Monitoring.

i. Policy

Studies have shown that lack of appropriate, or application of wrong policies has impaired the implementation process of decentralization in some countries, in terms of priority setting. One example is inability to integrate vertical programmes, and at the same time allowing the local levels to set their own priorities, allocating resources as they see fit. This centre-local tension can be a source of conflict. Canada, which has a highly devolved system of health care to the provinces, faced a difficult situation in 1983 when the Central Government and Alberta Province disagreed on the provinces' user-fee system. Consequently, in order to limit user fee charges, the government introduced legislation that restricted federal cash transfers. This led Alberta and other provinces to rethink their financing policies (Werling 1992). This shows the need to have clear and well-articulated policies and legislations.

ii. Balancing Inter-Regional Equity

Studies done in Papua New Guinea showed that costs rose and inequity escalated following decentralization (Thomason et.al., 1991). Their findings showed that the health headquarters proved to be ineffective in resolving the problem. Other countries have had difficulties in designing appropriate and politically acceptable criteria to allocate resources in a manner that reduces inequity (Sikosana et. Al, 1996).

iii. Capacity Building

A common operational problem in decentralization is lack of managerial capacity. The success of its implementation hinges upon adequacy of administrative and managerial capacity of the unit to which responsibility is devolved. A review of the Bamako initiative schemes in five African countries concluded that strengthening the capacity of lower levels of the health care is a prerequisite for successful decentralization (McPake et al., 1992). Pertinent issues are: whether decentralization should precede capacity building, the best composition of District Boards, appropriate skill mix and leadership of the health care management teams both from professional and technical view, assessment of processes and responsibilities of supervision and management of the decentralized systems.

iv. Evaluation and Monitoring

Some researchers concluded that there has been overemphasis on the content rather than reform processes, which has persistently led to implementation problems and that there has been insufficient evaluation on the effects of the reform processes (Thomason 1997).

v. Other issues

Decentralization has been an ideologically attractive concept, promoting values such as devolution of powers to the people and local decision-making. In reality, it has failed to produce the hoped for consequences as indicated in recent studies in Papua New Guinea (Thomason et al., 1991), and Brazil (Araujo Jr., 1997).

In Ghana the concept has had profound implications for the organization of the health sector, and the ministry of health is restructuring itself to facilitate the process (Cassels and Janovsky 1992). Ghana and Zambia have reported impressive degrees of success despite setbacks initially reported. Both countries however have integrated decentralization of health services with local government authority. Autonomy of health service delivery at lower levels has been transferred from the central government to local authority health facilities as the first contact for patients, with the District health facilities acting as first referral level (Cassels and Janovsky 1992).

Confusion about lines of authority and of accountability can also arise, where the central ministry retains the authority to hire some staff, yet supervisory role remains at the facility or provincial level. It requires the Central Ministry to give up some authority and the lower levels to assume it (Cassels and Janovsky 1992).

Despite many pitfalls as indicated in various studies, some degree of success has been reported in a number of countries. For example, in Benin, devolved decision-making has contributed to an increase in health care delivery and reinforced partnership with local communities. In Botswana and Tanzania decentralization has led the government to define its priorities to avoid exclusion of under-privileged population groups. In both countries this process has taken the form of transfer of sectoral responsibilities to elected local governments. However, in some cases, there has been discernible conflict over proprieties. There are cases where centrally designed programmes and projects come with money, which determines action without much local discussion or relevance or alternative priorities (Magedal et.al., 1995).

Proponents of decentralization argue that a centralized bureaucracy suffers from undue administrative rigidity, over extension and inability to tailor services to the needs of a heterogeneous clientele. Many countries have pursued the concept as a solution to delays, which are caused by congestion in channels of administration and communication. Literature exists to show increased government responsiveness to local public problems, which indicate that it is possible for the quality and quantity of services provided to the local communities to be upgraded.

Mark More (1995) suggests that the new demands in the health sector can only be successfully addressed in an entrepreneurial way. He adds that public managers must be enterprising, initiating and facilitating changes that will promote sustainability and viability of public service. Massie (1987) shares this view as she says hospitals in the USA are perceived and managed more like businesses.

Tom Peters (1994), however, has a radical approach for a solution. He reckons that "Crazy times call for crazy organizations". He argues that beyond decentralization, organizations need more than change. He prescribes a revolutionary approach of abandonment and not

incremental change. He says more and more decentralization makes sense when an organization or public service provider has to deal with an exploitation of unknowns. He proposes the approach of creating small independent business units.

2.2 Gaps in Research on Decentralization of Health Care Delivery in Kenya

Many countries in East and Southern Africa have undergone decentralization as a process of the health sector reforms, with the common goal of improving efficiency and effectiveness in service provision and delivery. It was envisaged that this would help promote greater accessibility, equity and quality of health care services. In Tanzania, Public Health Committees exist and meet regularly but their legal status is unclear, thus limiting their potential influence (Pichette and Mtasiwa 2001).

In Kenya, District Management Boards and Committees as well as Hospital Management Boards have been instituted under the auspices of District Development Committees and provide a clear forum but in reality their influence is often lacking (Sikosana et.al., 1996). Recent studies done in Kenya post decentralization showed that inefficiency in the Public Health Care Delivery remains a major concern to increasing access to health services in the country (Wasunna and Munga 1997). Other researchers concluded that more studies should be done to assess effectiveness of decentralization of the Health Sector in Kenya. They propose that a state of the art examination of the decentralisation process be done to help examine constraints to the effectiveness of the existing model. This will also help examine the long term framework, effects of more decentralisation on the provision of health care services, and role of the Ministry of Health headquarters vis – a -vis other tiers in the future (Wasunna 1997).

A recent study done in Kenya (Wasunna *et. al.*, 2001), highlighted the following findings:

Weak administrative linkages between the centre (MOH Headquarters), PMOs

A recent study done in Kenya (Wasunna *et. al.*, 2001), concluded the following:

- Weak administrative linkages between the centre (MOH Headquarters), PMOs office and DHMB, adversely affecting provision of health services.

- Infighting between the provincial and district tiers due to lack of clarity of role and responsibilities as well as terms of reference of PHMTs.
- Ineffective PMO Inspectorate.
- Priority setting done by the PMOs office, hence subversion of district priorities and impairment of the planning process.
- Ineffective linkages within the MOH itself and with other stakeholders in service delivery.
- Weak intra/inter-sectoral coordination, particularly donor activities, sometimes causing conflicts among personnel.
- External interference in the deployment of health personnel in district facilities.
- Lack of capacity building at district level.
- Lack of Policy and Legislation that support the new responsibilities.

Studies in other countries have also concluded that there is need for further research on the effects and impact of health sector reform processes as a whole. Research on the incremental administrative costs of decentralization is needed accounting for increases at the local level and any decrease, if any at the centre. Such research will assist governments to make cost effective decisions regarding decentralization (Bossert 1993).

Mills (1994) notes that, although there's a growing volume of literature that describes financial and organizational reforms in developing countries, evaluation of these reforms is conspicuously lacking. The dissemination of experience from both developed and developing countries should prove helpful for the development of indicators, analytical tools and information systems.

Thomason (1997) raised several issues that need more research work. She suggests that more studies be done on issues such as what underlies decentralization? She further suggests that mechanisms for monitoring the effects of health sector reform processes are needed to predict effects of reform proposals such as the effects of decentralization on the operations of the health sector. Other researchers concluded that even in the developed world, like New Zealand, reforms have been described as **Jumping on the spot** and have required significant increases in funds to sustain (Maynard and Bloor 1995). Reforms in the United Kingdom are hard to evaluate because they were implemented in conjunction with large increases in funding and the effects of funding and reforms are difficult to separate (Maynard 1994).

In the developing world, there's even less evidence of the success of health sector reform processes in achieving their broader objectives, partly due to absence of systematic monitoring and evaluation of the reform processes in the decentralized system. Many other issues have been raised in previous studies, which call for further research.

More research on these issues is required and it should consider country experiences with setting and monitoring national policies and standards and review options for making good infrastructure management. One of the challenges for Ministries of Health, which intend to decentralize health services or purchase them directly from private sector, lies with ensuring that there's value for taxpayer's money in terms of quality and quantity of service delivery.

In evaluating the success of decentralization of healthcare delivery, assessing perceptions of the health care provider (staff in Government Provincial Hospitals) and the consumer of services (patients) forms an important study topic.

CHAPTER III: RESEARCH METHODOLOGY

3.1 Research Design

The aim of the survey exercise was to generate data in determining and evaluating the effect of decentralization on Provincial Government Hospitals (PGHs) and the level of perceived efficiency in the same. In order to achieve the aforementioned objectives, survey study was done since it is a suitable method of collecting views of respondents in the target population. The set of objects studied involved sampling of conveniently selected cadre of hospital staff, Inpatients and Outpatients. Interviews conducted through the questionnaires were used to elicit various views and perception of merits and demerits on decentralization of Health Care Delivery Systems

3.2 Scope of study

This study was conducted on conveniently selected Hospital Staff, Inpatients and Outpatients in each of the selected Provincial Government Hospitals namely New Nyanza, Rift Valley and Embu. These Provincial Government Hospitals have been selected due to various reasons.

New Nyanza PGH is normally heavily burdened by recurring highland malaria and other disease epidemics while Rift Valley PGH is situated on the Nairobi Kisumu highway, which is notorious for road accidents. Embu PGH has been reported in recent studies as one the most successful with reference to Health Sector Reforms.

3.3 Population of study

The population of the study was drawn from the selected Provincial Government Hospitals in Kenya. There were two types of respondents, namely staff and patients. It comprised of all the staff and patients who were at or visiting the selected hospitals at the time the interviews were conducted.

3.4 Sampling

Convenient sampling was done whereby interviews were conducted on selected staff, outpatients and Inpatients.

Staff respondents in each hospital were divided into three categories: Senior Management, Middle Management and Lower Management. Senior Management in each hospital were to comprise five (5) respondents selected from the level of Medical Superintendents, Hospital Matrons, Casualty In-charges, the Provincial hospital departmental heads including Physicians, Surgeons and Pharmacists.

Selection of fifteen (15) middle management staff in each hospital was to be done as follows: four (4) clinicians (two clinical officers and two medical doctors) at the OP clinics, two (2) records officers (one each from OP and casualty departments respectively), five (5) nurses, out of whom three (3) were to be Ward In-Charges and one (1) each from OP and Casualty treatment rooms respectively. The rest were to be selected as follows: Laboratory in-charge, Theatre Officer and two (2) Senior Staff at the X-Ray department.

The lower cadre of staff were to consist of ten (10) respondents: seven (7) patient attendants, two from the OP clinics, one each from four selected wards and one from the OP-Pharmacy. The remaining three (3) were to be selected one each from the X-ray Department, Casualty and Main Theatres.

In the Patient category, five (5) Inpatients and five (5) Outpatients of both sexes were to be sampled in each hospital. A convenient sampling method was used whereby a questionnaire was administered to Inpatients who had been discharged and were yet to leave as well as Outpatients leaving the Pharmacy after collecting their medication. These patients were chosen because they were expected to be in a position to answer questions since they would have gone through the whole treatment cycle. Selection of hospital staff had been carefully done to include only those perceived to be conversant with the activities related to the objects of the study. The guiding principle adopted here was that the survey would have convenient sample size, which has in-built desired qualities of near representation, reliability, efficiency, flexibility, and cost effectiveness.

It was envisaged that a sample of 30 hospital staff selected from various categories and ten (10) patients, that is (5) five In-patients and five (5) Out-patients is large enough to provide adequate cross-sectional data that would allow meaningful statistical analysis and inferences to be made for each hospital. The data when pooled together should also be able to provide regional and national inferences about the level of success of decentralization of healthcare delivery systems.

3.5 Data Collection

Data collection was mainly from primary sources because management of the hospitals were reluctant to allow perusal of hospital records by the researcher. Structured questionnaires were used to collect primary data on selected defined topics in the questionnaire. Two questionnaires were used, one for staff and the other for patients. Primary data was collected through structured questionnaires administered by Research Assistants. The questionnaires are divided into four sections namely: Section I – Bio-data; Section II will focus on objective 1; Section III on objective 2; and Section IV on objective 3.

3.6 Data Analysis

The data collected from the survey was analyzed using SPSS (Statistical Package for Social Sciences). Data was be checked for accuracy and consistency before it was entered. A systematic analysis of the data was carried out for the various variables and parameters related to: proportion of referral patients in relation to those coming directly to the hospital, frequency of patients being referred to provincial hospitals with cases that can effectively be dealt with at the district hospitals, and efficiency in the patient referral system. The statistics captured from the analysis include measures of central tendency. The results were presented using tables and bar charts where appropriate.

CHAPTER IV: RESEARCH FINDINGS AND DISCUSSION

4.1 Introduction

A Survey on effects of decentralization on healthcare delivery services was carried out in three selected Provincial Government Hospitals namely: New Nyanza, Nakuru and Embu. It had been envisaged that a fourth hospital Coast Provincial Hospital would be included in the survey, however, its management's reluctance to grant authority to collect data resulted in its exclusion. Reasons given were attributed to some recent changes in the hospital management staff.

The survey was conducted in the month of August and September, 2003 in the three selected hospitals: New Nyanza, Nakuru and Embu. There were two samples of structured questionnaires. One was for Hospital Staff and the other was for both Inpatients and Outpatients and a team of Research Assistants collected data.

4.2 Type of Respondents

Two groups of respondents were used, namely hospital staff and patients.

4.2.1 Hospital Staff

A structured questionnaire was used to gather quantitative data. The questionnaire was divided into three sections. Section I dealt with Bio-data where background information was elicited i.e., Name of Hospital, Designation/Title of Staff, Department/section, Age, Gender, Academic and Professional qualification and Number of years worked at the hospital. Section II covered questions on types of services offered and channels of access to the hospital. Section III contained questions related to efficiency in treatment processes.

The study targeted staff in senior, middle and lower management. Sample size in the target population was (30) in each hospital or 90 overall. Out of the expected total sample of 90 in all the three hospitals, 71 (78.9%) answered the questionnaire. The composition of the 71 was: 3 in senior management, 65 in middle management and 3 in lower management. The distribution of the respondents, departments and sections is shown in table 4. Out of 71 respondents, there were 37 (52.1%) males and 34 (47.9%) females. The distribution of their

ages was: (i) 20 to 30 years, 39.4%, (ii) 31 to 40 years, 25.4%, (iii) 41 to 45 years, 21.1% (iv) 46 to 50 years, 12.7%, and 51 to 55 years, 1.4%.

Table 3: Percentage Distribution of Hospital Staff (Respondents) by Hospital

Hospital Name	No of Respondents	Percentage
1. New Nyanza Provincial General Hospital	28	39.4
2. Nakuru Provincial General Hospital	20	28.2
3. Embu Provincial General Hospital	23	32.2
TOTAL	71	100

Table 4: Percentage Distribution of Hospital Staff (Respondents) by Department/Section

Hospital Name	No of Respondents	Percentage
1. Administration	7	9.9
2. Out-patient/Casualty Clinic	23	32.4
3. Laboratory Dept	3	4.2
4. X-ray/Imaging Dept	5	7
5. Wards	17	23.9
6. Surgery/ theatre	8	11.3
7. Orthopedics (OPD)	2	2.8
8. Dispensing/Pharmacy Dept	3	4.2
9. Accounts Dept	1	1.4
10. Records/Information Dept	2	2.8
TOTAL	71	100

All the 71 Hospital Staff had acquired academic qualification of at least Form Four and only 5 (7%) had no formal professional training. 51 (71.8%) had worked in their respective hospitals for more than two years, hence were able to effectively compare the situation before and after decentralization was implemented.

4.2.2 Patients

The instrument of gathering quantitative data from patients was a structured questionnaire, which covered several aspects of patient's background and was divided into four sections. Section I dealt with Bio-data where background information was elicited: Name of Hospital attended, Patient's Status (Inpatient or Outpatient), Age, Gender and Marital Status. In Section II information extracted included how the patient decided to come to the particular hospital. Section III dealt with what reasons the patient had for coming to the hospital and here the common reasons ranged from specialized treatment, proximity, accident/emergencies, relationship with staff or merely on personal preference. The last section IV,

was designed to capture information on efficiency: (a) For both outpatient and inpatient, how long it took the patient to be attended at different stages of the treatment process. Furthermore, questions were raised in this section to probe whether the patients had to influence the speed at any of the service delivery processes, and if so, the specific activity and reasons for the influence; availability of facilities and efficiency of the services. Lastly, the patients were asked to rate the overall quality of the services they received at the hospital.

15 inpatients and 20 outpatients constituting 42.9% and 57.1% respectively, completed questionnaires as reflected in table 5.

Table 5: Distribution of Respondents (patients) by Type and Hospital

Hospital Name	Patients' Status					
	Inpatient		Outpatient		Total	
	Number	%	Number	%	Number	%
1. New Nyanza Hospital	6	17.1	9	25.7	15	42.9
2. Nakuru Provincial Hospital	4	11.4	6	17.1	10	28.6
3. Embu Provincial Hospital	5	14.3	5	14.3	10	28.6
TOTAL	15	42.5	20	57.1	35	100.0

As shown in table 5, 15 or 42.9% of the patients were aged between 20 and 30 years, followed by 9 (25.7%) aged between 31-40 years, 5 (14.3%) aged below 20 years, 3 (8.5%) and 3 (8.6%) falls under 41-45 and above 55 years respectively.

4.3 Effects of Decentralization on the Delivery of the Healthcare Services as Perceived By Staff

Despite the fact that provincial government hospitals function as referral facilities, their effectiveness is determined by various factors whose parameters have been highlighted in this section. Their performance largely depends on the effectiveness of the district hospitals and lower level health facilities which determines the number of cases referred and therefore, efficiency of the PGH's referral system.

4.3.1. Types of Services Offered

The findings indicate that all the three provincial government hospitals offer a 24 hour referral/emergency services as well as out-patient and in-patient services, besides vertical programmes like immunization, Mother and Child Health (MCH).

4.3.2 Relationship between decentralization of services and the percentage of patients referred

The ratings by patients on the effect of decentralization on referrals from district hospitals are presented in table 6.

Table 6: Ratings by Hospital Staff on the effect of decentralization on the percentage of referrals.

Hospital	Respondents' Ratings of changes in the Proportion of Referrals									
	Highly Increased		Moderately Increased		Not Affected		Moderately Decreased		Highly Decreased	
	No	%	No	%	No	%	No	%	No	%
New Nyanza	8	8.0	5	7.0	7	9.9	8	11.3	-	-
Nakuru	5	7.0	3	4.2	6	8.5	6	8.5	-	-
Embu	3	4.2	5	7.0	4	5.6	10	14.1	1	1.4
Totals	16	19.2	13	18.2	17	24.0	24	33.9	1	1.4

As shown on table 6, generally the number of cases referred to the PGHs from other health facilities have moderately decreased, as indicated by the highest frequency of rating of 33.9% by hospital staff.

Table 7 below shows that 'Self Preference' as a channel of accessing services at the PGHs has highly increased (33.8%). It is also shown that referrals from district hospitals to the Provincial Government Hospitals are rated as moderately decreased by majority, 19 (26.8%) of the patients; while other channels like referrals from health centres/ dispensaries, influential relatives and friends, and staff have not been affected by decentralization. It is

important, however, to note that out of 71, a few did not respond to this question as reflected in Not Stated column in the table.

Table 7: Perceived effect of decentralization on different channels of accessing Healthcare Services.

Channels Of Access	Respondents' Perceptions													
	Highly Increased		Moderately Increased		Not Affected		Moderately Decreased		Highly Decreased		Not Stated		Total	
	No	%	No	%	No	%	No	%	No	%	No	%	No	%
Direct (Self Preference)	24	33.8	10	14.1	17	23.9	11	15.5	1	1.4	8	11.3	71	100.0
Referrals from District hospitals	13	18.3	16	22.5	14	19.7	19	26.8	2	2.8	7	9.9	71	100.0
Referrals From Health Centres/ Dispensaries	11	15.5	12	16.9	17	23.9	14	19.7	11	15.5	6	8.5	71	100.0
Influential Relatives and Friends	14	19.7	10	14.1	27	38.0	10	14.1	1	1.4	9	12.7	71	100.0
Staff	9	12.7	17	23.9	27	38.0	3	4.2	2	2.8	13	18.3	71	100.0

In response to question 15 and 16 on the questionnaire, findings reveal that 34 or 47.9% of the respondents felt that the channels of accessing health services at the Provincial General Hospitals (PGH) determine the quality and speed of service delivery, while 35 or 49.30% felt that it had no affect. Overall, the findings show that majority of patients prefer to seek treatment directly at the PGHs rather than District Hospitals or other lower level health facilities. However, it should be noted that higher proportion of "Direct" patients will most likely affect efficiency of service delivery and hence the overall performance of the PGHs as referral facilities.

4.3.3 Common Clinical Cases Referred to the Provincial Government Hospitals, those that can effectively be handled at the District Hospitals and major reasons for such referrals

Questions 17 - 19 in section III of the questionnaire refer to:

- i) The common clinical cases referred to the PGHs
- ii) Those that can effectively be handled at the District Hospitals.
- iii) The major reasons for referrals

Perceptions of respondents are presented in tables 8 -to 10 below

Table 8: Percentage Distribution of Common Clinical Cases Referred to PGHs

Name of Hospital	Common Clinical Cases Referred Here To Hospital																					
	Accidents/ Emergencies		Simple Surgical Cases e.g ENT		Both Accidents And Surgical cases		Chest Pains/ TB		Malaria Anaemia etc		HIV/AIDs Anaemia		Laboratory Investigation Cases		Abdominal Emergencies Of all Types		Maternity/ Gynaecology/ Paediatric cases		Not Stated		<u>Total</u>	
	No	%	NO	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%
New Nyanza	3	4.2	13	18.3	5	7.0	2	2.8	2	2.8	1	1.4	1	1.4					1	1.4	28	39.4
Nakuru	2	2.8	4	5.6	-	-	-	-	4	5.6	3	4.2	-	-	2	2.8	2	2.8	3	4.2	20	28.2
Embu	1	1.4	7	9.9	2	2.8	-	-	8	11.3	-	-	-	-	1	1.4	3	4.2	1	1.4	23	32.4
Total	6	8.5	24	33.8	7	9.9	2	2.8	14	19.7	4	5.6	1	1.4	1	1.4	5	7.0	5	7.0	71	100.0

Table 9: Percentage Distribution of Common Clinical Cases referred but can effectively be handled By District Hospitals

Name of Hospital	Common Clinical Cases Referred Here To Hospital																					
	Accidents/ Emergencies		Simple Surgical Cases e.g ENT		Both Accidents And Surgical cases		Chest Pains / TB		Malaria Anaemia/ Meningitis		HIV/AIDs Anaemia		Consultancy Specialized Cases/Blood Transfusion/ Diabetes		Intestinal/ Obstruction/ diarrhea etc		Maternity/ Gynecology/ Pediatric cases		Not Stated		<u>Total</u>	
	No	%	NO	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%
New Nyanza	8	11.3			4	5.6	1	1.4	4	5.6	1	1.4	4	5.6	1	1.4	2	2.8	1	1.4	28	39.4
Nakuru	2	2.8	3	4.2	-	-	-	-	6	8.5	2	2.8	2	2.8	1	1.4	-	-	4	5.6	20	28.2
Embu	1	1.4	3	4.2	1	1.4	-	-	10	14.1	-	-	2	2.8	-	-	4	5.6	2	2.8	23	32.4
Total	11	15.1	6	8.4	5	7.0	2	2.8	20	28.2	3	4.2	8	11.2	2	2.8	6	8.4	7	9.8	71	100

In table 8 above, it is indicated that of the listed clinical cases commonly referred to PGHs, the most prevalent are: Malaria/Anaemia (mentioned by 14 or 19.7% of the respondents) and Minor Surgical Cases (mentioned by 24 or 33.8% of the respondents).

Table 9 shows clinical cases commonly referred to PGHs but can effectively be handled at the District Hospitals. Coincidentally, Malaria/Anemia and Minor Surgical cases were rated highest as they were mentioned by 19 or 26.8% and 14 or 19.7% of the respondents respectively.

Table 10 shows the major reasons for referrals as perceived by respondents:

Table 10: Percentage Distribution of Ratings on Changes in the Reasons for Referral

Reasons for Referral	Ratings of Changes in Reasons													
	Highly Increased		Moderately Increased		Not Affected		Moderately Decreased		Highly Decreased		Not Stated		Total	
	No	%	No	%	No	%	No	%	No	%	No	%	No	%
Specialized Treatment	37	52.1	14	19.7	8	11.3	9	12.7	-	-	3	4.2	71	100
Proximity	10	14.1	21	29.6	28	39.4	5	7.0	-	-	7	9.9	71	100
Relationship with Staff	4	5.6	16	22.5	33	46.5	4	5.6	4	5.6	10	14.1	71	100
Accidents/Assaults	23	32.4	18	25.4	14	19.7	9	12.7	2	2.8	5	7.0	71	100

As it can be observed in table 10, the most prevalent reasons for referrals and which have been rated by the majority of respondents as having highly increased are:

- i) Specialized Treatment, 37 or 52.1%
- ii) Accidents/Assault, 23 or 32.4%.

Comparative analysis of ratings on effect of decentralization on reasons for referrals reveal that New Nyanza Hospital had the highest rate of increase in minor surgery and accidents/assault, (as mentioned by 19 or 26.8% and 13 or 18.3% respectively), while Embu had 12 or 16.9% and 5 or 7.0% and Nakuru had 6 or 8.5% and 5 or 7.0%, respectively.

These findings show that some of the cases referred to Provincial Government Hospitals (PGHs) can effectively be handled at the District Hospitals – that is, if the District Hospitals

are well equipped and are effective in referring only cases that cannot be handled at that level. If this is done, the PGHs will be free to perform better as the referral level.

4.3.4 Perception of Staff on the Effects of Decentralization on Efficiency of Service Delivery at various stages and processes of treatment.

Perception of staff on the effects of decentralization of Changes in efficiency of service delivery at various stages and processes is covered in this section. Questions 21 to 26 cover various aspects of efficiency:

- i) Level of efficiency at the various stages of treatment process.
- ii) Efficiency in mechanisms for feedback on performance.

(i) Level of efficiency at the various stages of treatment process.

Perceptions of staff on the effect of decentralization on efficiency of service delivery at various stages and processes of treatment are presented in table 11.

Table 11: Percentage distribution of ratings of changes in efficiency at various stages and processes of treatment.

Process/Stage	RATING											
	Highly Increased		Moderately Increased		No Affected		Moderately Decreased		Highly Decreased		Not Stated	
	No	%	No	No	No	%	No	%	No	%	No	%
Admission	16	22.5	17	23.9	14	19.7	10	14.1	2	2.8	12	16.9
Casualty	14	19.7	22	31.0	13	18.3	7	9.9	2	2.8	13	18.3
Surgery	19	26.8	14	19.7	17	23.9	8	11.3	-	-	13	18.3
Pathology	16	22.5	12	16.9	22	31.0	9	12.7	-	-	12	16.9
Pharmacy	13	18.3	21	29.6	13	18.3	7	9.9	2	2.8	15	21.1
X-ray/ Medical Imaging	14	19.7	20	28.2	19	26.8	9	12.7	-	-	9	12.7
Catering (Food)	8	11.3	15	21.1	22	31.0	7	9.9	3	4.2	16	22.5

Table 11, shows that efficiency is perceived to have increased either moderately or highly in all the activities except Nursing Care, Surgery and Catering (Food) services in the wards. However, where efficiency was perceived to have decreased, main reasons given were:

- Understaffing/lack of specialized staff at PGHs
- Impact of HIV/AIDs
- Lack of necessary equipment and specialized staff at the District Hospitals, hence some cases that can be handled at District hospitals are referred to PGHs.

Further, responses given in question 22, explain the increase in efficiency of service delivery at PGHs as due to the fact that fewer cases are now referred to these facilities as compared to the situation before decentralization. This is further supported by the findings in Section 4.3.1 where it was revealed that the number of referrals from District Hospitals to PGHs has moderately decreased.

(ii) Mechanisms for feedback on performance.

Various aspects of mechanisms for feedback on performance is covered in this section. All the three PGHs were indicated to have similar complaint handling mechanisms namely: Through Relevant Officers and Departmental Heads, Suggestions Boxes (except Nakuru), Administrative Officers and Social Workers.

The findings on the level of efficiency in Service Delivery show that, generally, there is improvement at the PGHs. However, there is still need for further improvement as it is indicated that lack of equipment/facilities and specialized staff at both the District and Provincial General Hospitals are affecting efficiency at PGHs.

4.4: Effects of Decentralization on the Delivery of the Healthcare Services as received By Patients

4.4.1 Proportion of Direct and Referred Patients

Question 6 in section II of the patient's questionnaire refer to 'How Patients Were Referred to the PGHs. Table 12 show the distribution of responses against the common channels of accessing health care services.

Table 12: Percentage distribution of patients by channel of referral to the PGHs

Name of PGHs	Who Referred the Patient to the Provincial Government Hospital													
	Referred From District Hospitals		Referred from Health		Referred from Dispensaries		Introduced By Staff		Personal Preference		Referred from Private Clinics		Totals	
	No	%	No	%	No	%	No	%	No	%	No	%	No	%
New Nyanza	2	5.7	1	2.9	2	5.7	-	-	8	22.9	2	5.7	15	42.9
Nakuru	2	5.7	1	2.9	-	-	1	2.9	4	11.4	2	5.7	10	28.6
Embu	1	2.9	2	5.7	-	-	-	-	7	20.0	-	-	10	28.6
Totals	5	14.3	4	11.4	2	5.7	1	2.9	19	54.3	4	11.4	35	100.0

Table 12 above shows 'Personal (Self) Preference' as the most prevalent channel of accessing healthcare services at the PGHs. This is consistent with our earlier findings in section 4.3.1 of this chapter, where 'Self Preference' as a channel of accessing services at the PGHs was rated as having highly increased. However, this direct access to health services at the provincial hospitals is much lower compared to combined referrals which together constitute 70.1%.

4.4.2: The Patients' Reasons For coming to the PGH's

Question 7 in Section III of the questionnaire sought patients' reasons for seeking services at the PGHs. Table 13 below shows distribution of the responses.

Table 13: Percentage Distribution of reasons for coming to The Provincial Hospital

Name of Hospital	Reasons for Coming to the Particular PGH											
	Specialized Treatment		Proximity		Accidents		Relationship with Staff		Personal Preference		Total	
	No	%	No	%	No	%	No	%	No	%	No	%
New Nyanza	6	17.1	6	17.1	2	5.7	1	2.9	-	-	15	42.9
Nakuru	5	14.3	2	5.7	-	-	1	2.9	2	2.9	10	28.6
Embu	4	11.4	6	17.1	-	-	-	-	-	-	10	28.6
Totals	15	42.9	14	40.0	2	5.7	2	5.7	2	2.9	35	100.0

In table 13, the major reasons given by the patients for seeking treatment in these PGHs were: Specialized Treatment at 15 or 42.90% and Proximity at 14 or (40.0%, respectively).

4.4.3: Level of Efficiency

Question 8 to 11 in Section IV of the questionnaire required the patients to rate parameters of measuring efficiency:

- i) Time taken to be attended at various treatment stages
- ii) Availability of supplies/services
- iii) Overall quality of service delivery

i) Time Taken To be Attended at Various Treatment Stages

It is important to note that **NOT** every respondent required to go through all the listed stages of the treatment process. Table 14 and 15 below shows time taken by both Outpatient and Inpatient respondents to be attended at various stages of treatment process.

Table 14: Distribution of Responses by Time Taken for Outpatients to be attended at various stages of the treatment process

Process	Below 1Hour		2hrs –3hrs		4hrs to 5hrs		6hrs to 7 hrs		Over 7hrs		Totals seen at Treatment Stage	
	No	%^	No	%	No	%	No	%	No	%	No	%
Registration	20	90.9	2	9.1	-	-	-	-	-	-	22	100
1 st consultation	15	75.0	5	25.0	-	-	-	-	-	-	20	100
Pathology (X-ray, Lab etc)	6	66.7	3	33.3	-	-	-	-	-	-	9	100
2 nd Consultation	6	85.7	1	14.3	-	-	-	-	-	-	7	100
Pharmacy	13	68.4	5	26.3	1	5.3	-	-	-	-	19	100
Theatre	3	75.0	1	25.0	-	-	-	-	-	-	4	100
Payments	18	85.7	3	14.3	-	-	-	-	-	-	21	100

In table 14, it is observed that the majority of respondents indicated that in all the stages they were attended to in Less than one (1) hour, few were attended to within three hours and only one spent up to 5hrs to be served at the Pharmacy.

Table 15: Distribution of Responses By Time Taken for In-patients to be attended at various stages of the treatment process

Process	Below 1Hour		2hrs –3hrs		4hrs to 5hrs		6hrs to 7 hrs		Over 7hrs		Totals seen at Treatment Stage	
	No	%^	No	%	No	%	No	%	No	%	No	%
Admission	13	81.25	1	6.25	1	6.25	-	-	1	6.25	16	100
Bed	13	86.70	1	6.70	1	6.70	-	-	-	-	15	100
Ward	6	66.70	3	33.30	-	-	-	-	-	-	9	100
Consultation	6	66.70	2	22.203	1	11.10	-	-	-	-	9	100
Pathology (X-ray, Lab etc)	3	42.90	2	28.60	1	14.30	1	14.30	-	-	7	100
Theatre	2	40.00	2	40.00	1	20.00	-	-	-	-	5	100
Discharge	3	33.30	3	33.30	1	11.10	2	22.20	-	-	9	100
Payments	6	60.00	3	30.00	1	10.00	-	-	-	-	10	100

In tables 14-15, it is observed that majority of inpatient respondents showed that in all the stages they were attended to in Less than one (1) hour: Admission, and only a minority took longer to be attended to. One respondent, however, indicated that he had a spent a whole day to be admitted to the wards.

In question 9, respondents were asked if they influenced the speed of services at any of the treatment stages and if so which activity and the methods of influence used. Out of a sample population of 35 patients, 6 (17.1%) said Yes, the remaining 26 (74.3%) and 3 (8.6%) said No and Not Sure respectively. Those who said Yes indicated that the activities influenced were Registration (3), Pharmacy (1), Consultation (1) and Accounts (1) and the approach used were bribery and persuasion.

ii) Availability of Supplies/Services

Table 16 shows the perceptions of those patients who required the listed supplies/services and their ratings on the availability of the same in terms of sufficiency level.

Table 16: Distribution of Patients' Rating of the availability of Supplies and Services

Services/Supplies	Frequency of Ratings					
	More than Sufficient	Sufficient	Not Sufficient	Lacking	Not Sure	Total No needing Service/Supplies
	No	No	No	No	No	No
Bed	-	15	4	-	-	19
Linen (Beddings)	-	10	7	1	-	18
Injections	4	14	7	1	-	26
Oral Medicine	2	16	8	3	-	29
Meals	-	14	3	1	2	20
Counseling	-	5	1	4	2	12

As is shown in table 16, most patients rated the listed services and supplies as having been 'Sufficient'. Timeliness as a factor of efficiency in the provision of supplies and services was rated in question 10 of Section IV of the questionnaire and the responses are presented in table 17 below. Note that **ONLY** perceptions of those who responded to this question are shown on the table.

Table 17: Distribution of Respondents (Patients) Ratings of Timeliness in the Provision of Supplies and Services.

Supplies/Services	Frequencies				
	Timely		Not Timely		Total Number Needing Services/Supplies
	No	%	No	%	
Injections	18	64.3	10	35.7	28
Oral medicines	18	56.3	14	43.7	32
Bed	12	75.0	4	25.0	16
Linen (Beddings)	10	66.7	5	33.3	15
Meals	11	64.7	6	35.3	17
Counseling	5	71.4	2	28.6	7

As shown in table 17, in the provision of supplies and services, it is important to note that although a significant number (71.4%) of respondents indicated that this was timely, a good proportion (28.6%) indicated that it was not timely.

In Question 11 in Section IV of the Questionnaire, the Respondents were asked to rate the overall quality of the services they had received at the hospital and the frequencies are recorded in table 18 below.

Table 18: Percentage distribution of the Respondents' (patients) Rating of the overall quality of service received by the patients at the Provincial Government Hospitals

Hospitals	Respondents' Overall Ratings of the Overall Quality of Service Received											
	Very Satisfactory		Averagely Satisfactory		Satisfactory		Averagely Unsatisfactory		Not Stated		Totals	
	No	%	No	%	No	%	No	%	No	%	No	%
New Nyanza	-	-	10	28.6	3	8.6	2	5.7	-	-	15	42.9
Nakuru	3	8.6	5	14.3	1	2.9	1	2.9	-	-	10	28.6
Embu	4	11.4	1	2.9	3	8.6	1	2.9	1	2.9	10	28.6
TOTAL	7	20.0	16	45.7	7	20.0	4	11.4	1	2.9	35	100.0

The table above shows that the majority, 30 (85.7%) of respondents, found the services received at Provincial General Hospitals at least satisfactory and only 4 (11.4%) indicated that the services were averagely unsatisfactory.

CHAPTER IV: SUMMARY AND CONCLUSIONS

This chapter comprises a summary of findings and discussions, conclusions, limitations and recommendations on Effects of Decentralization on the Delivery of Health Care Services as perceived by both Hospital Staff and Patients.

5.1 Summary

In order to achieve the objectives of the study, the two questionnaires used comprised relevant questions which probed important aspects of Health Service Delivery at the Provincial General Hospital (PGHs). The objectives were to:

- i) Establish the proportion of direct and referral patients at the Provincial General Hospitals.
- ii) Determine how frequently medical cases that can be effectively dealt with at the District Government Hospital are referred to Government Provincial Hospitals
- iii) Determine the level of perceived efficiency of health care service delivery at the Provincial government Hospital.

Various studies have documented the need to monitor and evaluate effects of Health Sector Reform processes such as decentralization. Thus, this study highlights the proportion of direct and referral patients as determined by the channels of accessing services; cases commonly referred to the Provincial General Hospitals which can effectively be handled at the District Hospitals; and the levels of efficiency as measured by the time it takes for a patient to be attended to at various treatment stages as well as availability of certain services and supplies.

Majority of both Hospital staff and Patients rated Self Preference (Referral) as having highly increased since the implementation of decentralization. Majority of the Hospital staff indicated that referrals from the District Hospitals have Moderately Decreased. Of the cases, the need for Specialized treatment was cited by both hospital staff and patient respondents as a major reason for referrals. Referrals due to Accidents/Assaults were also indicated to have highly

increased. Minor Surgery and Malaria/Aneamia due to Malaria were indicated to constitute majority of the Clinical Cases Commonly Referred to PGH's. A majority of staff respondents, indicated that these two types of cases can be handled effectively at the District Hospitals. Referrals due to Accidents/Assaults were indicated to be highest at New Nyanza PGH.

Lack of specialized staff and equipment at the District Hospitals, understaffing at the Provincial Hospitals and the impact of HIV/AIDs were quoted as some of the reasons affecting efficiency at the provincial General Hospitals.

Efficiency was indicated by staff to have moderately increased and this was supported by majority of the patients, who were attended to within one hour at the various stages of the treatment process. Furthermore, majority (85.7%) of the patients rated services at the PGHs as Satisfactory. A small proportion (11.5%) rated overall quality of service at the PGH as Not Satisfactory.

5.2 Conclusions

On the overall, efficiency in service delivery has improved in the Provincial General Hospitals. However, findings of this study show that the PGH's are handling some clinical cases that can be effectively dealt with at the district hospitals, and patients who prefer to seek treatment directly at the PGH, rather than district hospitals and lower level health facilities. This is likely to affect the efficiency and hence quality of service delivery at the PGHs.

This study shows that equipping the district hospitals and lower level health facilities, and improving staffing of specialized staff cadre at the PGHs will improve performance of the PGHs.

It is important to note that from the findings of this study, it is not conclusive that improvement of efficiency of service delivery at the PGHs is solely due to decentralization. In fact other findings of this study show that 32.4% of the staff respondents indicated that the time taken to admit a referral case at casualty at the Provincial General Hospitals has moderately decreased.

5.3 Limitations and Recommendations:

This study was broad and lacking in detail, with three broad objectives. The findings would have been more conclusive if the study narrowed down to only one objective, live "Effects of Decentralization on Efficiency of Healthcare Service Delivery at the Provincial General Hospitals." It is also important to note that senior staff, like departmental heads were too busy to answer the questionnaires while lower management like patient attendants were either timid or semi-illiterate. Departmental Heads double up as Consultants hence they were too busy to answer the questionnaires.

Some questions on the questionnaire were not answered because the respondents (particularly staff) did not know, hence not ready to comment on, what happens in departments or sections other than where they work.

Time constraint was another limiting factor. It would have been more inspiring to conduct the study in all the Provincial General Hospitals in Kenya. Exclusion of Coast Provincial General Hospital from the study was partly due to time limitation. The hospital management had indicated that they would grant the authority if given time to settle. Limited financial resources at the disposal of the researcher constrained the scope of the study

It would be interesting to find out the strategies the government hospitals have developed in order to achieve their goal of providing accessible, acceptable and equitable health care services. It would be highly beneficial to find out the effects of decentralization on the quality of health care services at the District Hospitals, Health Centres and Dispensaries, since these are the levels where implementation of health sector reforms has began.

REFERENCES

- Araujo Jr J. (1997). Attempts to Decentralise in Recent Brazilian Health Policy: Issues and Problems, 1988-1994. *International Journal of Health Services*, 27 (1) 109-124.
- Bossert Thomas (1993). "Sustainability of Health Care Programs in Africa". Concept paper, discussion draft. Washington, DC: United States Agency for International Development.
- Cassels and Janovsky (1996). A Guide to Sector -wide Approaches for Health Development: Concepts, Issues and Working Arrangements, 1997, WHO.
- Cassels A, and Janovsky K (1996). Reform of the Health Sector in Ghana and Zambia: Commonalities and Contrasts. SHS Current Concern Number 11. WORLD Health Organization
- Collins, Araujo, and J. Barbosa (2000). Decentralizing the Health Sector: Issues in Brazil, Health Policy, 2000.
- Government Printers (1994). Kenya Health Policy Framework: 1994.
- Green Andrew (1992). An introduction to Health Planning in Developing Countries. Oxford: Oxford University Press.
- Jane A. Thomason (1997). Health Sector Reform in Developing Countries: A Reality Check.
- Leslie W. Rue, Llyod L. Byars (1977). Management Skills and Application.
- Magedal S et.al., (1995). Health Sector Reform and Organizational Issues at the Local Level: Lessons from Selected African Countries. *Journal of International Development*. Vol.7 No. 3. 349-367.
- Mark H. Moore (1995). Creating Public Value: Strategic Management in Government.
- Maynard A (1994). Lessons from the Reform of the UK National Health Services. *Social Science and Health Sector Reform in Developing Countries: Medicine*, 39(10) 1433-1446.
- Maynard and Bloor (1995). Health Care Reform: Informing Difficult Choices. *International Journal of Health Planning and Management*, Vol 10 247-264.
- McPake, Kara Hanson and Anne Mills (1992). "Experience to Date of Implementing the Bamako Initiative: A Review and Five Country Case Studies." London School of Hygiene and Tropical Medicine, Department of Public Health and Policy, Health Policy Unit
- Michael E. Porter (1985). Competitive Advantage: Creating and Sustaining Superior Performance.
- Mills, Anne. (1990b). "Decentralisation Concepts and Issues: A Review". Anne Mills, J. Patrick Vaughan, Duane L. Smith, and Iraj Tabibzadeh, Eds. Health System Decentralisation: Concepts Issues and Country Experience. World Health Organization, Geneva.

Mills, A., Maganu, J.P. Vaughal, D. L. Smith, and Tabibzadeh (1990). Health System Decentralization: Concepts, Issues and Country Experiences. World Health Organization, Geneva.

Ministry of Health (1999). National Health Sector Strategic Plan 1999-2004, Nairobi.

Owino Wasunna (1997). Health Sector Efficiency in Kenya; Increasing Access to Health Care Services in Kenya. IPAR Discussion Paper Series 007/97.

Wasunna Owino and Sam Munga (1997). Decentralization of Financial Management Systems: Its implementation and Impacts of Kenya's Health Care Delivery. IPAR Discussion Paper Series 006/97.

Owino Wasunna, Paul Odundo and Timothy Oketch (2001). Governance of the District Health Systems.

Patricia Langan (1993). Health Sector Reforms in Developing Countries.

Pichette P. and D. Mtasiwa (2001). The Tanzanian Health Sector Reform. L'Afrique Orientale Annuaire pg 203-274

Rachel Massie (1987). Essentials of Management Administering Health Services.

Regina, E.Herzhinger (1994). Can Public Trust in Non-Profits be restored? Harvard Business Review 1994.

Rondenelli, D.A., J.R. Nellis and G.S. Cheema (1983). Decentralization in Developing Countries: A Review of Recent Experience: World Bank Staff Working Paper No. 581. The World Bank: Washington.

Taal, Housainou (1993). "Decentralisation and Community Participation for Improving Access to Basic Services: An Empirical Approach." Innocenti Occasional Papers, Economic Policy Series 35. Florence, UNICEF International Child Development Center.

Thomason, Jane A., Riitta – Liisa Kolehmainen-Airken, and William C. Newbrander (1991). "Decentralization of Health Services in Papua New Guinea: A Critical Review". In Jane A. Thomason, William C. Newbrander, and Riitta-Liisa Kolhmainen-Airken, Eds. *Decentralization in a Developing Country: The Experience of Papua New Guinea and its Health Service*. Canberra: National Centre for Development Studies The Australian National University.

Tom Peter (1994). The Tom Peters *Seminar*: Crazy Times Call For Crazy Organizations.

Werlin, Herbert (1992). "Linking Decentralization and Centralization: A Critic of the New Development Administration". *Public Administration and Development* 12: 223-235.

Wilson Liambila (2002). Health System in Kenya: AMREF, Nairobi.

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

QUESTIONNAIRE (For Hospital Staff)

EFFECTS OF DECENTRALIZATION ON HEALTHCARE DELIVERY: **A SURVEY OF THE PERCEPTIONS OF HOSPITAL STAFF AND PATIENTS AT SELECTED PROVINCIAL GOVERNMENT HOSPITAL**

QNO: _____

SECTION I - Bio-data

1. Name of Hospital _____

2. Name of Respondent (optional): _____

3. Position/Title: _____

3a) Department/Section _____

4. Age:

- 1. 20-30 Years
- 2. 31-40 Years
- 3. 41-45 Years
- 4. 46-50 Years
- 5. 51-55 Years
- 6. 56 and above

5. Gender:

- 1. Male
- 2. Female

6. **Academic and Professional Qualifications.** (Tick all that is applicable).

- 1. Secondary
- 2. Higher (Form 6)
- 3. Certificate
- 4. Diploma
- 5. Undergraduate
- 6. Post Graduate Qualification
- 7. Any Other Training _____

7. No of years worked at this Hospital?

--	--



SECTION II

8. Does this Hospital offer the following Services?

Outpatient	1. Yes	<input type="checkbox"/>	2. No	<input type="checkbox"/>
In-patient	1. Yes	<input type="checkbox"/>	2. No	<input type="checkbox"/>
Immunization	1. Yes	<input type="checkbox"/>	2. No	<input type="checkbox"/>
Antenatal	1. Yes	<input type="checkbox"/>	2. No	<input type="checkbox"/>
Post-Natal	1. Yes	<input type="checkbox"/>	2. No	<input type="checkbox"/>
Other -specify	<hr/>			

9. Does this hospital provide a 24-hour referral/emergency health services?

1. Yes 2. No

10. What is the average time it takes to admit a patient referred to the Hospital during off regular hours?

1. Below 1hr	<input type="checkbox"/>
2. 1hr to 2hrs	<input type="checkbox"/>
3. 3hrs to 4hrs	<input type="checkbox"/>
4. 5hrs to 6hrs	<input type="checkbox"/>
5. Over 6hrs.	<input type="checkbox"/>

11. To what extent has the implementation of decentralization of Health Care Services affected the number of cases referred to this hospital?

1. Highly Increased	<input type="checkbox"/>
2. Moderately Increased	<input type="checkbox"/>
3. Not affected	<input type="checkbox"/>
4. Moderately decreased	<input type="checkbox"/>
5. Highly decreased	<input type="checkbox"/>

12. On average how long does it take for a referred case received at casualty to be admitted to the wards?

- 1. Below 1hr
- 2. 1 to 2hrs
- 3. 3 to 4hrs
- 4. 5 to 6hrs
- 5. Over 6hrs

13. In reference to question 12 above, to what extent has the time changed due to decentralization?

- 1. Highly Increased
- 2. Moderately Increased
- 3. Not Affected
- 4. Moderately decreased
- 5. Highly decreased

14. To what extent has decentralization affected each of the following channels of accessing Health Services in this hospital?

(Please enter your rating in the appropriate box below)

Key

- 1. Highly Increased
- 2. Moderately Increased
- 3. Not Affected
- 4. Moderately decreased
- 5. Highly decreased

- Directly (Self Preference)
- Referral from District Hospitals
- Referral from Health Centers/Dispensaries
- Through influential relatives and friends
- Through Staff
- All of the above
- Other, specify _____

15. Are any of the above methods of accessing this Hospital adversely affecting the quality and Speed of service delivery?

1. Yes 2. No

16. If yes, to question 15 specify _____

SECTION III

17. In your observation, what are the most common clinical cases referred to this hospital?

18. Which of the above clinical cases could be effectively handled at the District Hospitals?

19. To what extent has decentralization affected each of the following reasons for referral? (Please enter your rating in the appropriate box below)

Key

- 1. Highly Increased
- 2. Moderately Increased
- 3. Not Affected
- 4. Moderately decreased
- 5. Highly decreased

Reasons for Referral:

Specialized Treatment

Proximity

Relationship with Staff

Accidents

Others _____

20. Are there any aspects of the services offered that you think are inefficient?

1. Yes 2. No 3. N/A

21. To what extent has decentralization affected efficiency in the following?
(Please enter your rating in the appropriate box below)

Key:

1. Highly Increased
2. Moderately Increased
3. Not Affected
4. Moderately decreased
5. Highly decreased

Admission

Casualty

Surgery (Theatre)

Pathology

Pharmacy

Consultation

Nursing Care

Food

Other _____

22. In reference to question 22, if efficiency has either highly or moderately decreased what are the reasons?

Admission? _____

Consultation? _____

Surgery? _____

Registration? _____

Pharmacy? _____

Discharge Process? _____

Nursing care in the wards? _____

Pathology? _____

Food? _____

Other Specify: _____

23 Does the hospital have any mechanisms through which complaints are channeled?

1. Yes 2. No 3. Not sure

24 If yes to question (Q23) above, specify

25. If no to question (Q24) above, how do you get to know about complaints?

26. Does the Hospital have a specific department/section that handles public relations?

1. Yes 2. No. 3. Not sure

QUESTIONNAIRE (For Patients)

**EFFECTS OF DECENTRALIZATION ON HEALTHCARE DELIVERY:
A SURVEY OF THE PERCEPTIONS OF HOSPITAL STAFF AND PATIENTS AT SELECTED
PROVINCIAL GOVERNMENT HOSPITALS**

QNO: _____

SECTION 1-Biodata

1. Name of Hospital: _____

2. Patient's Name (Optional): _____

2a) Patient's Status: 1. Out-patient
2. In-patient

3. Age: 1. Below 20 years
2. 20-30 Years
3. 31-40 Years
4. 41-45 Years
5. 46-50 Years
6. 51-55 Years
7. Above 55 years

4. Gender: 1. Male
2. Female

5. Marital Status: 1. Single
2. Married
3. Divorced
4. Widowed
5. Separated
6. Other: _____

SECTION 11

6. How did you decide to come to this hospital?

Referred from District Hospital
Referred from Health Center
Referred from Dispensary
Introduced by Hospital Staff

Personal Preference
Referred from Private Hospital/Clinic

SECTION III

7. **What are your reasons for coming to this particular hospital? (Tick all that apply)**

- 1. Specialized treatment
- 2. Proximity
- 3. Accident (Emergency)
- 4. Relationship with staff
- 5. Personal (Please state) _____
- 6. Other: _____

SECTION IV

8. **How long did it take you to be attended at the following areas?**

a) **Out-Patient: (Please enter your rating in the appropriate box below)**

(Key - Time taken:

- 1. < 1hr,
- 2. 1hr to 3hrs
- 3. 3 hrs to 5hrs
- 4. 5hrs to 7hrs.
- 5. Over 7hrs

- Registration
- 1st Consultation
- Pathology (X-ray, Lab etc)
- 2nd Consultation (if applicable)
- Pharmacy
- Theatre
- Payments
- Other (Specify) _____

b) **In-Patient: (Please enter your rating in the appropriate box below)**

Key i.e Time taken

- 1 < 1hr
- 2 1hr to 3hrs
- 3 3 hrs to 5hrs
- 4 5hrs to 7hrs
- 5 Over 7hrs

- Registration Ward
- Bed Consultation
- Pathology (X-ray, Lab etc) Payments
- Theatre Discharge
- Other (Specify) _____

9. Did you have to influence the speed of any of the activities above? 1. Yes 2. No 3. Not sure

a). If yes, which Activity? _____
 b). Please state reasons _____

10. How would you rate the availability and the efficiency of the following?
 (Please enter your rating in the appropriate box below)

a) Availability (Please enter your rating in the appropriate box below)

Key
 1. More than Sufficient
 2. Sufficient
 3. Not Sufficient
 4. Lacking
 5. Not Sure

Injections
 Oral Medicine
 Bed
 Linen (beddings)
 Meals
 Counselling
 Any Other _____

b). Efficiency (Please enter your rating in the appropriate box below)

Key:
 1. Timely
 2. Not Timely

Injections
 Oral Medicine
 Beds
 Linen (beddings)
 Meals
 Counselling
 Any Other _____

11 Please rate the quality of the service that you have received in this hospital?

1. Very satisfactory
 2. Averagely satisfactory
 3. Satisfactory
 4. Averagely unsatisfactory
 5. Very unsatisfactory

ANNEX 3: LETTER OF INTRODUCTION FROM THE FACULTY



UNIVERSITY OF NAIROBI
FACULTY OF COMMERCE
MBA PROGRAM – LOWER KABETE CAMPUS

Telephone 732160 Ext 708
Telegrams "Varsity" Nairobi
Telex 22095 Varsity

P.O. Box 30197
Nairobi, Kenya

DATE.....

TO WHOM IT MAY CONCERN

The bearer of this letter Ruth O. Wasuna

Registration No: D/GI/P/8851/98

is a Master of Business Administration (MBA) student of the University of Nairobi.

He/she is required to submit as part of his/her coursework assessment a research project report on some management problem. We would like the students to do their projects on real problems affecting firms in Kenya. We would, therefore, appreciate if you assist him/her by allowing him/her to collect data in your organization for the research.

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

Thank you.



**RUTH ONGORO WASUNA
UNIVERSITY OF NAIROBI
FACULTY OF COMMERCE
NAIROBI**

09.09.03

Dear Sir/Madam,

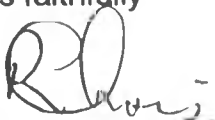
RE: REQUEST TO GET INFORMATION

I am a postgraduate student at the University of Nairobi. In partial fulfillment of the requirements for the award of the MBA degree, I am conducting a study titled "Effects of Decentralization on Healthcare Delivery."

Your hospital, which falls within the point of interest, has been randomly selected to form part of this study. You are kindly requested to assist me collect data by filling the accompanying questionnaire or affording me an opportunity to help you fill it.

The information and data provided will be strictly for academic purposes and will be treated with strict confidence. A copy of the research and suggestions may be availed to your hospital upon request.

Yours faithfully



RUTH O. WASUNA

ANNEX 5: LETTER OF AUTHORIZATION FROM MEDICAL
SUPERINTENDENT – NEW NYANZA PGH

NYANZA PROVINCIAL GENERAL HOSPITAL
P.O. BOX 849 • KISUMU • TEL. 057-44298

ST.2

1st September, 03

MED. SUPT'S DESK

To All Departments

**SUBJECT: RESEARCH ON DECENTRALISATION OF HEALTH
CARE DELIVERY BY DR. WASUNA RUTH - UNIVERSITY OF NAIROBI**

The above named has been allowed to collect data from the Hospital on the above subject. Kindly accord her all the necessary assistance.



DR. J. O. ODONDI
MEDICAL SUPERINTENDENT
PGH - KISUMU

**ANNEX 6: LETTER OF AUTHORIZATION FROM MEDICAL
SUPERINTENDENT – EMBU PGH**

MINISTRY OF HEALTH

Telegrams: MED/SUPT". EMBU
Telephone: Embu 20055/56/57
Fax No. 20159



MEDICAL SUPERINTENDENT,
PROVINCIAL GENERAL HOSPITAL
P.O. Box 33,
EMBU.

Our Ref:
and date

Date

Ref. T.I

15th September 2003

**TO: ALL DEPARTMENTAL HEADS
EMBU P.G.H.**

RE: AUTHORITY TO CONDUCT A RESEARCH

1. GABRIEL ABENO
2. ROBERT OUKO

The above named who are students from Nairobi University have been authorized to conduct some research in this hospital.

Please accord them the necessary assistance.


(DR. J. WEKESA MASASABI)
MEDICAL SUPERINTENDENT
EMBU

ANNEX 7: ENDORSEMENT FOR COLLECTION OF DATA BY MEDICAL SUPERINTENDENT – NAKURU PGH

**RUTH ONGORO WASUNA
UNIVERSITY OF NAIROBI
FACULTY OF COMMERCE
NAIROBI**

09.09.03

Dear Sir/Madam,

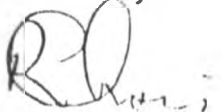
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I am a postgraduate student at the University of Nairobi. In partial fulfillment of the requirements for the award of the MBA degree, I am conducting a study titled "Effects of Decentralization on Healthcare Delivery."

Your hospital, which falls within the point of interest, has been randomly selected to form part of this study. You are kindly requested to assist me collect data by filling the accompanying questionnaire or affording me an opportunity to help you fill it.

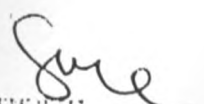
The information and data provided will be strictly for academic purposes, and will be treated with strict confidence. A copy of the research and suggestions may be availed to your hospital upon request.

Yours faithfully



RUTH O. WASUNA

*Authorized to conduct
interview in the
Hospital*



**PROVIDENT GENERAL HOSPITAL
NAIROBI**