

**CHALLENGES OF IMPLEMENTING THE SOCIAL PILLAR  
STRATEGY OF THE KENYA VISION 2030 IN THE DEVOLVED  
HEALTH SECTOR IN KISUMU COUNTY**

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## DECLARATION

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

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

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## **DEDICATION**

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## **ABBREVIATIONS AND ACRONYMS**

<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>CBOs</b>	Community Based Organizations
<b>CDF</b>	Constituency Development Fund
<b>CEC</b>	County Executive Committee
<b>CEO</b>	Chief Executive Officer
<b>CESH</b>	County Executive Secretary for Health
<b>CFSP</b>	County Fiscal Strategy Paper
<b>CHS</b>	Centre for Health Solutions
<b>CIDP</b>	County Integrated Development Plan
<b>CME</b>	Continuing Medical Education
<b>CPD</b>	Continuous Professional Development
<b>ENT</b>	Ear, Nose and Throat
<b>ERS</b>	Economic Recovery Strategy for Employment and Wealth Creation
<b>FBOs</b>	Faith Based Organizations
<b>GDP</b>	Gross Domestic Product
<b>GoK</b>	Government of Kenya
<b>HIV</b>	Human Immunodeficiency Virus
<b>HMSF</b>	Hospital Management services Fund
<b>HMT</b>	Hospital Management Team
<b>HSSF</b>	Health Sector Services Fund
<b>ICEDA</b>	Institute for Civic Education and Development in Africa
<b>ICU</b>	Intensive Care Unit
<b>JOOTRH</b>	Jaramogi Oginga Odinga Teaching and Referral Hospital
<b>KCB</b>	Kenya Commercial Bank

<b>KCHSSP</b>	Kisumu County Health Sector Strategic and investment Plan
<b>KDHS</b>	Kenya Demographic and Health Survey
<b>KEMSA</b>	Kenya Medical Supplies Agency
<b>KHSSP</b>	Kenya Health Sector Strategic and investment Plan
<b>LATF</b>	Local Authority Transfer Fund
<b>MCA</b>	Member of County Assembly
<b>MDGs</b>	Millennium Development Goals
<b>MTEF</b>	Medium Term Expenditure Framework
<b>MTP</b>	Medium Term Plan
<b>NGO</b>	Non Governmental Organization
<b>NHIF</b>	National Hospital Insurance Fund
<b>OJT</b>	On the Job Training
<b>RBV</b>	Resource Based View
<b>UN</b>	United Nations
<b>USAID</b>	United States Agency for International Development
<b>WHO</b>	World Health Organization

## ABSTRACT

Many organizations today have adopted strategic planning as a way to survive in the turbulent, dynamic and complex business environment. Strategy implementation is the action phase of any strategic management process and is often the most challenging than formulating strategies. Strategy should be effectively operationalized and institutionalized in the organization for it to be properly implemented. Organizations go through different challenges in strategy implementation including poor leadership, change management, organization structure, power and politics, inadequate human and material resources and poor information and communication technology. Strategy therefore has to evolve and adapt to the different and unique circumstances that each organization finds itself in. The social pillar strategy has various components including education, science and technology, health, water and sanitation, housing and urbanization. Health care in Kenya is now a devolved function under county governments. This study sought to establish the challenges facing the implementation of the social pillar strategy of the Kenya Vision 2030 in the devolved health sector in Kisumu County, and to determine the measures being put in place to address these challenges. This was a case study of Kisumu County and the primary data was collected using interview guides while secondary data was collected through scrutiny of documents such as minutes of previous meetings, County Integrated Development Plan, County Fiscal Strategy Plan, and County Health Sector Strategic and investment Plan. Key people interviewed were County Executive Secretary for Health, Chief Officer for Health, County Director for Health, Chief executive of Jaramogi Oginga Odinga Teaching and Referral Hospital and Medical superintendent of the Kisumu East County Hospital. Content analysis of collected data was done. The main challenges of strategy implementation in the devolved health sector in Kisumu County were inadequate human resource for health, bureaucratic organization structure, inadequate financing from central government, weak leadership and governance structures, dilapidated or inadequate health infrastructure, political interference, poor information and communication technology, and inadequate pharmaceuticals and non-pharmaceuticals. To remedy the situation the county is looking for more funding by seeking alternative sources including public-private partnerships, more investments in upgrading health infrastructure, recruitment and developing of more human resource, increased investment in preventive and promotive health care, and developing more accountable leadership. It is recommended that alternative financing be sought and collaborations with academic and research institutions be enhanced. Future research could focus on other aspects of social pillar like poverty reduction and youth empowerment, or on the effective models of implementing devolution as a governance strategy in health care.

# **CHAPTER ONE**

## **INTRODUCTION**

### **1.1 Background of the Study**

Many organizations today have adopted strategic planning as a way to survive in the turbulent, dynamic and complex business environment. Successful organizations are open systems that constantly interact with their environment to exploit the opportunities available while minimizing any threats posed to their existence (Meadows, 2008). Their operational environment is both uncertain and complex, and for these organizations to achieve their objectives, they must adjust and align to their external environment through proper strategies. However, the formulation of an excellent strategy does not assure good performance. Indeed many well-formulated strategies fail to realize their objectives because the implementation is not effectively and efficiently carried out, hence creating a gap between strategy formulation and its implementation (Niven, 2006). Strategy implementation is therefore a fundamental process, which ensures that the formulated strategies are executed to achieve organizational objectives.

There are number of theories that anchor strategy implementation. Such theories include the institutional theory, contingency theory, resource based view (RBV), and McKinsey's 7-S framework. Institutional theory is about formal or informal procedures, routines, norms, conventions, moral templates, cognitive scripts and symbol systems in the organization (DiMaggio & Powell, 1991; Clemens & Cook, 1999). Contingency theory posits that there is no one way or universal way to manage,

organize, and lead a company or make decisions. Therefore optimal leadership or decision-making is dependent on various internal and external constraints. The Resource Based View (RBV) suggests that the resources possessed by a firm are the primary determinants of its performance, and they include all assets, capabilities, organizational processes, firm attributes, information, and knowledge controlled by the firm (Wenerfelt, 1984; Barney, 1991).The McKinsey's7-S framework focuses on seven internal, interdependent and mutually reinforcing aspects of an organization that need to be aligned if it is to be successful. These elements include strategy, structure, systems, style, skills, shared values, and staff (Peters & waterman, 1982).

Generally, the health sector in Kenya is severely under-resourced by global standards. For example, in the 2014 – 2015 National Budget, health care was allocated a paltry 2.8% against the Abuja Declaration of a minimum of 15% of the GDP. There is also glaring inequality in resource allocation among the various geographical and economic groups. Health indicators such as infant and child mortality, maternal mortality, immunization coverage, and fertility rates demonstrate a correlation between high poverty levels and poor health outcomes. Kisumu County, with poverty levels of about 60% according to the County Fiscal Strategy Paper (CFSP, 2015), experiences many structural and health challenges which impact negatively on the health of the population. Its performance on the health related Millennium Development Goals (MDGs) is poor, with infant (95 per 1000) and child (133 per 1000) mortality rates that are double the national average, poor maternal and reproductive health, high morbidity and mortality due to malaria, low immunization coverage of 53.6% against national average of 80%, and an HIV/AIDS prevalence of 15.1% against the national average of 6.3% (Blaustein, 2011).

### **1.1.1 The Concept of Strategy Implementation**

Strategy implementation is a fundamental management process that ensures that the formulated strategies are put into practice or actualized. According to Porter (1985), strategy refers to the goals and practices that an organization adopts to survive and gain competitive advantage in the midst of fierce competition by its rivals. Strategic management is defined as the set of decisions and actions that result in the formulation and implementation of plans designed to achieve a company's objectives (Pearce & Robinson, 2007). Johnson and Scholes (1993) point out that successful strategy implementation depends on the organizational structure, resource availability and allocation, and the effectiveness of strategic change management.

Strategy formulation is usually the beginning of a challenging and delicate task, which culminates in strategy implementation and evaluation. According to Johnson (1987), strategy should be effectively operationalized and institutionalized in the organization for it to be properly implemented. Institutionalization of strategy means that it should be aligned to organization's structure, culture, systems and procedures, management style, staffing, skills and resources. Operationalization implies action planning. An action plan indicates what will be done, by whom, when and with what expected results. Action planning provides a link between strategy formulation and action. It is also a tool for monitoring and evaluation.

Given that different organizations undergo unique challenges due to the fluidity of their business environment, they adopt different strategic approaches to be able to survive the turbulences in their circumstances (Mintzberg, Quinn & Ghosal, 1998).



Some of these challenges include poor leadership, change management, organization structure, power and politics, inadequate human and material resources and poor information and communication technology. Strategy therefore has to evolve and adapt to the different and unique circumstances that each organization finds itself in. There is no one strategy that fits all businesses or organizations. Johnson, Scholes and Whittington (2002) observe that implementation involves restructuring and synergizing an organization's systems to support successful performance and change management practices for the effective execution of strategies.

### **1.1.2 The Social Pillar Strategy of the Kenya Vision 2030**

The Kenya Vision 2030 is the master development blueprint in the country whose overall goal is the attainment of a middle-income nation status that will not only be globally competitive and prosperous, but will also accord high quality of life to her citizens. It is anchored on three pillars: economic, political and social. It is implemented in successive five- year medium term plans, the first one having covered the period 2008 -2012, while the current one covers the period 2013- 2017. The economic pillar aims at providing prosperity of all Kenyans by realizing an average Gross Domestic Product (GDP) growth rate of 10 % per annum. Six key sectors were identified and prioritized to act as catalysts for economic growth: tourism, agriculture, wholesale and retail trade, manufacturing, business process off-shoring and financial services. The political pillar aims at realizing a democratic political system founded on issue-based politics that respects the rule of law. The political pillar is based on eight core strategies: constitutional supremacy; sovereignty of the people; equality of citizens; national values, goals and ideology; the bill of rights; a viable political party system; public participation in governance; separation of powers between the three

arms of government; and decentralization of decision-making and resources (GoK, 2008).

While the concept of Sustainable Development generally refers to achieving a balance between environmental, social and economic pillars of sustainability, the social pillar tends to be the most conceptually elusive with varied meanings and diverse applications (Thin, 2002). Murphy (2012) notes that the four pre-eminent concepts within the social pillar strategy include: equity, awareness for sustainability, participation and social cohesion. Further, Murphy (2012) argues that the existing approaches have narrowed the social pillar to national and welfare objectives for current generations rather than broaden it to incorporate international and intergenerational dimensions. The social pillar strategy within the Kenya Vision 2030 has incorporated the environmental sustainability component of sustainable development. It has also incorporated the concepts of equity, participation and social cohesion from which the key priority sectors for development are derived.

The overall aim of the social pillar of Kenya Vision 2030 is to build a just and cohesive society with social equity in a clean and secure environment. Eight key sectors earmarked for development in the social pillar include: education and training; health; water and sanitation; the environment; housing and urbanization; gender, youth, sports and culture; equity and poverty reduction; and science, technology and innovation. This pillar also has special provisions for people living with various forms of disabilities and the previously marginalized communities. In education and training, Kenya will provide globally competitive quality education, training and research. Kenya aims to conserve water sources and start new ways of harvesting and using rain

and underground water. Kenya aims to be a nation that has clean, secure and sustainable environment. Under housing and urbanization, there is need for decent, affordable and high quality urban livelihoods. There is need for equity in power and resource distribution between the sexes, improved livelihoods for the vulnerable groups, globally competitive youth, and a reduction in the number of people living in poverty (GoK, 2008).

In the first MTP (2008 - 2012), several achievements were made in the social pillar. According to Mwenza and Misati (2014) early childhood education increased by 40%; transition from primary to secondary school increased from 64% to 77%; the number of students enrolled at the universities increased by 103%; and more teachers for both primary and secondary schools were employed. The proportion of land under forest cover increased marginally from 3.47% to 3.82%. The youth enterprise fund increased from 2.2 billion in 2009 to 6.5 billion in 2012. Improvements in health care provision were realized as 70% of the health facilities targeted for rehabilitation were completed and a comprehensive medical scheme for civil servants through NHIF implemented. Mwenza and Misati (2014) also observed that there were several obstacles including: negative ethnicity and ethnic conflicts; insecurity and terrorism; official corruption in government; over-reliance on donor funding; brain drain; climatic changes and natural hazards; and the HIV/AIDS pandemic.

### **1.1.3 Kenya's Public Health Sector**

According to The Constitution of Kenya (2010) health care is a devolved function. Devolution, according to Potter (2001), is a form of decentralization involving the transfer of political, administrative and fiscal management powers between central

government and lower levels of government. Kimenyi and Meaghar (2004) note that the advantages of devolution include: distributing authority over public goods and revenues to lower levels; fostering cooperation, harmony and unity of purpose among communities; enhancing democracy by bringing governance closer to the people; improving efficiency in resource allocation; ensuring checks and balances along the various levels of government; empowering the minority and the marginalized; and, tailoring policies and service provision according to local values and preferences. However, empirical evidence about the impact of devolution globally depicts mixed results. For example, Besley and Burgess (2002) noted that decentralization promotes government responsiveness in service delivery to the citizenry in India. But Calamai (2009) in Italy observed that devolution could worsen regional economic and political disparities especially in public spending and accountability. The Constitution of Kenya 2010 envisages regular consultation and cooperation between the central and county governments.

The fourth schedule of the Constitution of Kenya (2010) outlines the functions of the central and county governments. The central government is in charge of policy formulation and national referral hospitals. The county governments are in charge of county health facilities and pharmacies, primary health care, ambulance services, licensing and control of food vendors, veterinary services, cemeteries, refuse and waste disposal, water and sanitation. According to the Kenya Health Policy (2012-2030), health care in the devolved system is organized in a four tier system: the community health services, primary care services, county referral services, and national referral services. The community health services comprise of all community-based demand creation activities, that is, the identification of cases that need to be

managed at higher levels of care. The primary care services are comprised of all dispensaries, health centres and maternity homes for both public and private providers. The County referral services include hospitals operating in, and managed by a given county and are comprised of the former level four and district hospitals in that county but also include public and private facilities. The national referral services include all tertiary referral facilities that provide highly specialized services. In this new structure, the county governments are in charge of the first three levels while the national government is then left in charge of the highly specialized national referral services.

Any good health system must finance and deliver a wide range of public health, prevention and promotion programmes. The Kenya Health Sector Strategic and investment Plan (KHSSP) 2013 -2017 is the second MTP for health in Kenya. Its impact targets include: to reduce maternal and neonatal deaths by 50%, to reduce by at least 25% the time spent by persons in ill health, and improve by at least 50% the levels of client satisfaction with services. To achieve these targets, KHSSP prioritizes attainment of health outcomes such as eradicating polio, eliminating malaria and controlling HIV/AIDS. These outputs will be achieved by investing in 7 policy orientations: service delivery systems, health workforce, health infrastructure, health products, health financing, health leadership and health information. The policy orientations are implemented through sector flagship programs including establishment of functional referral system, promoting health and medical tourism, human resource for health, use of locally derived natural health products, health care subsidies to improve social protection, establishment of model county hospitals, and establishing e-health hubs (GoK, 2013). The KHSSP 2013-2017 provides the Kisumu

County health sector medium term focus, objectives and priorities to enable it move towards attainment of the Kenya Health Policy Framework. Indeed the KHSSP formed the basis for the development of the Kisumu County Health Sector Strategic and Investment Plan 2013-2017.

#### **1.1.4 The Health Sector in Kisumu County**

Kisumu County is one of the 47 counties in Kenya. It occupies a land area of 2, 009.5 km<sup>2</sup> and another 567 km<sup>2</sup> is occupied by water. By 2009, the population was estimated to be 968 909 people with males being 474 687, and females being 494 222 (KDHS, 2008-9). It has seven Constituencies: Kisumu East, Kisumu West, Kisumu Central, Seme, Nyando, Muhoroni, and Nyakach. The Kisumu County Integrated Development Plan (CIDP) 2013 – 2017 notes that there is one provincial hospital, 1 county hospital, 2 sub-county hospitals, 16 public health centres, 27 public dispensaries, 5 private hospitals, 2 Mission hospitals, 4 nursing homes, and 5 privately run dispensaries. The average distance to a health facility is 5 km. The doctor to population ratio of 1: 44 634 and the nurse to population ratio of 1: 2383, are way below World Health Organization (WHO) standards. Fifty four percent (54%) of women deliver their babies at home. Malaria remains the number one cause of morbidity and mortality at 44.7%. The overall immunization coverage stands at 53.6% against the national average of 80%. Just about 50% of the under-fives sleep under treated bed nets. There is a relatively high rate of malnutrition in children with 20.3% underweight, 15.8 % wasted, and 28.7% stunted (CIDP, 2013-2017).

According to the Kisumu County Fiscal Strategy Paper (CFSP) 2015, about 60% of the population is poor against the national average of 46%. The main causes of poverty

include HIV/AIDS, collapse of local industries, unemployment, low agricultural and fish production. Other causes include food insecurity; inaccessibility to affordable healthcare; lack of proper storage facilities; erratic and unreliable rainfall; poor and inaccessible road network; frequent floods; problems with the sugar, rice, cotton and fish industries; poor water and sanitation systems; malaria, and water borne diseases. Generally, poor health care contributes the largest share to the poverty situation in the county.

Several aspirations of the social pillar in the health sector have not been realized in Kisumu County. For example, whereas the KHSSP 2013 – 2017 envisions a reduction of maternal and neonatal deaths by 50%, these have generally remained high in Kisumu County, with neonatal deaths being double the national average, and mothers still dying from avoidable causes such as malaria and anaemia (Blaustein, 2011). A child under-five in Nyanza is three times more likely to die than a child in Central Province (KDHS, 2008). According to the Kisumu East Development Plan 2008 – 2012, only 33.3% of women delivered in a health facility against a national average of 44%, while just a mere 10% of the facilities had the capacity to offer comprehensive emergency obstetric care. The contraceptive acceptance rate was 27.1% against a national average of 46%. Tuberculosis (TB) detection rates were 32% against the WHO target of 70% (GoK, 2010). According to the 2013 Kenya Household Health Expenditure and Utilization Survey (KHHEUS), Kisumu County reported one of the highest inpatient admission rates of 50 to 60 against the national average of 38 per 1000 population (Ministry of Health, 2014).

## **1.2 The Research Problem**

Implementation of strategy remains the biggest and most challenging task of any strategic management process. Having a brilliant strategy does not assure successful performance. Implementation portends more challenges than formulation of strategies. There is often a gap between strategy and its performance with about 63% being the average realized performance while 37% is the average realized performance loss (Mintzberg, Quinn & Ghosal, 1999). Often, 66% of organizational strategies are not executed at all (Johnson, 2004). There are a number of reasons for this mismatch including inadequate resources, poor leadership, poor communication, lack of clear accountability structures, and lack of motivation and reward (Mashhadi, Mohajeri & Nayeri, 2008). No two organizations face the same challenges at any one given time. There is no one single remedy for all the challenges faced by different organizations and so it is important to understand what these unique challenges are for any organization, in order to come up with relevant and appropriate solutions.

The overall aim of the social pillar of Kenya Vision 2030 is to build a just and cohesive society. Among the functions devolved to the 47 counties under the social pillar strategy is health care. Devolution implies the transfer of political, administrative and fiscal powers to the county governments. Empirical evidence in other countries suggests that devolution may have a positive (Besley & Burgess, 2002) or a negative (Calamai, 2009; Afzar *et al*, 2001) impact on governance. Locally, devolution of health care has posed a myriad of challenges including lack of experience with devolution, poor coordination between central and county governments, inadequate budgetary allocations, delayed pay for the health workers, frequent strikes, lack of human resource development policy, and poor leadership (CHS, 2014). Kisumu



County remains unique because of its high poverty (60%), high rates of youth unemployment and collapse of local industries, high disease burden and the inadequate health infrastructure (CFSP, 2015). Whereas the KHSSP 2013-2017 envisions a reduction of maternal and child mortality by 50%, Kisumu County has one of the highest infant (95 per 1000), child (133 per 1000) and maternal mortality rates; high HIV/AIDS prevalence (15.1%); high morbidity and mortality due to malaria; low immunization (53.6%) and contraceptive (27%) coverage; high malnutrition rates; and with only about 10% of facilities offering comprehensive obstetric care (Blaustein, 2011).

A number of studies have been done in the field of strategy implementation and its challenges. Musyoka (2011) looked at challenges of strategy implementation at Jomo Kenyatta Foundation. Bolo and Nkirote (2012) studied the bottlenecks in the execution of Kenya Vision 2030. Kilonzi and Ndungu (2014) looked at the challenges of implementing Kenya Vision 2030 strategy in Laikipia County. Mwenza and Misati (2014) looked at the challenges of implementing first medium term plans of Vision 2030. But none of these studies paid attention to the challenges of strategy implementation in the devolved health sector. Kisumu County has adopted and domesticated the Kenya Health Sector Strategic Plan (KHSSP) 2013-2017 which is the second medium term plan for the devolved health sector and which emphasizes seven key investment areas namely: service delivery, human resource for health, health infrastructure, health products and technologies, health information, health financing, health leadership and governance. So far no study has been done to determine the challenges to the implementation of the KHSSP 2013-2017 in any county including Kisumu. There is therefore a knowledge gap about the specific

challenges of strategy implementation in the devolved health sector, especially in Kisumu County. This study therefore sought to bridge that gap. What are the challenges of implementing the social pillar strategy of Kenya Vision 2030 in the devolved health sector in Kisumu County?

### **1.3 Research Objectives**

- i. To establish the challenges facing the implementation of the social pillar strategy of Kenya Vision 2030 in the devolved health sector in Kisumu County.
- ii. To determine the measures being put in place to address the challenges facing the implementation of the social pillar strategy of Kenya Vision 2030 in devolved health sector in Kisumu County.

### **1.4 Value of the Study**

This study will be of value to those that deal with policy formulation and implementation at the Ministry of Health and the Kisumu County government. They will benefit from the findings especially on the challenges of financial and human resources and the suggestions on how some of these challenges and obstacles can be overcome. Some of the findings and recommendations from this study may in future be applicable to other sectors of the economy as well. Practitioners and other stakeholders in health care will also find the results of this study useful particularly on the challenges to do with availability of drugs and other supplies, information technology, communication and feedback.

Since this study is limited to the health sector in Kisumu County, other researchers may find the results useful as a guide for future inquiry into other counties and subsectors of the economy. This study will therefore contribute to a body of knowledge to the academic community and may be a stepping-stone for further research on the implementation of the Kenya Vision 2030 in the various sectors and flagship projects. It will particularly be important to conduct more research in future on how best to implement the devolution strategy, especially in health care, in the various counties in Kenya.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1 Introduction**

This chapter is devoted to the review of literature related to the theoretical perspectives, strategy implementation, the challenges of strategy implementation, the measures to address those challenges, and a summary of the knowledge gap.

#### **2.2 Theoretical Perspectives**

There are a number of theories that anchor our understanding of strategy implementation. Examples of such theories include the institutional theory, the contingency theory, the Resource Based View (RBV), and the McKinsey's 7-S framework. Institutional theory emphasizes the dependence of modern organizations on their environments. The premise is that human behavior is highly embedded in institutional contexts; that individuals are creatures of habit, groups are controlled by customs, and societies are organized around cultures (Camic, 1986). Organizations are inserted in an environment that is constituted by rules, beliefs and values, created and consolidated through social interaction. In this sense, their survival depends on the capacity to follow collectively shared guidelines (DiMaggio & Powell, 1991). Scott (1995) looks at institutions as systems of meaning that must incorporate representational, constitutive, normative, cognitive, and regulative structures and activities that provide stability and meaning to social behavior. Clemens and Cook (1999) posit that institutions are about formal or informal procedures, routines, norms, and conventions in the organization.

The RBV suggests that the resources possessed by a firm are the primary determinants of its performance, and these may contribute to a sustainable competitive advantage of the firm. According to Barney (1991), the concept of resources includes all assets, capabilities, organizational processes, firm attributes, information, and knowledge, controlled by a firm that enable the firm to conceive of and implement strategies that improve its efficiency and effectiveness. These resources must be inimitable, non substitutable, valuable and rare. Grant (1991) noted that resources are stocks of available factors that are owned or controlled by the firm, which are converted into final products or services. Capabilities, in contrast, refer to a firm's capacity to deploy resources, usually in combination, using organizational processes, to produce a desired effect.

Contingency theory contends that there is no one best way of organizing and leading and that an organization's leadership style that is effective in some situations may not be successful in others. Therefore the optimal organizational leadership style is contingent upon certain internal and external constraints. These constraints may include the size of the organization, how it adapts to its environment, differences among resources and operational activities, strategies, and differences in technology. Four important ideas underlie the contingency theory: there is no one universal or best way to manage; the design of an organization and its subsystems must fit with the environment; an effective organization not only have a proper fit with the environment but also between its subsystems; and, the needs of an organization are better satisfied when it is properly designed and the management style is appropriate both to the tasks undertaken and the nature of the work group (Fiedler, 1996).

The McKinsey's 7-S framework looks at seven internal, interdependent and mutually reinforcing aspects of an organization, categorized as hard or soft, that needs to be aligned if it is to be successful. The hard elements are easier to define, identify and influence, and they include strategy, structure and systems. Strategy refers to the direction and scope of the company over the long term. Structure implies the basic organization of the company, its departments, reporting lines, areas of expertise, and responsibilities. Systems refer to the formal and informal procedures that govern everyday activity. The soft elements are more difficult to describe, less tangible and more influenced by culture. They include skills, style, shared values, and staff. Skills refer to the capabilities and competencies that exist within the firm. Shared values are the values and beliefs of the company that will ultimately guide behavior of the employees. Staff is the company's people resources and how they are developed, trained and motivated. Style describes the leadership approach of top management and the company's overall operating approach (Peters & Waterman, 1982).

These four theories are about how to survive in and reap maximum benefit in the competitive business environment. They are related to this study in that Kisumu County as an administrative unit has various organizational, leadership, cultural, informational, financial and human resource potentials that when properly harnessed could lead to improved performance in the health sector and the overall survival of its people. These theories can also help explain the challenges of strategy implementation in Kisumu County in terms of leadership, human and financial resource management and distribution, change management, communication, corporate culture, information technology, and power and politics, and also how to overcome these challenges.

## **2.3 Strategy Implementation**

This is the process of converting strategic plans into actions and finally into results. Strategy implementation is inward looking and aims at using the managerial and organizational resources effectively and efficiently towards accomplishing organizational goals and objectives. According to Sababu (2007) strategy implementation is the process by which strategies and functional policies are put into action through the development of action plans, goals, programmes, budgets, procedures, structures, cultures, motivation, communication, leadership, allocation of resources, favourable working climate and adequate enforcement. It also involves the monitoring and evaluation of the effectiveness of the objectives and functional policies towards the achievement of the overall mission of the organization.

Strategy formulation is usually the beginning of a challenging and delicate task, which culminates in strategy implementation and evaluation. According to Johnson (1987), strategy should be effectively operationalized and institutionalized in the organization for it to be properly implemented. Institutionalization of strategy means that it should be aligned to organization's structure, culture, systems and procedures, management style, staffing, skills and resources. Operationalization implies action planning. An action plan indicates what will be done, by whom, when and with what expected results. Action planning provides a link between strategy formulation and action. It is also a tool for monitoring and evaluation. If the implementation process is not well managed, then the strategic plan amounts to a mere white elephant project. But the process of implementation is never easy; it is challenging, arduous and full of risks and uncertainties because of the realities prevailing in the operational environment.

Strategy implementation and execution is the most demanding and time consuming part of the strategy management process. It is an operations-oriented task that shapes the performance of core business activities of an organization. As observed by Thompson, Gamble and Strickland (2006), converting strategic plans into action and results is a great test of the manager's ability to perform the key managerial responsibilities of directing organizational change, motivating people, building and strengthening company competencies, creating a strategy supportive climate, and achieving the set performance targets. Leadership is at the core of strategy implementation. A good leader should be able to influence and galvanize the people towards a specific and desired direction. But this will depend on the leadership style, the personality type, commitment, reputation, attitude and aptitude, skills and experience of the individual leader. Transformational rather than conservative leadership is required for effective strategy implementation (Sababu, 2007).

Resource availability is central to effective strategy implementation. Pearce and Robinson (2007) note that to effectively direct and control the firm's resources, certain essential ingredients including organizational structure, information systems, management and leadership styles, reward and control systems, and budgeting system, should be in place. Almost all the management functions of planning, controlling, organizing, motivating, leading, directing, integrating, communicating and innovating, are important during the strategy implementation process. Good strategy implementation, according to Thompson, Gamble and Strickland (2006), requires creating strong fits between strategy and organizational capabilities; strategy and organizational climate and culture; strategy and the reward system; and strategy and operating systems.



## **2.4 Challenges of Strategy Implementation**

Strategy implementation is the most difficult task in any strategic management endeavour. It needs to be carefully thought out, planned and executed. There are several challenges that are encountered in the process of executing strategies. These challenges can either be internal or external to the firm and can originate from poor or inappropriate strategy, poor implementation of the chosen strategy, or failure to couple strategy development and implementation. Mashhadi, Mohajeri, and Nayeri (2008) found such barriers to include organization structure, organization culture, information and communication technology, motivation and reward systems, availability of adequate resources, decision-making processes, ineffective communication, capabilities and skills of the implementers.

An empirical study by Bolo and Nkirote (2012) on the bottlenecks in the execution of Kenya vision 2030 strategy showed that it faced many challenges such as inadequate and limited resource allocation; political interference; uncertain political environment; constant inflation compounded with the weak currency; and, global recession, hence limited donor funding. They also noted other factors including corruption and misappropriation of funds; inadequate and ineffective involvement by the citizens; unsustainability of programmes; insufficient disaggregated data; poor linkage of policy, planning and budgeting at the grass root levels; natural and man-made disasters such as famine, drought, and post-election violence of 2007; and, economic crisis leading to reprioritization.

Chemwei, Leboo and Koech (2014) in their study of strategy implementation in secondary schools in Baringo District found that poor leadership and conflicting or unclear roles contributed 75% and 52% to the failure of strategy implementation, respectively. Musyoka (2011) looked at the challenges of strategy implementation at the Jomo Kenyatta Foundation. She found that some of the barriers to effective strategy implementation included unaligned systems and processes, increased competition and rivalry within the industry, poor human resource management leading to high staff turnover, unfavourable government policies, lack of flexibility and resistance to change among staff. Kilonzi and Ndungu (2014) did a study on challenges affecting the implementation of Vision 2030 strategic decisions in Laikipia County. They identified 21 potential challenges out of which only 5 were statistically significant. These 5 include: untimely intervention by top management during periods of challenges or crisis; poor or ineffective coordination of activities within and between the various departments; competing interests among the implementers; lack of a sense of ownership of, and commitment to, the strategy execution process by the employees; and, the constantly changing business environment.

A study by Chemwei, Leboo and Koech (2014) showed that there was a relationship between organization structure and performance. Sixty one percent (61%) of the respondents in the study said that inappropriate organization structure impeded strategy implementation efforts. Another 65% of the respondents cited unclear vision and mission as the reasons for poor implementation of strategies. According to Sababu (2007), organization structure is determined by the size; the stage at which the organization is; the complexity of tasks and responsibilities; diversity and

interdependence of tasks to be performed; the prevailing business environment; and the overriding ideology that drives the organization and its membership forward.

Chemwei, Leboo and Koech (2014) found out that inadequate human resource and limited budgetary allocations accounted for 65% and 61% of the failure of strategy implementation, respectively. Studies by Okumus (2003) found that the main barriers to the implementation of strategy include lack of a supportive culture, poor coordination, resistance from lower levels, and poor planning of activities. Taslak (2004) sought to find out the factors that hamper strategy implementation in Turkish textile industry. He found out that uncertainties emanating from the national economic environment, uncontrollable factors in the external environment and longer duration of implementation were the main factors that hampered effective strategy implementation. Aldehayyat and Anchor (2010) did a similar study among the Jordanian publicly quoted companies and found out that poor leadership, poor human resource management, poor communication, uncertainties in the national economic environment, poor coordination of activities, inadequate staff training, and external environmental factors were some of the impediments to effective strategy implementation.

Freedman (2003) identified a number of implementation pitfalls such as isolation, lack of stakeholder commitment, strategic drift, strategic dilution and strategic isolation, failure to understand progress, initiative fatigue, impatience, and failure to celebrate success. Sterling (2003) found out that strategies fail due to unanticipated market changes, lack of senior management support, ineffective counter-competitor responses,

insufficient resources; poor communication; timeliness and distinctiveness; lack of focus; and bad strategy with poorly conceived business models. Alexander (1985) studied strategy implementation in medium and large-sized USA companies and noted that several factors impeded strategy implementation including: more time required than originally allocated; poor coordination of activities; unforeseen crises that distract the smooth flow of execution; external environmental influences; poor information and communication technology; lack of clear definition of responsibilities; inadequate training and capacity building; poor leadership; and, lack of clear vision and direction.

Rapert, Velliquette and Garretson (2002) in their empirical study, found that organizations where employees have easy access to management through open and supportive communication climates tend to outperform those with more restrictive communication environments. As further observed by Sababu (2007), the flow of strategic communication in an organization happens in three directions: downwards, upwards, and laterally or horizontally. Thompson, Gamble and Strickland (2006) observe that a good information and technology system is important for the managerial task of executing strategy successfully, achieving greater operating excellence and strengthening organizational capabilities. Pearson and Robinson (2007) note that the crafting of policies, and the influence of power and politics, pose major challenges for the effective implementation of strategies within the organization and requires careful attention by the top management.

## **2.5 Measures to Overcome the Challenges of Strategy**

### **Implementation**

One of the most important measures to overcome the challenges of strategy implementation is having a logical approach to execution. Managers need and benefit from a logical model to guide execution decisions and actions. Without proper and clear guidelines, execution becomes a labyrinth. Without proper guidance and direction, individuals do the things they think are important, often resulting in uncoordinated, divergent, and even conflicting decisions (Hrebiniak, 2005). As was observed by Heracleous (2000), integration and coordination of the various units and functions within the organization to achieve a common goal is another important measure that ensures that there is synergy and direction of purpose. This also involves clarifying responsibilities and accountability for each functional unit within the integrated whole, since such responsibility is often blurred when people from different departments or units come together.

It is important to have a clear focus of where the firm is and where it intends to go, if the strategy is to be well implemented. According to Porter (1985), the key task of strategic management is thinking through the overall vision and mission of the organization. This task involves asking certain key questions: What is our business? Where are we? Where do we want to go? How do we get there? This in turn leads to formulating of objectives, crafting of strategies and effectively implementing those strategies to achieve the vision and mission of the organization. Liabotis (2007) in his study of small and medium-sized Canadian firms, showed that for successful strategy implementation, there was need to strengthen the execution infrastructure through eliminating departmental or regional silos, utilizing leading indicators and performance

drivers that align with the strategy, and growing leaders at all levels- both managerial and non-managerial. He also demonstrated that supportive infrastructure comprising of organizational capabilities that are valued by customers, a management-performance system and scorecard that focuses on leading indicators and the drivers of growth, and strong leadership practices at every level of the organization, were very essential for effective execution of strategies.

Strategic decisions are generally subject to greater uncertainty compared to administrative or operational decisions. These decisions are concerned primarily with external rather than internal aspects of the firm. There is need to create a sense of ownership among the employees and other stakeholders if the strategic decisions and choices have to be implemented effectively and to avoid sabotage. This is the basis of effective institutionalization and operationalization of strategy, so that all employees feel part and parcel of the formulation, development and implementation process (Johnson, 1987). Additionally, Chan and Mauborgne (2005) found that successful companies were those where employees were involved in strategy formulation and its eventual execution. They observed that voluntary cooperation and participation by employees was a positive sign that they were ready and willing to invest their energies and initiative to ensure the success of a given strategy.

Change remains the only constant thing in any organization. Organizations must strive to grow their people in terms of capacity and capabilities in order for them to embrace change positively. Change is an emotional process and therefore everyone must be involved including the customers. Four principles of change management include

sensing the urgency for change, developing the vision for the change, empowering people to carry out the change, and execution of the change in the organization. There is need to develop organizational capability to handle change through technical and team skills, training, hiring new skills, and frequent reorientation (Hrebiniak, 2005; Yabs, 2007). A study by Raps (2004) demonstrated that the four key factors that determined the success of strategy implementation were organizational culture, organizational structure, effective communication and change management practices.

Strategy is dynamic and an ongoing process which is refined through the process of organizational learning. New ideas will emerge over time that may necessitate a revision of current strategy. Open organizations are systems that interact with their environment through a double feedback loop. Even the best laid out strategy or plans must be responsive to the ever changing, unpredictable and volatile business environment. The management must therefore strive to create new opportunities from the fresh ideas emanating from the environment (Thompson & Strickland, 1993). A study by Heracleous (2000) showed that where there were effective incentives and controls, strategy execution was more coordinated and successful. He noted that incentives motivate and guide performance while effective controls provide timely and valid feedback about organizational performance.

Mintzberg, Quinn and Ghosal (1998) viewed strategy from five different but interrelated perspectives: a ploy, a plan, a pattern, a position and a perspective. As a plan, strategy is a consciously perceived and intended course of action or a guideline to deal with a situation. Strategy as a ploy means the specific maneuver intended to

outwit an opponent. Strategy as a pattern refers to a consistent stream of actions or consistency in behaviour over a period of time. Strategy as a position looks at an organization and how it fits in its external environment. As a perspective, strategy implies that everyone in the organization shares a common view of its purpose and direction. Strategy, according to these authors, emerges over time as intentions collide with, and accommodate a changing reality in the environment. Raps (2004) also observed that having a good and executable strategy is the starting point to effective implementation. He emphasized that business strategy is essential to the successful execution of corporate strategy.

Transformational leadership is required for effective strategy implementation. Effective leadership should provide the impetus, the vision, the initiative and the inspiration needed to steer the organization to greater achievements (Chemers, 2000). Adequate resources must be availed for effective strategy implementation. This will require that proper organizational structure, information systems, management and leadership styles, reward and control systems, and budgeting system, are in place (Raps, 2004). The corporate culture should be aligned to the organizational goals (Heracleous, 2000). Effective communication of organizational strategies by the top management fosters a positive culture where there is free exchange of information and ideas (Sababu, 2007). Best (1997) emphasizes three major forces that affect execution of strategy namely: ownership of the plan, supporting the plan, and adaptive planning. All stakeholders must feel they own the strategy for them to fully support it.



## **2.6 Summary of Knowledge Gaps**

The formulation of an excellent strategy does not guarantee excellent implementation. Mintzberg, Quinn and Ghosal (1998) observed that there is often a mismatch between strategy and implementation thus creating a gap. They noted several reasons for this mismatch including poor leadership, inadequate resources, unclear accountability structures, poor communication, and poor human resource management. Different organizations face unique challenges at different times and so there is no one best remedy or solution to these challenges. In Kenya, various studies have been done in the field of strategy implementation focusing on different sectors. Bolo and Nkirote (2012) looked at the bottlenecks in the execution of Vision 2030. Musyoka (2011) studied the challenges of strategy implementation at Jomo Kenyatta Foundation. Kilonzi and Ndungu (2014) looked at the challenges of implementation of Vision 2030 in Laikipia County. Whereas many of these were case studies like the current study, none of them focused on challenges of implementation of the social pillar of Vision 2030 in the devolved health sector Kisumu County.

Devolution as a form of decentralization of political, administrative and fiscal power to the counties is a fairly new governance strategy in Kenya. Empirical studies on its benefits in other countries have produced mixed results (Besley & Burgess, 2002; Calamai, 2009). In Kenya, it has been characterized by lack of experience and understanding, lack of consultation between central and county governments, inadequate budgetary allocations to counties, delayed pay for the health workers, lack of human resource development policy, and poor leadership and management skills by the county executives (CHS, 2014). Whereas this is overall national picture, there is no

specific study done to tease out the unique circumstances of individual counties, specifically the health sector in Kisumu County.

## **CHAPTER THREE**

### **RESEARCH METHODOLOGY**

#### **3.1 Introduction**

This study had the objectives of establishing the challenges facing the implementation of the social pillar strategy of Kenya Vision 2030 in the devolved health sector in Kisumu County; and, to determine the measures being put in place to address the challenges facing the implementation of the social pillar strategy of Kenya Vision 2030 in devolved health sector in Kisumu County. This chapter is a presentation of the research methodology that was used to gather data and information about the stated research objectives. It includes topical issues such as research design, data collection, and data analysis.

#### **3.2 Research Design**

Orodho and Njeru (2003) define research design as a scheme, outline or plan that is used to generate answers to research problems. It constitutes the blue print for the collection, measurement and analysis of data. The research design used here was a case study of the devolved health sector in Kisumu County. Kothari (1990) described a case study as a careful and complete examination of a social unit, family, institution, cultural group or entire community. A case study embraces depth rather than breadth of the study phenomenon. The objective of a case study is to locate the factors that account for the behavior patterns of the given unit as an integrated whole.

The case study design is a powerful research methodology that combines individual interviews with record analysis and observations. In this study interviews were conducted among the top leadership at the county department of health and the two leading hospitals to gain an indepth understanding of the challenges they face in implementing the county's health sector strategic agenda, as enshrined in the KHSSP 2013-2017. Documentary reviews were also done in the same departments to corroborate the findings from the interviews. This approach also agrees with the observations by Yin (2003) who noted that the major strength of a case study is the opportunity to use many different sources of evidence which allows the investigator to address a broader range of historical, attitudinal and behavioural issues.

### **3.3 Data Collection**

In this case study, both primary and secondary data were collected. Primary data were collected through interview guides. The interview guides were developed after a review of literature on the challenges of strategy implementation and in line with the KHSSP 2013-2017 aspirations. The instrument had questions touching on leadership, human resource, ICT, communication, health infrastructure, change management, organization structure, and power and politics. For each question asked on challenges of strategy implementation, a corresponding question was asked on the measures being taken to address those challenges. Interview guides were used to ensure crucial data were not left out during the discussions. The interview guides reflected the study objectives and research questions that the study sought to answer. Those interviewed at the county headquarters included the Kisumu County Executive Secretary for Health, the Chief Officer of Health, and the County Director of Health. Additionally, those in charge of the two major health facilities in the county, that is, the Chief Executive

Officer of Jaramogi Oginga Odinga Teaching and Referral Hospital and the Medical Superintendent in charge of the Kisumu East County hospital, were also interviewed.

Secondary data were collected through a scrutiny of minutes of meetings, financial reports, the Fiscal Strategy Paper, County Integrated Development Plans, the Kisumu County Health Sector Strategic and investment Plan 2013 -2017, and the strategic plans of the JOOTRH and the Kisumu East County Hospital. Also, any signed communications on the notice boards, whether as a notice or a memo, were also scrutinized for their relevance to this study.

### **3.4 Data Analysis**

The data collected from the indepth interviews were qualitative in nature and were subjected to content analysis. Nachiamis and Nachiamis (1996) defined content analysis as the technique for making inferences by systematically and objectively identifying specified characteristics of the messages and using the same approach to relate to trends. It is the use of replicable and valid methods for making specific inferences from text to other states or properties of its source. Content analysis is important for making replicable and valid inferences from data to their context, with the purpose of providing knowledge, new insights, a representation of facts and a practical guide to action. The aim is to attain a condensed and broad description of the phenomenon, and the outcome of the analysis is concepts or categories describing the phenomenon. A category is a group of words with similar meanings or connotations. According to Weber (1990) categories must be mutually exclusive and exhaustive.

Usually the purpose of those categories is to build up a model, conceptual system, or a conceptual map.

Both the primary and secondary qualitative data collected during this study were grouped into major categories including health statistics, leadership and governance, financing, organization structure, health infrastructure, human resource, health products and technologies, communication, culture, information and communication technology, power and politics, and policies and legal framework. These major themes had been derived from the literature review of empirical studies on challenges of strategy implementation. Under these major themes there were subthemes that emerged. For example, under leadership and governance there were subthemes such as vision, mission, values, style, collaboration, and meetings. These themes and subthemes were checked and edited for completeness and consistency throughout the study. This deductive content analysis enabled the researcher to analyze and interpret meanings of the categories while also seeking to understand the interviewees' perceptions and beliefs concerning the challenges of strategy implementation in the devolved health sector in Kisumu County and the measures being put in place to address them. Other researchers who have used content analysis in their studies include Nyororo (2006) and Mwangi (2011). Nyororo (2006) argues that content analysis is scientific since the data collected can be developed and be verified through systematic analysis.

## **CHAPTER FOUR**

### **DATA ANALYSIS, FINDINGS AND DISCUSSION**

#### **4.1 Introduction**

This chapter presents the analysis of findings from the in-depth interviews and documentary reviews in line with the study objectives namely: to establish the challenges facing the implementation of the social pillar strategy of Kenya Vision 2030 in the devolved health sector in Kisumu County; and, to determine the measures being put in place to address the challenges facing the implementation of the social pillar strategy of Kenya Vision 2030 in devolved health sector in Kisumu County.

Primary data were collected through interviewing the Kisumu County Executive Secretary for Health, the Chief Officer of Health, and the County Director of Health. Additionally, the Chief Executive of the Jaramogi Oginga Odinga Teaching and Referral Hospital (JOOTRH) and the Medical Superintendent of the Kisumu East County Hospital, were also interviewed. Interviews were recorded in a notebook which was later subjected to content analysis. Secondary data were gathered through documentary reviews of the minutes of meetings, Kisumu County Integrated Development Plan 2013-2017, Kisumu County Fiscal Strategy Paper (2015), Kisumu County Health Sector Strategic and Investment Plan 2013-2017, the JOOTRH strategic plan, the Kisumu East County Hospital strategic plan, and notices and memos on the notice boards.

## **4.2 Implementation of the Social Pillar Strategy in the Devolved Health Sector in Kisumu County**

The County Executive Secretary for Health (CESH) began by making some general remarks about devolution as a governance strategy. The CESH noted that “devolution has brought governance, resources, power and decision making closer to the people,” but regretted that a few people were using the opportunities presented through devolution to amass wealth and enrich themselves at the expense of the general good. She also noted that many health facilities that were previously neglected are now either functional or under renovation and will soon be functional. She was very optimistic about improvements in health indicators in the county following deliberate efforts at strengthening community health services which in her opinion, had been neglected by the central government despite Kenya’s commitment to the Primary Health Care Declaration in Alma Ata in 1978. She observed that the health sector had “lagged behind other sectors like agriculture and adult education which have developed extension services that bring services closer and directly benefit the communities.” She particularly thanked the Governor of Kisumu County for prioritizing and supporting health care in his development agenda.

The County Executive Secretary for Health emphasized the department’s commitment to the “overall national guidelines on health care,” as enshrined in the Kenya Health Sector Strategic and Investment Plan (KHSSP) 2013-2017. She noted with pride that the county had come up with the Kisumu County Health Sector Strategic and Investment Plan (KCHSSP) 2013-2017 which is largely derived and modified from the KHSSP 2013-2017 to “reflect and respond to local health care needs.” The KCHSSP 2013-2017 defines institutional and management structures in the County



Health Department to coordinate and manage delivery of the constitutionally defined health mandates and services at the county level.

The overall roles and responsibilities of the County Department of Health as reported by the County Executive for Health and corroborated in the KCHSSP 2013-2017 include: strategic and operational planning, and coordination; supportive supervision, monitoring and evaluation of health service delivery in the county; providing linkage with the County Executive Committee (CEC) and other actors to facilitate health sector dialogue at the county level; provide leadership and stewardship for overall health management in the county, through building linkages with, and putting in place strategies to influence health related sectors in the county, such as education, roads, gender, nutrition, and others. It also aims to mobilize resources for county health services, and coordinate the referral system across the facilities in the county, and between the different tiers of the health sector in line with the referral guidelines (KCHSSP, 2013-2017).

The County Executive for Health outlined the key service delivery outcomes of the KCHSSP 2013-2017 as: to eliminate communicable conditions; halt and reverse the rising burden of non-communicable conditions; reduce the burden of violence and injuries; provide essential health services; minimize exposure to health risk factors; and, strengthen collaboration with health related sectors. To achieve these service delivery outcomes, 7 system investment areas have been identified and prioritized. These include organization of service delivery, human resources for health, health infrastructure, health products and technologies, health information, health financing, and health leadership and governance. It is these seven system investment areas that

formed the bases for further enquiry into the challenges of implementing the social pillar strategy in the devolved health sector in Kisumu County and the measures in place to overcome them.

The County Executive Secretary for Health noted that the KCHSSP 2013-2017 is “an ambitious plan which the county is willing and ready to implement despite the various resource challenges”. She particularly noted the enormous financial requirements necessary to fulfill this strategy. But her approach would be to bring all the major stakeholders in health together and have them “understand their complementary and supplementary roles in the implementation of this strategy.” Some of the important stakeholders mentioned include Ministry of Health, public health facilities, training and research institutions, the non-governmental organizations (NGOs), community based organizations (CBOs), private hospitals, and mission/faith based health institutions. The Ministry of Health would play a facilitatory role through policy guidelines, regulation and enforcement; the NGOs and CBOs would be expected to supplement the county’s effort to conduct capacity-building programs; private health institutions would supplement the effort of the public health sector; and, the donor community would be expected to provide funding for health services provision and strengthening. She noted that most of these stakeholders were already in the field doing their work but that there was need for better coordination to achieve synergy and unity of purpose, and to avoid duplication of roles and responsibilities. The roles of the other stakeholders are outlined in Appendix XI.

### **4.3 Challenges of Strategy Implementation**

This section is a presentation of the study findings in line with the first objective of the study which was to establish the challenges facing the implementation of the social pillar strategy of Kenya Vision 2030 in the devolved health sector in Kisumu

County. These findings are based on responses by the interviewees and, where necessary, are corroborated through documentary review. Generally, the study findings show that the health sector in Kisumu County is faced with several challenges. These challenges include inadequate health services, leadership and governance, inadequate human resource, inadequate health products and technologies, financial and budgetary constraints, poor health infrastructure, underdeveloped ICT, communication barriers, and poor coordination of policy, power and politics.

#### **4.3.1 Inadequate Health Services and Poor Health Demographics**

The interviewees were in agreement about the high disease burden and poor health indicators of the population which is also a reflection of the poverty levels and the poor health seeking behavior. They noted that there have been some improvements in child and maternal mortality in the recent past due to increased public health awareness and strengthening of community health services. They identified the top 10 leading causes of death in the county to include: HIV/AIDS, lower respiratory infections, malaria, perinatal conditions, tuberculosis, diarrhoeal diseases, injuries mainly from road traffic accidents, meningitis, heart diseases, malnutrition and cancers.

However, the interviewees pointed out that the leading cause of morbidity and mortality in children was malaria and anaemia which accounted for nearly 30% deaths. This is in contrast to the KCHSSP 2013-2017 statistics that shows HIV/AIDS as the leading cause of death (shown in Appendix VII). The main risk factors for morbidity and mortality were noted to include poor health seeking behavior, retrogressive cultural beliefs and practices, early sexual debut and unsafe sexual practices, ignorance and lack of education, poor hygiene and sanitation, drug and alcohol abuse, and road traffic accidents mainly due to “boda boda.”

Lack of employment was identified as the main reason why the youth engaged in risky behaviours including early sexual debut, drug and alcohol abuse and criminal activities. These risk factors differ from those listed in the KCHSSP 2013-2017 except for unsafe sexual practices, poor hygiene and sanitation, and drug abuse (shown in Appendix VII).

Table 4.1 is a summary of the health status estimates for Kisumu County showing the poverty levels (60%); life expectancy (43 years); crude birth (41/1000) and death (27/1000) rates; child (217/1000), maternal (488/100000) and adult (672/100000) mortality rates. It also shows the high number of orphans and child labour mainly due to parental death as result of HIV/AIDS.

**Table 4.1: Health Status Estimates for Kisumu County**

<b>Impact Level Indicators</b>	<b>County Estimates</b>
Life Expectancy at birth (years)	43
Crude Birth Rate	41/1000
Crude Death Rate	27 /1000
Neonatal Mortality Rate (per 1,000 births)	39/1000
Infant Mortality Rate (per 1,000 births)	95 /1000
Under 5 Mortality Rate (per 1,000 births)	217/1000
Maternal Mortality Rate (per 100,000 births)	488/100000
Adult Mortality Rate (per 100,000 births)	672/100000
Child Labour (total number)	32, 000
Orphaned children (total number)	35, 000
Physically disabled persons (total number)	52, 517
Absolute poverty levels (percentage)	60
Absolute poverty levels (total number)	538, 485

**Source: KCIDP, 2013-2017**

The interviewees at the Department of Health emphasized that their department seeks to fulfill its mandate to the people through preventive, curative and rehabilitative services. But the emphasis is on preventive and promotive services through targeted investments in community health by scaling up primary health care services. Their reasoning is guided by the old adage that “prevention is better than cure.” So more funding is earmarked for promotive and preventive services as opposed to curative services (as shown in table 3). But given the already existing high disease burden, curative services are also being scaled up to meet the increasing demands.

It was reported that the local poverty levels is of particular importance to the health seeking behavior in that it causes high dependency and poor access to health care. It also results in inability to pay hospital bills. The leadership of the two hospitals reported a waiver rate of more than 30% of all user charges, meaning that the revenue collection and financial stability of the hospitals are substantially compromised. In addition, the high poverty levels may be the reason for the increased disease burden due to both communicable and non-communicable causes, such as malnutrition, HIV/AIDS, diarrhea and vomiting and respiratory diseases.

Interviews with the heads of the JOOTRH and the Kisumu East County hospital demonstrated an overstretched capacity at the facilities, with overall bed occupancy percentages varying between 94% - 153%. A bed occupancy level above 100% implies that the hospitals are congested and mostly serving beyond their capacity with patients either sharing beds or sleeping on the floor. This has serious implications on the ability of the hospitals to offer quality health care. The highest bed occupancy was noted to be in the surgical wards (153%) meaning urgent measures should be put in

place to expand the wards to increase bed capacity. The patient turnover was shortest in maternity wards but longer in the adult medical and surgical/orthopaedic wards. The in-patient admission rates were reported to be generally high in both hospitals. This is in agreement with the findings of the Kenya Household Health Expenditure and Utilization Survey (KHHEUS, 2013), where Kisumu County reported one of the highest inpatient admission rates of 50 to 60 against the national average of 38 per 1000 population (Ministry of Health, 2014). It is also a reflection of the overall morbidity rates in Kisumu County which is generally high at 45.4% (KCIDP, 2013 - 2017).

The population projections for Kisumu County for the years 2013-2017 are summarized in Appendix VI. Table 4.2 is a summary of the general health demographics of Kisumu County showing the average distances to health facilities (6.4 km), doctor/population ratio (1: 44, 634), nurse/population ratio (1: 2, 383), children fully vaccinated (53.6%), places of delivery, contraceptive acceptance rate (27%) and a high average county morbidity rate (45.4%).

**Table 4.2: General Population Health Demographics for Kisumu Country**

Information Category	Statistics
Community distribution by distance to the nearest health facility (percentage):	
0-1 km	21.1
1.1 – 4.9 km	45.6
5 km and more	33.3
Average distance to health facility (km)	6.4
Doctor/ population ratio	1:44, 634
Nurse/population ratio	1:2, 383
Children fully vaccinated (percentage)	53.6
Contraceptive acceptance (percentage)	27
Place of delivery (percentage)	
Hospital	32.7
Health centre	7.7
Dispensary	1
At home	53.8
Total County Morbidity Rate (percentage)	45.4

Source: KCIDP 2013-2017

### 4.3.2 Health Leadership and Governance

It was reported that the leadership at the Department of Health is guided by a clear vision and mission. Their vision is a dynamic, excellent and globally competitive county health service, which contributes to a healthy and productive population by 2017. Their mission is to transform the livelihood of the the people of Kisumu County through responsive and sustainable technologically-driven evidence-based and client-centered health system for accelerated attainment of highest standard of health. Some of their core values include integrity, professionalism, accountability and responsibility, equity, human rights, team work, commitment and dedication, client-

centredness, and evidence-based decision making. These were corroborated with the KCHSSP, 2013-2017. One interviewee at the department of health stated that they were very clear in their minds about “what we want to achieve, how to achieve it and what it takes to achieve it,” and that, “everyone will be brought on board irrespective of their political and ideological persuasions.”

All of the interviewees had gone through some leadership training courses, mainly at the Kenya School of Governance and at the Strathmore University. A few had taken leadership courses at institutions out of the country particularly in Israel. One of the challenges with leadership, as noted by one of the interviewees, was the “bureaucratic structure and working of the devolved system of government.” The interviewee observed that devolution was not so new because there have always been aspects of health care that were decentralized and run by the local government and individual health institutions, like disease surveillance, infrastructure development through facility improvement funds, and the health centres that were run by the former municipal councils. He reported that some administrative staffs were seconded to the counties from the former municipal councils and had to “learn to work in the new structure led by the governor as opposed to the former system that was led by the mayor.” It was reported that the expectation of the public of their elected leaders had also shifted. Instead of being told what to do, “a diverse public now expects to have a strong voice, to be routinely informed, and to be satisfied on many levels. The public are restlessly looking to the leader to make things happen and do it quickly.” At the same time the leader is expected to be both personally decisive about the issues that matter to public while still being collaborative and inclusive. The interviewees particularly talked of the difficulties in handling the many young people looking for



jobs in the health sector given that there was no recruitment going on. Leaders, it was reported, were also being followed through by the electorate to accomplish their campaign pledges. The other challenge is how to strike a healthy balance between work and professional life on the one hand and personal and family life on the other hand. Majority of the interviewees talked of having no time for their families.

Meetings provide an opportunity for the leadership to share views and pass information. Meetings are expected for the county executive committee, facility/hospital management teams, various hospital departments, and even between the administration and the staffs. A scrutiny of the minutes of management meetings, as corroborated by the KCHSSP 2013-2017, revealed that there were 316 facility management team meetings held in the past 12 months which was 90.3% of the target. There were 636 quarterly meetings of the facility management teams, representing 100% of the target. The quarterly stakeholder's meetings held in the past 12 months were 20 which represent 83.3% of the expected. A total of 7 annual operational (work) plans were available from the major facilities, accounting for 100% of the expected. The hospital management committee meetings held in the past 12 months were 9 out of a target of 8, making 112% of the expected.

### **4.3.3 Financing**

Kenya's economy is now ranked 9<sup>th</sup> largest in Africa following the rebasing of our GDP which effectively put Kenya in the lower middle income economy. However, it was generally observed that financing of health care remains very poor in Kenya. The 2015 - 2016 National Budget allocated a paltry 2.8% of the total national budget (1.7

trillion) to health care. Kisumu County received just about 6 billion from that budget. As shown in Appendix XIII, the county has several on-going projects worth billions of shillings and which are way above its annual allocation. The poor budgetary allocation from the central government, the interviewees noted, has posed a major barrier to provision of quality health care because there are no sufficient funds to buy drugs and non-pharmaceuticals, improve health infrastructure, employ enough staff, and even for research since over 70% of the budget goes to recurrent expenditures.

The recurrent health expenditures for Kisumu County are summarized in Appendix IX. As outlined in the Kisumu County Fiscal Strategy Plan (CFSP, 2015) the total cumulative revenue for Kisumu County amounted to Ksh. 4.09 billion in the first half of the financial year 2014-2015, against the approved budget of 11.4 billion. The local revenue realized in the same period was Ksh 442.8 million, which was just 47.3% of the annual target of Ksh 935,307. The total expenditure in the same period amounted to 2.2 billion against a revised target for the year of Ksh 9.4 billion. Recurrent expenditure in the first half of the financial year amounted to Kshs 1.7 billion against a target of Kshs 5.4 billion for the financial year. Development expenditure in the same period was only Kshs 529 million compared to a target of Kshs. 4.1 billion for the whole year (CFSP, 2015). These figures show that the county spends more on recurrent expenditures (over 70%) as opposed to development expenditures hence the poor state of health infrastructure.

The annual budget for the JOOTRH in the 2013-2014 financial year was reported to be Kshs. 1.1 billion. The total collection from cost sharing was Ksh.178 million while

the recurrent allocation from government was Kshs. 395,636,481. In the financial year 2014-2015, the total budget was Kshs. 1.3 billion, but only Kshs. 206 million from cost sharing and 250 million from recurrent allocation was available. In 2015-2016 financial year, their collection from cost sharing was Kshs. 207 million while the recurrent allocation from government was Kshs. 338 million, again just about 50% of their annual requirement, as reported by the interviewee, and corroborated through the hospital financial documents. The main concern was that even the recurrent allocation from government always comes in late, at times in the last quarter of the financial year, forcing the hospital to incur a lot of debt while also compromising the quality of health services delivered. But these figures differed with the estimates in their strategic plan which shows that annually the hospital receives about kshs. 20 million from government and generates additional Kshs.160 million through cost sharing.

The Kisumu East County Hospital did not receive any recurrent allocation from county government in the financial year 2013-2014 but managed to raise Kshs. 52.5 million from cost sharing, against an annual budget of Kshs. 141.5 million. In the financial year 2014-2015, the annual budget was 163 million out of which cost sharing raised Kshs. 63 million and the recurrent allocation was Kshs.13 million. Generally the hospital receives less than 50% of its annual budget, making it difficult to provide optimum services to the people. One interviewee remarked that “we only survive by the grace of God,” since the money allocated is less than 50% of the requirement. This certainly compromises the quality of health services delivered to the people.

#### **4.3.4 Organization Structure of Kisumu County Health Services**

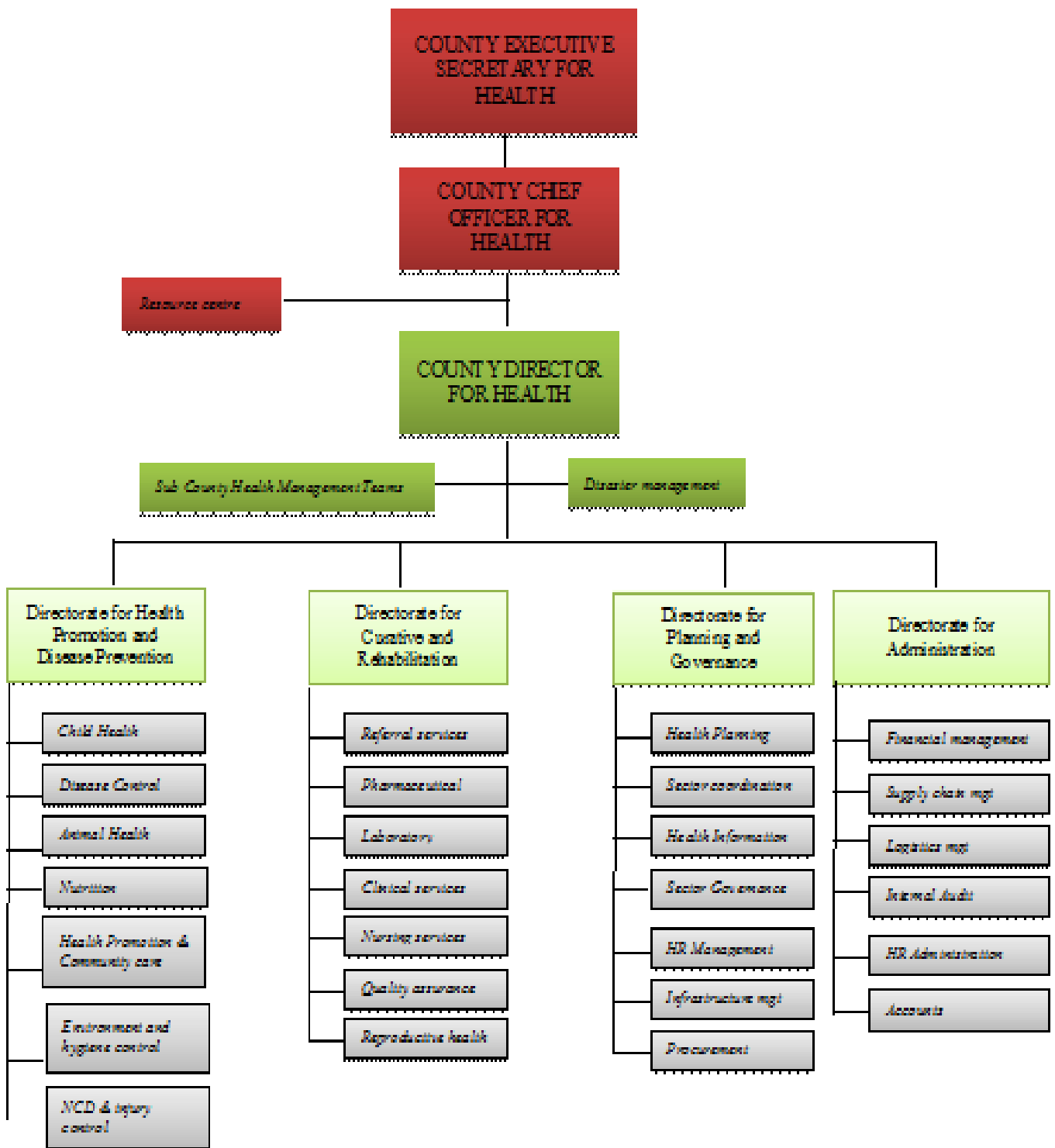
In coming up with their organization structure, the County Department of Health had to think of how they relate with the parent ministry so as to fit in the overall leadership framework for the Ministry of Health (shown in Appendix XI). They also had to think of how to relate with the hospital management teams within the county. The overall organizational framework recognizes the relationship between the different levels and types of partnerships and the stakeholders in health as well as the dynamic situation that is prevailing at this moment of the transition from a centralized to a devolved system. This is important for decision making for resource planning, allocation and utilization as well as implementation of the health agenda. The leadership framework recognizes governance, management, and technical roles of key players. The overall leadership of the department is provided by the County Executive Committee (CEC), under whom the County Executive Secretary of Health, serves. Then there is the County Chief Officer of Health under whom is the County Director of Health and the various directorates.

At the county level it was reported that all health activities are coordinated by the County Health Management Team that is linked to the various partners in the county both health and non-health and governmental and non-governmental (shown in Appendix XII). There are 6 sub-counties namely: Seme, Kisumu West, Kisumu East, Kisumu Central, Muhoroni, Nyando and Nyakach. Each of the six has a sub-county health management team. The CEC is responsible for supervising and monitoring all health activities to ensure their implementation meets the standards set in the County Integrated Development Plan (CIDP). The CEC also implements any other legislated functions by the county assembly. The health services to be supervised by the CEC

include healthcare provision, ambulance services, food licensing, and veterinary services. The chief officer for Health is responsible to the County Executive Secretary for Health (CESH) for all administrative functions and any other functions that may be assigned from time to time by the CESH. Director for Health is responsible for all the technical activities of the department and operates through the various directorates.

The interviewees at the department of health were quite optimistic about their organogram noting that “it was prepared after wide consultations and clearly spelt out lines of authority and accountability.” They hope to particularly empower the various directorates who will handle day to day issues from the hospitals and other health facilities. They also thought that the organogram was fairly easy to understand. They did not think that the organization structure posed any impediments to effective implementation of the health strategy. Their only worry is how to link it to the major health facilities in the county for ease of coordination. But as observed by the researcher, this organogram was not displayed openly on notice boards outside the department and in the hospitals. The department of health’s organogram is shown in figure 4.1.

**Figure 4.1: Organization structure of the department of health**



Source: KCHSSP, 2013 – 2017

The interviewee at JOOTRH reported that the hospital had its own organogram showing that the hospital is headed by the Chief Executive Officer. Under the Chief Executive are Directors in charge of administration and finance, inpatient services,

outpatient services, nursing, and research and training. In their minutes of management meetings they have come up with the terms of reference for each director and how they relate with the chief executive. It was also reported that the Kisumu East County Hospital has an organogram where the overall management is under the hospital management team (HMT) headed by the Medical Superintendent under whom are the various heads of departments. Generally, the interviewees agreed that the organograms were fairly simple to understand and that it was clear who was responsible for what roles. The directors at the JOOTRH are not paid for these additional roles neither are the other heads of departments in the two hospitals.

#### **4.3.5 Health Infrastructure**

All the interviewees were in agreement about the inadequacy of health infrastructure within the county. The CESH particularly pointed out that the “infrastructure for implementing the community health strategy is quite wanting given that only 60% of the available facilities can carry out HIV testing and offer PMTCT services for pregnant mothers.” The CESH indicated that some money had been set aside to put up and renovate dispensaries and health centres which will “act as the epicenter for the implementation of the community health strategy.” It was reported that the county barely has 50% of the required health facilities to serve the current population and that the situation could get worse in future given the rate of increase in population and the bigger catchment area for the county.

Within the individual hospitals there were also challenges reported. The interviewee at the JOOTRH reported that it serves a catchment population of about 5 million

drawn from the surrounding 10 counties in the larger western part Kenya. Most of these clients come to JOOTRH as their first point of care instead of being referred from the county hospitals hence contributing to the congestion in the hospital. Also the JOOTRH does not have a trauma and a burns ward. The facilities within the existing wards are either outdated or dilapidated. There are no cabinets for patients to store personal effects. Wards are congested because the hospital was initially designed for less than 300 patients but now accommodates more than double the number. There is at least a six bed intensive care unit (ICU) which was renovated by funding from the General Electric (GE) Foundation. The Kenya Commercial Bank (KCB) Foundation also renovated the renal unit and donated some dialysis machines.

The Kisumu East County Hospital has several challenges including lack of patient examination rooms, lack of patient privacy since wards are not divided into cubicles, lack of high dependency unit or ICU for the critically sick patients, no resting rooms for doctors and nurses especially those on night duty, congestion within the wards, and lack of specialized units like renal, cardiac, orthopaedic and burns. The interviewee reported that the hospital was experiencing an upsurge in patient numbers because it is considered cheaper than JOOTRH after the latter increased its user charges. Despite all these challenges, the hospital recently received a trophy from a German Foundation in recognition of its “remarkable quality improvement initiatives in service delivery.”

The information from interviews was corroborated through documentary review. The KCHSSP 2013-2017 outlines the available health infrastructure in the county. Kisumu



County has 20 hospitals which is about 60% of the target number of 33. In terms of fully equipped units, the county has 45 maternity units which is 45% of the target; 69 laboratories which is 50% of the target; only 13 radiology and imaging units which is less than 50% of the target; and, only 2 eye units which is about 14% of the target. Other available units include 3 ear, nose and throat (ENT) units comprising 14% of the target and 8 dental units comprising 40% of the expected number. There are no rehabilitation centres whereas the county expects to have at least one and no centre for the elderly out of an expectation of at least one. The available and equipped minor theatres are 34 out of a target of 84. There are 34 fully equipped wards available out of an expected number of 87. There is only one well equipped physiotherapy unit (at JOOTRH) out of an expected number of 14. Also, there is only one fully equipped ambulance available in the county, stationed at JOOTRH, out of an expected number of 17. The county has only 12 support utility vehicles out of the expected number of 44 (KCHSSP, 2013-2017). The available health infrastructure in Kisumu County is summarized in Appendix X.

#### **4.3.6 Human Resource for Health**

Kisumu County has an estimated population of 1.15 million which is projected to reach over 2.2 million by 2017 (shown in Appendix VI) but with a catchment population of more than 5 million. The interviewees were unanimous about the inadequacy of human resource in the county to serve this big population. This challenge cuts across the clinical, nursing and support staffs. It was reported that the county has less than 50% of the required number of nurses, and that even those who had retired or died had not been replaced. A good number of medical officers were reported to be resigning to join research institutions and NGOs immediately on

completing their internship training. Whereas there were a number of clinical officers looking for employment, the county did not have a budget for their recruitment. Some of these gaps have been filled by development partners notably KEMRI/CDC, KEMRI/ Walter Reed Project, IMPACT Research, ICARP, and FACES program, who have seconded their staffs to the various health facilities. But it was reported that since most of these partners had experienced reduced donor funding, they had scaled down their support and even withdrawn some of their staffs.

The head of JOOTRH lamented that they barely have one half of the required number of nurses. The number of nurses available is 214 against the required number of 538. Some of their nurses retired but were not replaced. The Kisumu East County Hospital has 105 nurses against a requirement of 210. The number of consultants/ specialists, medical officers, clinical officers, pharmacists, laboratory technologists, nutritionists and social workers in both hospitals is just about 50% of their requirement. The JOOTRH seems to have the highest number of medical specialists compared to other hospitals in the county. For example, the Kisumu East County hospital has just one physician, one surgeon, one gynaecologist and one paediatrician. But the JOOTRH has 6 surgeons, 4 gynaecologists, 4 paediatricians and 5 physicians, though half of these are from Maseno University which uses JOOTRH as the teaching hospital for medical and nursing students.

Whereas the interviewees at the department of health believe that there are adequate opportunities for staff training and advancement, this did not seem to be the case on the ground as observed by the interviewees at the hospitals. Training opportunities for the staff in the county remain a challenge because there is no clarity on who between

central or county government is responsible for the postgraduate training of the doctors, and the other staffs as well. Staff morale tends to be low because sometimes the salaries are delayed and some allowances previously enjoyed under the central government have been reduced or completely removed. Strikes and industrial action have been witnessed in the past years due some of these reasons. At the JOOTRH it was reported that there is a staff training committee which decides who goes for training when the budget allows. The same applies to the Kisumu East County hospital. The main constraint in both institutions is availability of finances to sponsor staffs for the trainings.

From documentary review, it was noted that Kisumu County has diverse staffs of various cadres and qualifications, but mostly less than 50% of the required number, as outlined in the KCHSSP 2013-2017. These staffs include medical officers, 36 out of the required 66; nurses, 953 out of the required 1760; medical consultants/specialists, 23 out of the required 96; dentists, 6 out of the required 17; clinical officers, 137 out of the required 297; occupational therapists, 10 out of the required 25; and, physiotherapists, 17 out of the required 56. The other cadres of staff available include pharmacists who are 26 out of the needed 58; nutritionists, 17 out of the required 65; laboratory technologists, 96 out of 146; orthopaedic technologists, 8 out of 20; and public health officers, 108 out of the needed 140. There are only 9 pharmaceutical technologists against the expected number of 228, while dental technologists are 5 out of the expected 15. The radiographers are 18 out of the expected 42, while laboratory technicians are 23 out of the expected 142. The number of health records and information officers is 16 out of the expected 43 (KCHSSP, 2013-2017). The current health workforce in Kisumu County is summarized in Appendix VIII.

### **4.3.7 Health Products and Technologies**

The interviewees at the department of health acknowledged that there are shortages of drugs and non-pharmaceuticals due to poor funding. The interviewees reported that the hospitals have to buy the required pharmaceuticals and non pharmaceuticals from their recurrent allocations and from their own cost sharing. As was discussed under financing, the hospitals receive less than 50% of their requirements in terms of finances. This means that at any one time there is some shortage as the hospitals struggle to purchase the most essential items.

Mostly the priority for the hospitals is on food and essential/basic medicines after settling their water and electricity bills. The situation is not helped by the delays in disbursing the funds from the government. For example, the Kisumu East County hospital did not receive any recurrent allocations in the financial year 2013-2014, meaning that they had shortages of supplies and their suppliers went unpaid for long as they waited for allocations in the following financial year. It was reported that in the financial year 2014 -2015, the JOOTRH had a budget of 80 million and 71 million for pharmaceuticals and non pharmaceuticals, but only received 49 million and 34 million, respectively. Generally these hospitals experience stock outs and shortages of supplies due to inadequate funding. This in turn compromises the quality of service delivery to patients.

Documentary review of the KCIDP 2013-2017 shows that the county allocates more to food, water and electricity (Kshs. 1.57 billion), followed by non-pharmaceuticals (Kshs. 885 million) and finally, pharmaceuticals (Kshs.578 million). But the financial

gaps were huge especially for non-pharmaceuticals (Kshs. 743, 226, 601) which call for alternative sources of funding to bridge the gap. Table 4.3 below shows the summary of health products for the year 2012-2013.

**Table 4.3: Health products for the year 2012-2013**

Units of assessment		Pharmaceuticals (Kshs)	Non-pharmaceuticals (Kshs)	Food, water, & electricity
Requirements from annual quantification (Ksh.)		<b>577,782,470</b>	<b>885,118,188</b>	<b>1,573,011,460</b>
Amounts received in past 12 months (Ksh.)	KEMSA	123,906,963	123,906,963	
	MEDS	701,000	701,000	
	OTHER (SPECIFY)	5,322,400	5,322,400	
Amounts procured using user fees in past 12 months		13,914,007	11,961,224	
Gap (Kshs)		62,155,988	743,226,601	
<b>TOTAL</b>		<b>577,782,470</b>	<b>885,118,188</b>	

**Source: KCIDP 2013-2017**

#### **4.3.8 Communication**

Communication is the process of transmitting information from one person to another through specific channels in a given environment. It is the process of sharing ideas, facts, opinions and even emotions. In organizational strategy implementation, communication flows in 3 directions, downwards, upwards and lateral or horizontal (Sababu, 2007). The Kisumu County's Department of Health has an organization structure that shows the lines and direction for communication from the top leadership down to the various directorates. The interviewees noted that the leadership also has

an open door policy where any staff that has issues to discuss can approach them. The other channels of communication available include memos, circulars, emails, newsletters, and reports. Hospital visits are also conducted to address specific challenges.

At the JOOTRH, the management has come up with a system where there is at least one staff meeting per month. This is a compulsory meeting for all cadres ranging from consultants to subordinates. The meeting is chaired by any member picked by the gathering. Here, people are encouraged to freely share opinions and problems encountered in the course of duty. It is in these meetings where important hospital information and policy issues are relayed to the staff. These meetings take place from 7.30 am to 9 am and breakfast is provided. Besides, there are departmental meetings chaired by heads of departments, which are supposed to be held once monthly, even though some departments do not meet as regularly as required. Hospital staff are also encouraged to join the many committees in the hospital including: anticorruption, research and ethics, tendering and procurement, quality control, rapid results initiative, theatre users, disease surveillance, HIV/AIDS, blood transfusion, medicines and therapeutics, among others. Other *ad hoc* meetings are convened when there is urgent need. The Kisumu East County hospital does not have regular staff meetings though departments are encouraged to hold regular meetings. Staff meetings are called when there is need. The various hospital committees have also not been formally constituted. Overall, all the interviewees felt that the communication channels available were adequate.

#### **4.3.9 Information and Communication Technology**

Information and communication technology (ICT) systems within any organization should enable co-ordination and achievement of appropriate and desired objectives and outcomes. The ICT department at the county is just being developed. The ICT department is not well resourced in terms of equipments and budgetary allocations. Information technology is therefore not interlinked within the county departments and the health facilities. This scenario was observed to make coordination of health activities within the county difficult.

However, individual hospitals like the JOOTRH are now implementing their own ICT within the various departments. For example, JOOTRH now has computerized patient data storage in their outpatient departments, even though there are complaints of frequent breakdowns of the system and also some staffs have not been trained on how the system works. The JOOTRH is trying to achieve a paperless clerkship system where all patient history, diagnosis and medications are online and could be accessed even by the administration. They have managed to have their payroll, receipting, billing and stores management system computerized. The Kisumu County hospital is also in the process of computerizing its operations and is currently able to do receipting and billing online. Due to budgetary constraints, the hospital is currently seeking for partners to finance its computerization program, which is also clearly outlined in the strategic plan. Their challenge is that most partners now are also going through financial constraints.

### **4.3.10 Culture**

Whereas the department of health is encouraging the culture of openness in resolving issues, there is still fear of victimization and possible loss of jobs by the lower hierarchy staff. This means that conflict resolution may not be well handled. This may partly be responsible for the strikes often experienced in the county by the health workers. As was observed by one interviewee, “where the relationship between employees and management is not cordial, then employees informally unite against official structures and frustrate any change initiatives.”

One of the negative cultures pervading the hospitals is late coming to work. The management at JOOTRH had tried to introduce a clocking system where people sign in when they report and sign out when they leave for home. But this was not taken kindly by the employees who saw it as punitive and was therefore sabotaged. But a positive trend is the continuous medical education (CMEs) sessions and grand rounds which are held weekly at the JOOTRH. These offer opportunities for learning new developments in the field of medicine and patient management. Continuous professional development (CPD) points are earned during those meetings, and these are a requirement by the regulatory bodies for renewal of medical practice licenses. Workshops and seminars are also held regularly at JOOTRH which are learning avenues for staffs. At the Kisumu East County hospital CMEs are not so regular, neither are workshops and seminars.

As concerns the local community, it was observed by the interviewees that certain cultural practices were a hindrance to health seeking behaviour. They talked of women who fear delivering in hospitals because their children could die. The culture



of widow inheritance was noted to be on the downfall but was still being practiced “especially among the older generation.” Recklessness among the youth and indiscipline in schools were cited as contributory factors to the spread of sexually transmitted diseases and drug abuse. Stigma was still rampant especially against those with chronic diseases like HIV/AIDS, epilepsy, and some skin diseases.

#### **4.3.11 Power and Politics**

The direction and stability of political factors are a major consideration for managers on formulating and implementing strategy. Political factors define the legal and regulatory parameters within which counties must operate. Any unpredictability of leadership such as abrupt changes to the members of county executive committee affects the smooth operations within the county. One interviewee observed that “sometimes there is a conflict of interest as some politicians, including members of the county assembly (MCAs), prefer to have their relatives or friends take up certain positions at the expense of the most qualified candidates.”

At one time there was a threat by the Senate to withhold funds for Kisumu County due to what was deemed to be corruption from the governor’s office. The governor had resisted summons to appear before the Senate Committee investigating graft in the county. This scenario, as observed by one interviewee, caused panic among staff because there were many pending projects. The passage of county legislation including the budget was also delayed remarkably when there were disagreements among the MCAs which even led to physical injury to the Speaker of the County

Assembly. Politicians also tend to interfere with who gets appointed to the county boards and oversight committees and who wins which tender.

The interviewees at the hospitals particularly complained about politicians interfering in their work by always claiming that they were corrupt and misusing funds leading to poor service delivery. One interviewee narrated an incidence where a local politician wrote to the minister for health accusing her of arrogance and ineptitude and asking for her transfer or dismissal. Another interviewee complained of “receiving orders from above” directing him on who should be awarded a particular tender. But one common complaint was about receiving letters from Chiefs, District Officers, MCAs and even members of parliament asking for waivers for particular constituents “who are very poor and cannot even afford food every day.” These waivers reduce the revenue collection for running the facilities and offering essential services.

#### **4.3.12 Policies and Legal Framework**

An interviewee at the department of health noted that the major policy issue now is the devolution of health to the counties and how the scarce resources should be equitably distributed. The interviewee added that “the central government did not do much to prepare and capacity-build the counties for the task of implementing devolution. We were given functions but with no adequate capacity and structures in place to accommodate those expanded functions. Effective accountability structures and mechanisms were also lacking.” Whereas the framers of the Constitution of Kenya 2010 envisaged a situation where there would be constant consultations between the central and county governments, this has not been the case and so the central government has been accused of working to derail devolution, especially due

to poor funding. The Transitional Authority initially outlawed the recruitment of new staffs by county governments yet those inherited from the defunct local government were not enough and most were lacking the requisite technical skills and expertise to run the new expanded functions, especially in finance, planning and administration. But one interviewee exuded optimism that “the county’s health agenda is right on track besides a few teething problems here and there.”

Locally in the hospitals, policies on promotion, training and transfer are a major challenge. Promotion is not transparently done in some departments. Some staffs take too long to be promoted. Trainings are poorly coordinated so that few people are being trained continually at the expense of other equally deserving employees. The training budget is also extremely small because it cannot be a priority when patients are going without food and drugs. Some staffs who have certain specializations are transferred to areas where they are least qualified denying them the opportunity to fully give their best. For example, at JOOTRH, there are midwives who work in the trauma wards and paediatric nurses who work in the adult medical wards. There are also staffs that were transferred from peripheral facilities to these two major hospitals for disciplinary reasons and are therefore not giving their best to work since they feel punished.

#### **4.4 Measures to Overcome the Challenges of Strategy**

##### **Implementation**

Leadership remains a challenge partly due to the nature and complexity of the tasks involved but also due to the rising public awareness and the active civil society. To

overcome this, the leadership has in place a clear vision and mission for the health sector. As was noted by most interviewees, the leaders always work towards achieving consensus when deciding on important matters. This they easily achieved by setting a personal example and by ensuring that ethical behavior, policies and practices are in place. One area where the interviewees have set a good example is in punctuality to work since all of them talked of being the first ones to arrive in the offices every morning. Open door policy has also been very helpful in this regard as a way to resolve issues faster.

Moreover, it was reported that to improve on health leadership, the county was strengthening capacity building for health staff on leadership and management as well as capacity for planning and supervision. One way has been through sponsoring some senior staffs to attend a leadership and management course at the Kenya School of Government. The JOOTRH has a functional anticorruption committee that receives complaints from clients and recommends disciplinary action against the offenders. It was reported that external and internal audits are being conducted both at the county department of health and within the individual hospitals for transparency. Procurement procedures are also in place with individual hospitals encouraged to constitute tendering and procurement committees for more transparency and accountability.

In financial management, it was reported that the County Treasury is striving to ensure maximum revenue collection and management of public financial resources. During the MTEF period of 2014-2015 the department introduced electronic system of revenue collection to increase revenue as well as minimize loss of revenue. Internal

audit department is being strengthened to support its oversight role in ensuring that funds are prudently utilized. Documentary evidence from KCHSSP 2013-2017, shows that the other activities being undertaken by the County Treasury are revenue mobilization, asset management services, management of public financial resources, budget formulation, coordination and management services, and public debt management.

One interviewee observed that the county had embarked on cleaning the payroll to strike out dead, redundant or “ghost” workers who continue to increase the wage bill. The county was in the process of domesticating the public finance management laws by way of County Laws. The county has recently concluded recruitment of qualified and skilled finance management staff to guide the fiscal policy and management. The county is also in the process of adopting an effective e-financial management system – both software and hardware – to reduce wastage and pilferage. An example is the e-ticketing already in place targeting parking and market fees. As shown in Appendix XIII, a total of Kshs. 265 million is being invested in strengthening health financing in the county. Individual hospitals have also put in place measures to increase their revenue collections like computerization of all cash points and increasing the number of cash points and billing offices. The JOOTRH has an amenity wing (Victoria Hospital) which admits patients willing to pay premium charges hence raising more revenue for the hospital.

The development of human resource remains central to the achievement of the aspirations of the KCHSSP 2013-2017. Improvement of efficiency and effectiveness in service delivery is highly dependent on the availability of an adequate, competent

and motivated workforce. The county, it was reported, has embarked on strengthening supportive supervision and increasing motivation through recognition of good performance, promotions and remuneration. The county is also collaborating with institutions of higher learning like Maseno University, to increase their workforce, especially those with special skills. The county is seeking for international exchange programs for specialist training in China and Egypt. The Egyptian government has recently given scholarship opportunities for training in oncology and palliative care. The Chinese government gave scholarships for training on infectious diseases. Kenyatta National Hospital has been training staff of JOOTRH on dialysis and neonatal care. Two biomedical engineers at JOOTRH were given scholarships to study in Germany. Recently, the Centre for Public Health and Development (CPHD) organized and funded trainings for clinical staffs from the two hospitals on continuous positive airway pressure (CPAP) resuscitation for the newborn child. Due to the limited funding, staffs at the two hospitals are also being encouraged to adopt on-the-job training (OJT) and also to attend seminars, workshops and CMEs.

For effective communication, an open door policy has been adopted by the leadership. Employees have been assured that there will be no victimization for freely sharing their views. Feedback to the employees from their seniors is being encouraged especially during the quarterly performance reviews. Individual hospitals are being encouraged to conduct patient-exit surveys regularly as a way of knowing the levels of satisfaction with the services being offered. The JOOTRH has already started implementing the patient exit surveys. Hospitals are being encouraged to have monthly staff meetings where important policy issues and directions can be relayed and also to constitute various committees where staffs can participate. As shown in

the CFSP (2015), the Communication, Planning and Development department at the Kisumu County is currently undertaking the following: result tracking, monitoring and evaluation of performance; capacity building and training; formulation of county planning policy; as well as establishment of information and documentation centres within the county.

There are plans to display the organization structure for the department of health on the notice boards at the county headquarters and at the various hospitals. There are also plans to develop an overall organogram that shows the relationship of the county department of health and the various health facilities and the health management committees. The Kisumu East County hospital intends to laminate and display its organogram openly on the notice boards. As indicated by one interviewee, ‘there is a lot of room for improvement in our organogram. The important thing is that everyone understands their role.’”

The health infrastructure in Kisumu County is below expectation. The interviewees were in agreement that the existing infrastructure has to be upgraded. The county needs more laboratories, dental units, radiology and imaging units, renal units, eye/ophthalmology units, ENT units, orthopaedic/trauma units, and other specialized services. One option being pursued by the county government is fostering more public-private-partnerships (PPPs) to encourage investments in any of the mentioned areas. The county government is currently trying operationalize the non-functional facilities; expanding and upgrading existing facilities; and constructing new facilities as required. Prudent policies on effective maintenance of existing equipment and the

procurement of new equipment are being developed. A functional transport management system is being established in the county to deal with emergencies and address any shortages. The hospitals are currently purchasing essential equipments while disposing any idle assets. The JOOTRH is reportedly rehabilitating the borehole and also investing in harvesting of rainwater to reduce its water bills. Both hospitals are planning to expand their mortuary capacities as a way of generating more revenue. Appendix XIII shows that the current investment in health infrastructure is Kshs. 3.6 billion and another Kshs. 692 million will be invested in the purchase of diagnostic equipment for the county hospitals.

Concerning health products and technologies, the county is seeking alternative funding through donors and public-private partnerships to bridge the financing gap. The hospitals are sourcing for suppliers whose products are reasonably priced and of high quality for purposes of affordability, effectiveness and durability. KEMSA has traditionally been the single biggest government agency supplying drugs to public hospitals, but this has since changed with devolution because counties now have to buy their pharmaceuticals and the non-pharmaceuticals using the allocated recurrent budgets. Majority of the interviewees observed that KEMSA has become inefficient and unreliable because of frequent stock-outs and delays in delivering products to the hospitals. Other major suppliers mentioned include MEDS, Hurleys, Cosmos, Sai, Laborex Kenya, MEDICEL Kenya, and a few local ones like Winam and Ramogi pharmaceutical companies. The stores departments are being strengthened to reduce wastage especially breakages and pilferage of products. Information in the KCHSSP 2013-2017 shows that the department of health is in the process of establishing an electronic commodity management system for the individual health facilities and also



upgrading their storage and dispensing systems. Procurement procedure for essential health commodities is also being streamlined. As shown in Appendix XIII, the county is investing Kshs. 7 billion in strengthening health commodity management.

The ICT department at the County Department of Health is just currently being established and equipped so as to act as the linkage and coordination centre with the hospital information systems. This will facilitate the monitoring of patient flow, the pharmaceuticals and non-pharmaceuticals, and any shortfalls. The Kisumu East County hospital is seeking partners to facilitate the computerization of both its outpatient and inpatient services. The JOOTRH is in the process of completing their inpatient computerization. Social media platforms such as facebook and twitter are being utilized by the department of health and the various hospitals in communicating with their workers and for marketing of their services. Notably, from the KCIDP 2013-2017, the county is currently implementing a free Wi-Fi project which is targeting installations and institutions within the central business district but which is later expected to be rolled out to the rural areas. The county also has plans to set up digital villages and open at least one radio station for disseminating information about its development agenda.

The culture of openness and free sharing of ideas among the employees has been widely adopted. The CMEs and grand rounds are being expanded to involve Maseno University and the other training institutions that have students at JOOTRH, to inculcate a culture of learning and sharing of information. The JOOTRH currently has staff uniforms and identity cards which staffs are encouraged to put on every day to

foster a sense of identity with the hospital. Team building activities are still lacking in the county except staff parties at the end of the year.

The local political networks are being encouraged to lobby for more funding and investments in health. Corruption at the county and within the hospital hierarchy is being addressed through tighter internal and external audits and controls and through the anticorruption agencies. The JOOTRH has an anticorruption committee that handles complaints and recommends disciplinary measures against offenders. Internal and external audit systems are being strengthened as a means to minimize pilferage and sleaze. More harmony among the MCAs will ensure that budgets are passed in time for investments in health. Recruitment criteria and procedures are being streamlined and strengthened at the county and within the hospitals for more transparency.

#### **4.5 Discussion**

This study has brought to the fore the many challenges facing the social pillar strategy in the devolved health sector in Kisumu County. These challenges broadly have got to do with leadership and governance, human resource, financing, health infrastructure, products and technologies, change management, ICT, communication, policy, power and politics. These are the same challenges that were found by Chemwei, Leboo and Koech (2014), Okumus (2003) and Sababu (2007). Devolution as a new governance strategy has not been easy to understand and implement given the lack of preparedness and incapacity of the counties. Empirical studies elsewhere have shown that devolution has mixed impact on health outcomes (Besley & Burgess, 2002; Calamai, 2009). This study has shown that devolution faces the challenge of

inadequate budgetary allocation and lack of proper coordination between the two levels of government, a finding that is similar to that of a study done by the Centre for Health Solutions( CHS, 2014).

The findings of this study also correspond to those of Bolo and Nkirote (2012) who found that the challenges that faced the implementation of Kenya Vision 2030 included limited resource allocation, organization culture, political interference, corruption and misappropriation of funds, poor linkage of policy, planning and budgeting, and ineffective involvement of the citizens. However, the two studies differ in that this study has also brought to the fore the health infrastructural and commodity deficiency challenges that were not observed by Bolo and Nkirote (2012). Also, Bolo and Nkirote carried out their study just before the implementation of the devolution strategy so it might not have captured some of these inherent challenges.

In this study the interviewees talked of having an open door policy to management and decision making. This policy is a positive step to good performance and service delivery. However, this study did not interview low cadre staffs to find out their perception and experience with accessibility of the top management, though there was a general mention of fear of victimization by staff. A study by Rapert, Velliquette and Garretson (2002) showed that organizations where employees have easy access to top management through open supportive communication outperform those with more restrictive environments.

The lack of a well developed and functional ICT department at the county headquarters may be compromising coordination and supervisory efforts by the department of health and hence the overall operational excellence. Presently, ICT is the engine that drives most economies. It is laudable that the county is making effort towards this end. Thompson, Gamble and Strickland (2006) observed that a good information and technology system is important for the managerial task of executing strategy successfully, achieving greater operating excellence and strengthening organizational capabilities.

This study has shown that there are serious inadequacies in human resource and budgetary allocations to the county and hence to the hospitals. The county generally operates at 50% of its requirements. It is no wonder that service provision and quality is compromised. Chemwei, Leboo and Koech (2014) showed that inadequate human resource and financing accounted for 65% and 61% of the reasons for failure of strategy implementation, respectively.

The findings of this study are also in agreement with theories such as the resource based view (RBV) and institutional theory. The RBV posits that the resources possessed by any firm are the primary determinants of its performance. These resources include all the assets, capabilities, organizational processes, firm attributes and knowledge (Barney, 1991). This study has shown that because of inadequate human resource, lack of training opportunities, poor health infrastructure and insufficient products the overall service provision and quality is compromised. The institutional theory argues that organizations are inserted in environments constituted

by rules, beliefs, norms, values, conventions, traditions and cultures which determine the sense of shared guidelines, procedures and objectives (Clemens & Cook, 1999). In this sense, this study has shown that cultural manifestations like openness in communication, conflict resolution, punctuality, a positive attitude towards learning and sharing knowledge, and the putting on of uniforms and identity tags may all influence the success of strategy implementation.

## **CHAPTER FIVE**

### **SUMMARY, CONCLUSION AND RECOMMENDATIONS**

#### **5.1 Introduction**

This chapter presents a summary of major findings, conclusions and recommendations based on the two objectives of this study: to establish the challenges facing the implementation of the social pillar strategy of Kenya Vision 2030 in the devolved health sector in Kisumu County; and, to determine the measures being put in place to address the challenges facing the implementation of the social pillar strategy of Kenya Vision 2030 in devolved health sector in Kisumu County.

#### **5.2 Summary**

The Kisumu county Health Sector Strategic and Investment Plan was adopted from the Kenya Health Sector Strategic and investment Plan 2013-2017. The main challenges of strategy implementation include a leadership that is not well grounded on the new structures under devolution and an increasingly informed public demanding for results; inadequate financing and budgetary allocations from the central government; inadequate health infrastructure including hospitals, maternity units, dental units, radiology and imaging units, and other specialized services; inadequate human resource for health including doctors, nurses, dentists, pharmacists, physiotherapists and other cadres of staff; and poorly established ICT system at the department of health leading to poor coordination of functions with the hospitals; a bureaucratic county organization structure that lacks clear linkages with individual

hospital structures; and political interferences in the running of the affairs of the department of health.

Some of the key measures to address these challenges include leadership development through learning; seeking alternative sources of financing; increased investments in human resource and health infrastructural development; increased budgetary allocations for health products and technologies; open door leadership policy; increased transparency and accountability in the use of public resources; increased investments in ICT; and less political interference in the running of the affairs of the department of health.

### **5.3 Conclusion**

The study has identified key challenges to strategy implementation including leadership and governance, financing, inadequate human resource for health, inadequate supply of health products and technologies, poor service delivery, inadequate health infrastructure, and a bureaucratic organization structure. Some of the measures in place to address these challenges include seeking alternative sources of financing, increased investments in human resource and infrastructure, ensuring sufficient health products is available, investments in ICT, improved communication, and political goodwill and support.

These findings largely agree with empirical literature. Studies by Chemwei, Leboo and Koech (2014) also showed that the challenges of strategy implementation included human resource, communication, ICT, financing, communication and political influences. These findings are similar to those in other studies (Rapert,

Velliquette & Garretson, 2002; Okumus, 2003; Bolo & Nkirote, 2012). But these findings differ to the extent that low cadres of staff were not interviewed in this study to corroborate some of the positions taken by their leaders. The findings also agree with the RBV and the institutional theory in as far as the availability of resources, both human and material, and the prevailing cultural climate at work, determines the performance of the task of strategy implementation.

#### **5.4 Recommendations for Policy and Practice**

For the effective implementation of the devolved health function, the policy of the central government should be to allocate more funds to the Ministry of Health and hence to the counties. The Abuja Declaration requires at least 15% of the annual national budget to be allocated to the ministry of health. But in the previous budget only 2.8% was allocated. This has substantially undermined the availability of health products, health personnel and infrastructure. Kisumu County also needs to rope in more donors and development partners to support its health sector strengthening initiatives like reduction of morbidity and mortality, health care financing, health commodity management and human resource development. An initiative that the county should promote to help generate financing is health tourism given its strategic geographical location.

There should be enhanced investment in research and development on areas such as effective disease surveillance, prevention and management and on service delivery innovations. This will help to lower the burden of diseases and ill-health in the county. The coordination function of the department of health should be enhanced so that it can bring together the various research institutions to focus their researches on



areas that are of direct relevance to the county, like HIV/AIDS and malaria. As a capacity building initiative and for motivation, some staffs from the county should be seconded to these research institutions to learn basic research techniques and proposal writing so that the hospital staffs can actively seek for grants to carry out research and innovation.

Information and communication technology should be upgraded and integrated to enhance quality, reliability, and accuracy of information and improve efficiency in service delivery and decision making. The County department of health should complete the setting up and equipping of its ICT department. This should then be clearly linked with the ICT departments at the JOOTRH and the Kisumu East County hospital. The sub county hospitals should be roped in to this ICT network for easy coordination and supervision from the County headquarters. The county should fast-track the setting up of e-health hubs as envisioned in KCHSSP 2013-2017.

To enhance leadership and communication, an annual health sector performance report should be developed by the county's department of health to assess the achievement of the sector against the standards and indicators derived from the KHSSP 2013-2017. Information on indicators should be analyzed to obtain the overall county achievement and disaggregation of achievement by policy objective, intervention, sub-county and facility. Individual health facilities should also submit their annual sector reports so that their unique challenges can be addressed. All the health facilities should have monthly staff meetings attended by at least a team from the county department of health to address any issues that may arise. There should be

a reward scheme for heads of departments and individual employees who perform better than others and who show a great sense of creativity and innovation.

The county will need to foster more inter-sectoral collaboration in order to reduce poverty levels which currently are responsible for most of the poor health outcome. For example, agricultural production and mechanization has the potential to employ several thousands of jobless youths besides ensuring food security. Fish farming also has the potential to create thousands of jobs and income instead of just relying on Lake Victoria. Enhanced management and promotion of tourism will earn the county large amounts of revenue that can be ploughed back into developing the health infrastructure and other social facilities. There are many Universities and colleges setting up in the county which could provide the needed avenue for human resource development through training and capacity building for health.

## **5.5 Implications for Theory**

This study was anchored on four main theories: the institutional theory, the RBV, the McKinsey's 7-S framework and the contingency theory. Of these, the RBV and the institutional theories were the most relevant from the study findings. The study has brought out the important role of organizational resource endowment in enhancing strategy execution. It has shown that Kisumu County lags behind in health status indicators because of poor financial, human, and infrastructural resources. These findings are also the basis of the RBV which posits that the resources possessed by the organization such as assets, capabilities, attributes, knowledge and firm processes, are the primary determinants of its performance (Barney, 1991). Whereas the RBV proposes that these resources should be inimitable, non-substitutable and rare, the

kind of resources required in Kisumu County are not necessarily unique but are the same ones applicable in other counties and sectors of the economy.

The institutional theory was also quite relevant and applicable in this study. This theory emphasizes the interdependence between organizations and their environments and posits that organizational environment is constituted of rules, values, norms, beliefs and cultures that provide stability and meaning to social behavior (Scott, 1995). This study has shown that organizational leadership, culture, power and politics play a positive role in fostering a sense of belonging and ownership which in turn enhances the implementation of health strategy.

## **5.6 Limitations of the Study**

This study has focused mainly on the existing challenges and the measures being undertaken to overcome these challenges of strategy implementation in the devolved health sector within the social pillar strategy. These findings are therefore limited to the health sector and cannot be generalized to the other aspects of the social pillar strategy like education, water and sanitation, youth and women empowerment. Also, conceptually this study focused purely on strategy implementation, which is just one aspect of strategic management. Areas such as strategy development and formulation and its challenges were not studied.

Contextually, this study was limited by scope and time. This study was done in Kisumu County and the interviewees were executives at the department of health or the heads of the two major hospitals. Their responses may not be the actual reflection of the feeling and situation on the ground. Interviews with ordinary employees would have probably yielded different results. Also, many other functions have been

devolved not just health yet this study only focused on the challenges of the devolved health function. The time available for the study was fairly short and so only limited areas could be focused on.

This being a case study and relying on interviewees to answer all the questions honestly, it is possible that some interviewees were not honest and were just saying what they thought the interviewer wanted to hear. Most people in leadership positions do not like to take a position that may be at variance with that of their organization. Also, the nature of the documents required such as minutes of meetings and financial documents were deemed to be fairly confidential. There was reluctance to divulge some confidential information particularly those to do with political interference in the affairs of the county, financial dealings, tendering and procurement of commodities.

### **5.7 Suggestions for Further Research**

This study focused on challenges facing the implementation of the social pillar strategy in the devolved health sector in Kisumu County. It will be important to also do a study on the other aspects of strategic management such as challenges of strategy formulation in Kisumu County. Also, whereas some of the challenges identified may be cross-cutting, there will be need to carry out similar studies for other counties to bring out the unique challenges that they face. This is because of the demographic, geographic, economic and political differences among the various counties. The social pillar has several priority areas including education and training; water and sanitation; housing and urbanization; gender, youth, sports and culture; equity and poverty reduction; and science, technology and innovation. This study has focused only on

health as a priority area. There is need to conduct other studies that should focus on the other key areas such as housing and urbanization, which also has an influence on health particularly for those who live in the informal settlements in the urban centres. From the CFSP (2015), poverty reduction will be another interesting area of research particularly in Kisumu County where the poverty levels are estimated at 60% against the national average of 46%.

There is need to do a similar study but focusing on the low cadre staffs and employees as opposed to the leadership. This will help bring out any discrepancies in the responses from the leaders but also gauge the feeling and perception on the ground. Devolution as a model of governance is fairly new to Kenya. There is a general misconception about what it is and what it is not. There should be studies that benchmark with those countries where devolution has been successfully implemented as a way to create models for effective implementation.

The same study should still be repeated but with a different methodology. A longitudinal study, for example, would be more appropriate for long term assessment of the implementation process of the various strategies and the eventual health outcomes realized. This may also minimize biases resulting from selective reporting or situations where the interviewees say what they think the interviewer needs to hear.

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## APPENDICES

### Appendix I: Letter of Introduction



# UNIVERSITY OF NAIROBI

## SCHOOL OF BUSINESS

### KISUMU CAMPUS

Telegrams: "Varsity" Nairobi  
Fax: 4181650  
Kisumu, Kenya  
Telex: 22095 Varsity  
Mobile: 0720348080  
Email: [ajaleha@uonbi.ac.ke](mailto:ajaleha@uonbi.ac.ke)

P.O Box 19134-40123  
Kisumu, Kenya

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Date: 29<sup>th</sup> September, 2015.

#### TO WHOM IT MAY CONCERN

The bearer of this letter Awuonda B. B Onyango

REGISTRATION NO: D61/65587/2013

The above named student is in the Master of Business Administration degree program. As part of requirements for the course, he is expected to carry out a study on **"Challenges of implementing the social pillar strategy of the Kenya Vision 2030 in the Devolved Health Sector in Kisumu County."**

He has identified your organization for that purpose. This is to kindly request your assistance to enable him complete the study.

The exercise is strictly for academic purposes and a copy of the final paper will be availed to your organization on request.

Your assistance will be greatly appreciated.

Thanking you in advance.

Sincerely,

**MR. CHARLES DEYA**  
**ADMINISTRATOR, SOB, KISUMU CAMPUS**

Cc File Copy

ISO 9001:2008  
The Fountain of Knowledge

29 SEP 2015

## **Appendix II: Letter of Authority**

AWUONDA B. B. ONYANGO

P. O. BOX 19234 – 40123

KISUMU

1<sup>st</sup> October, 2015

OFFICE OF THE GOVERNOR

KISUMU COUNTY

KISUMU

THRU,

THE COUNTY EXECUTIVE SECRETARY FOR HEALTH

KISUMU COUNTY

Dear sir/Madam

### **RE: AUTHORITY TO COLLECT DATA**

I am currently pursuing a Masters of Business Administration (MBA) in Strategic management, from the University of Nairobi. As a requirement for the degree, I have to carry out a research project in an area of interest. I have chosen to research on the challenges that face the implementation of Kenya Vision 2030 in the devolved health sector, specifically focusing on Kisumu County. I therefore wish to seek your permission and participation to collect relevant data through interviews.

Attached is an introductory letter from the University of Nairobi for ease of reference.

Thanks in advance

Yours faithfully,

AWUONDA .B. B. ONYANGO

D61/65587/2013

## **Appendix III: Request for Interview**

AWUONDA B. B. ONYANGO

P. O. BOX 19234 – 40123

KISUMU

1<sup>st</sup> August, 2015

Dear respondent,

### **RE: REQUEST FOR INTERVIEW**

I am currently pursuing a Masters of Business Administration (MBA) in Strategic management, from the University of Nairobi. As a requirement for the degree, I have to carry out a research project in an area of interest. I have chosen to research on the challenges that face the implementation of Kenya Vision 2030 in the devolved health sector, specifically focusing on Kisumu County. You have been selected to be part of this study.

The purpose of this letter is to request you to grant me an opportunity for an interview. Any information that you provide will be used exclusively for academic purposes and will be treated with strict confidence. A copy of the final report may be availed to you if you request for it.

Thanks in advance

Yours faithfully

AWUONDA B. B. ONYANGO

D61/ 65587/2013

## **Appendix IV: Interview Guide 1**

(For the County Executive Officer for Health, Chief Officer of Health and County  
Director of Health)

Designation of respondent-----

### **Comment on the following challenges of strategy implementation:**

1. How ready were you as a leadership to take over health care function in the devolved system?
2. What are the main causes of morbidity and mortality in the county?
3. How adequate is the financing by the central government compared to your health care budget?
4. Do you have any other sources of financing for health care beside the recurrent allocations?
5. What leadership challenges have you experienced as you try to manage health care in the devolved system?
6. How comprehensive is the county department of health organization structure in clearly outlining the responsibilities of different cadres of staff?
7. How have the values, attitudes and beliefs held by your staff fostered or impeded the effective delivery of health care services to the people?
8. How efficient and prompt is the flow of information from your office to, and from, the lower levels on matters of health care delivery?
9. Comment on the current staffing levels against your actual needs, and how that impacts on health care delivery
10. Are there training and development opportunities for the various cadres of staff in the county?

11. What are the causes of the frequent strikes by health care workers and how are you addressing those concerns?
12. Who are the main stakeholders in health in this county and how do you engage them when developing new health policies and plans to ensure broader participation and acceptability?
13. How have you managed to harness the power and politics in the county for purposes of resource availability and policy directions in health care?
14. Comment on the adequacy of information technology and support system for the effective health care coordination in the county
15. What change management measures do you have in place for smooth uptake and implementation of any new policies and ideas by the employees?
16. How well have you performed in the realization of the aspirations of the KHSSP 2013-2017 which Kisumu County has domesticated?
17. Comment on any measures that have been put in place or that are anticipated to help minimize or solve the challenges in health care mentioned above.

## Appendix V: Interview Guide 2

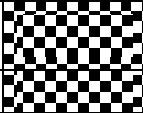

(For the heads of JOOTRH and Kisumu East County Hospital)

Designation-----

1. What are the main causes of morbidity and mortality in the hospital?
2. To what extent have the following factors/ challenges affected the effective delivery of health services to clients in your hospital? (Probe for details)
  - i. Recurrent allocations from the government
  - ii. Availability and adequacy of human resource/ staffing
  - iii. Availability of pharmaceuticals and non-pharmaceuticals
  - iv. Leadership, direction and organizational governance
  - v. Communication with employees and with the seniors at the county health department
  - vi. Change management practices
  - vii. Power and politics both within and without
  - viii. Current hospital organization structure/organogram
  - ix. Values, beliefs and attitudes of the staff towards their work
3. Comment on any measures you have in place to remedy each of the above challenges (Probe for details).



## Appendix VI: Population Projection by Cohorts (2013 -2017)

	Description	Population estimates	Target population				
			Year 1	Year 2	Year 3	Year 4	Year 5
1	Total population		<b>1,086,287</b>	<b>1,117,789</b>	<b>1,150,205</b>	<b>1,183,561</b>	<b>1,217,884</b>
2	Total Number of Households		217257	223558	230041	236712	243577
3	Children under 1 year (12 months)	3.71%	45608	46520	47517	48774	50524
4	Children under 5 years (60 months)	16.9%	210667	214883	219478	225276	233314
5	Under 15 year population	42.3%	531555	542197	553793	568396	588607
6	Women of child bearing age (15 – 49 )	24%	298337	304305	310816	319030	330422
7	Estimated Number of Pregnant Women	3.84%	48055	49017	50065	51387	53216
8	Estimated Number of Deliveries	3.84%	48055	49017	50065	51387	53216
9	Estimated Live Births	3.79%	47078	48565	49602	50911	52721
10	Total number of Adolescent (15-24)	26.2%	270363	272036	278445	286557	297841
11	Adults (25-59)	27.3%	234268	239145	244194	249627	255700
12	Elderly (60+)	3.4%	55003	46217	53237	54697	56616

**Source: KCHSSP 2013-2017**

## Appendix VII: Leading Causes of Morbidity and Mortality

CAUSES OF DEATH				CAUSES OF ILL HEALTH (DISEASE OR INJURY)			
National		County-specific		National		County-specific	
No	Condition	No	Condition	No	Condition	No	Condition
1	HIV/AIDS	1	HIV Related Diseases	1	HIV/AIDS	1	Other Disease of Respiratory System
2	Perinatal conditions	2	Lower respiratory infections	2	Perinatal conditions	2	Malaria
3	Lower respiratory infections	3	Malaria	3	Malaria	3	Diarrhoea
4	Tuberculosis	4	Perinatal conditions	4	Lower respiratory infections	4	Disease of the skin
5	Diarrhoeal diseases	5	Tuberculosis	5	Diarrhoeal diseases	5	Urinary Tract Infection
6	Malaria	6	Injuries (RTA,ASSAULT)	6	Tuberculosis	6	HIV/AIDS
7	Cerebrovascular disease	7	Meningitis	7	Road traffic accidents	7	Injuries (RTA,ASSAULT)
8	Ischaemic heart disease	8	Heart diseases	8	Congenital anomalies	8	Eye Infections
9	Road traffic accidents	9	Malnutrition	9	Violence	9	Pneumonia
10	Violence	10	Cancers	10	Unipolar depressive disorders	10	Ear Infections

Source: KCHSSP 2013-2017

## Appendix VIII: Health Workforce

No	Staff cadres	No, available	No. / 10,000 persons		Available by tier			Required numbers			Total gaps		
			County	National	Hospitals	Primary care	Community	Hospitals	Primary care	Community	Hospitals	Primary care	Community
1	Medical officers	36			31			66			30		
2	Dentists	6			5			17			11		
3	Dental Technologists	5			5			15			10		
4	Public Health Officers	108			11			140			32		
5	Pharmacists	26			19			54			28		
6	Pharm. Technologist	9			5			228			219		
7	Lab. Technologist	96			52			146			50		
8	Orthopedic technologists	8			8			20			12		
9	Nutritionists	17			8			57			48		
10	Radiographers	18			18			42			24		
11	Physiotherapists	17			17			56			39		
12	Occupational Therapists	10			9			24			15		
13	Plaster Technicians	6			6			20			14		
14	Health Records & Information Officers	16			14			43			27		
15	Medical engineering technologist	13			12			23			10		
16	Medical engineering technicians	2			0			12			10		
17	Mortuary Attendants	1			1			22			21		
18	Drivers	22			12			38			16		
19	Accountants	2			1			10			8		
20	Administrators	14			9			19			5		
21	Clinical Officers (specialists)	26			18	6		67	4		60	2	
22	Clinical Officers (general)	111			63	63		105	108		49	49	
23	Nursing staff (KRCHNs)	427			260	164		921	507		300	343	
24	Nursing staff (KECHN)	426			227	141		388	198		210	53	
25	Laboratory Technicians	23			22	27		37	128		18	101	
26	Community Oral Health Officers	3			3	0		8	22		6	22	
27	Secretarial staff / Clerks	49			33	15		53	31		20	17	
28	Attendants	6			0	0		40	50		40	48	
29	Cooks	11			26	10		61	69		35	57	
30	Cleaners	89			95	27		245	145		140	114	
31	Security	0			16	0		87	131		68	127	
32	Community Health Extension Workers (PHT's, social workers, etc)	75			18	51	39	27	105		12	86	104
33	Community Health Workers	2144			162	1333	719	90	150		50	60	596
34	Other (specify)-Social workers, counselors Procurement assistant,	42			10	0		36	42		16	52	
35	Consultants	23			23			57	50		38	36	

Source: KCHSSP 2013-2017

## Appendix IX: Recurrent Health Expenditure (Previous Year)

Item	Calculation	Source of funds					
		HSF(HSSF+)	Other GoK (Reccurent+ Dev)	User fees (FIF)	CDF	LATF	Partners (FACES/A+/ ICAP (specify))
Amount Budgeted	(A)	285,273,403	130,440,468	316,383,499	14,780,000	0	27,229,236
Amount Received	(B)	36,155,054	11,693,687	<u>196,347,421</u>	7,080,000	82,500	50,509,966
Expenditure	(C)	36,760,258	10,477,449	188,295,035	7,070,000	82,500	48,713,874
Expenditure accounted for (SOE's submitted)	(D)	36,429,008	10,477,449	176,823,614	6,470,000	82,500	48,169,874
Funds utilization rate	(C/B X 100)	100%	90%	95.9%	99.9%	100%	96.4%
Accounting rate	(D/C X 100)	99%	100%	93.9%	91.5%	100%	98.9%

**Source: CFSP 2015**

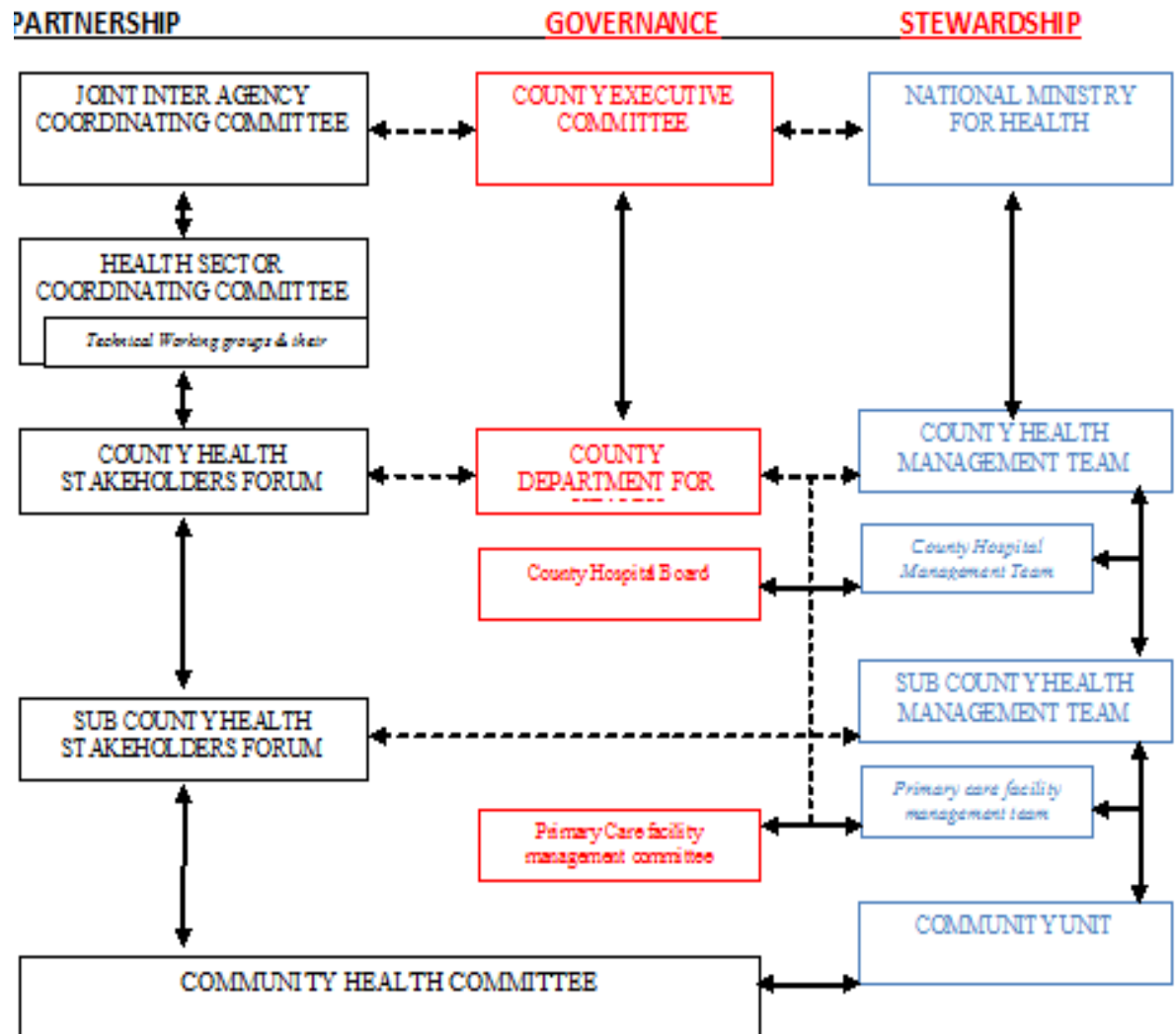
## Appendix X: Health Infrastructure

Health Inputs & processes	No. available			Required numbers	Gaps
		County	National		
<b>Physical Infrastructure</b>					
<i>Hospitals</i>	20			33	13
<i>Primary Care Facilities</i>	146			154	8
<i>Community Units</i>	159			218	59
<b>Full equipment availability for</b>					
<i>Maternity</i>	45			141	96
<i>MCH / FP unit</i>	103			161	58
<i>Theatre</i>	18			32	14
<i>CSSD</i>	12			29	17
<i>Laboratory</i>	69			136	67
<i>Imaging</i>	13			26	13
<i>Outpatients</i>	137			203	66
<i>Pharmacy</i>	43			169	126
<i>Eye unit</i>	2			15	13
<i>ENT Unit</i>	3			15	12
<i>Dental Unit</i>	8			20	12
<i>Mental health unit</i>	2			4	2
Rehabilitation Centre	0			2	2
Elderly centres	0			1	1
<i>Minor theatre</i>	34			84	50
<i>Wards</i>	34			87	53
<i>Physiotherapy unit</i>	9			22	13
<i>Mortuary</i>	12			23	11
<b>Transport</b>					
<i>Ambulances</i>	1			17	16
<i>Support / utility vehicles</i>	12			44	32
<i>Bicycles</i>	228			1395	1167
<i>Motor cycles</i>	81			322	241

Source: KCIDP 2013-2017

## Appendix XI: Health Sector Leadership Framework

### Health Sector Leadership framework



Source: KCHSSP 2013-2017

## Appendix XII: Role of Stakeholders in Health

<b>STAKEHOLDER</b>	<b>ROLE</b>
Ministry of health services.	Enforcing National Health Policy guidelines at the subcounty level. Developing and implementing sub-county specific cost effective packages. Mobilizing resources, Inter-sectoral collaboration and health service delivery. Curative and health infrastructure development
Private sector, NGOs, and CBOs	Providing healthcare services and resources. Capacity building and service delivery, Bursaries and scholarships to the OVCs.
APHIA II Nyanza	HIV/AIDS activities in the sugar belt, maternal health care services and infrastructure in hospitals
Liverpool VCT	Mobile VCT, community VCT services
AMREF Maanisha	HIV/AIDS activities, capacity building, financial support to CBOs in HIV and AIDS activities
University of Nairobi	PMTCT program
FACES	Promotion of male circumcision (MCC)
Faith Based organizations	Development and management of Health Facilities.
Donors (JICA,DFID, World Bank among others)	Provision of funds for health services and strengthening.
National Aids Control council	Coordination, monitoring and evaluation, resource mobilization for HIV and AIDS programmes
Kenya red Cross Society	Responding to disasters and diseases outbreaks
Private Health provider	Supplement public effort in the provision of medical services
UNICEF	Nutrition supplements, maternal health immunization and health care facilities and strengthening of health care systems.
CDC	HIV/AIDS lab test scans, TB, malaria research
Constituency Development Fund	Support in construction of health facilities
Kisumu City Management	Provision of health care services and construction of health facilities.

**Source: KCIDP, 2013-2017**

### Appendix XIII: On-going Health Sector Projects and their Cost Estimates

<b>PROJECT NAME</b>	<b>COST ESTIMATE</b> (Kshs)	<b>TIME FRAME</b> (Years)
Improving uptake of maternal health	1.2 billion	2013-2017
Reduction of under 5 mortality	191 million	2013-2017
Reduction of HIV/AIDS prevalence	13.5 billion	2013-2017
Reduction of malaria prevalence	1.2 billion	2013-2017
Diagnostic equipment	692 million	2013-2017
Reduction of diarrhoeal disease burden	964 million	2013-2017
Reduction of TB prevalence	68 million	2013-2017
Reduction of non communicable diseases	69.8 million	2013-2017
Community health service coverage	200 million	2013-2017
Strengthening health commodity management	7 billion	2013-2017
Strengthening human resource for health	19 billion	2013-2017
Refuse management	106 million	2013-2017
Strengthening mental health care	91 million	2013-2017
Health infrastructure	3.6 billion	2013-2017
Strengthening health care financing	265 million	2013-2017
Emergency and disaster management	102 million	2013-2017
Services for children with special needs	32 million	2013-2017
Comprehensive school health program	28 million	2013-2017
Improving nutritional status	153 million	2013-2017

**Source: KCIDP, 2013-2017**