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An assessment of the state of public healthcare governance in Tana River County, Kenya

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AN ASSESSMENT OF THE STATE OF PUBLIC HEALTHCARE GOVERNANCE IN TANA RIVER COUNTY, KENYA

BY

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DECLARATION AND APPROVAL

I declare that this work has not been previously submitted and approved for the award of a degree by this or any other University.

To the best of my knowledge and belief, this thesis contains no material previously published or written by another person except where due reference is made in the thesis itself.

Signed: 

Date: 15 May 2018

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Approval

This dissertation was approved by

Professor Gilbert Kokwaro,

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Date……

ABSTRACT

There are six (6) building blocks in the health systems, namely health service delivery, health information systems, healthcare financing, health workforce, medical technologies and products and health leadership and governance. Since devolution of healthcare services in Kenya in 2013, there has been an increased investment in the various building blocks of healthcare, with varied improvement in health outcomes. Health leadership and governance has not received much attention of the blocks of the healthcare system. To foster accountability, transparency, integrity, professionalism, customer focus and innovativeness, H.E Uhuru Kenyatta launched *Mwongozo,* the Code of Governance for State Corporations in 2015, as a firm foundation and guide for the management, governance and oversight to state corporations and public bodies as grounded in Kenya's constitution's values and principles as well as best global practices of governance. The code is to be implemented on a 'Comply or explain' basis, meaning that public bodies may adopt this code to suit their field, with the stakeholders' being the goal. The general objective of this study was to assess the extent to which Tana River County has complied with the *Mwongozo* Code of Governance for State Corporations. Data was collected from five health facilities' governance bodies through use of structured and unstructured questionnaires and by use of a focus group discussion..'R', free software for descriptive statistical computing and graphics, was used for analysis. The study revealed that healthcare governance bodies in Tana River County are neither constituted nor operated in line with the Mwongozo code of governance for state corporations. The study also revealed that current health governance bodies have limited capacity to effectively offer strategic direction and oversight to the healthcare system in Tana River County. The study identified lack of legitimacy, financial weakness, low technical capacity and lack of a structured appointment of healthcare governance body members as some of the challenges facing healthcare governance. The study recommends creation of policies and structures to aid recruitment and empowerment of health governing bodies that are capable of effectively carrying out their roles according to the Mwongozo code and global best practices.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

LIST OF ABBREVIATIONS

CDF: Constituency Development Fund

CEC: County Executive Committee (Member)

CHMB: County Health Management Board

CO: Chief Officer (County Chief Officer)

CRA: Commission for Revenue Collection

DHIS: District Health Information System

DMOH: District Medical Officer of Health

DMS: Director of Medical Services

FMC: Facility Management Committee

HMB: Health Management Board

HSSF: Health Sector Services Fund

KIPPRA: Kenya Institute for Public Policy Research Analysis

KNBS: Kenya National Bureau of Statistics

MCA: Member of the County Assembly

MOH: Ministry of Health

MSH: Ministry Sciences for Health

PDMS: Provincial Medical Services

SCHMC: Sub County Health Management Committee

TRC: Tana River County

USD: United States Dollars

WHO: World Health Organization

DEDICATION

To my son, Mwenda Arthur,

All the time you have lived, I have been studying,

The times I was away from you,

When you could not understand ‘bye, see you in two weeks’, this I was doing for you.

ACKNOWLEDGEMENT

I am grateful to **Professor Kokwaro**, my supervisor, for his tireless guidance and support throughout the proposal development and dissertation writing.

Thank you for your determination towards this work, mostly way above my own. If I become only half the time manager, half the patient people, half an understanding teacher as you are, I will accomplish a lot in life. Much gratitude to the Strathmore Business School family for all the support way above all I ever needed. Far too kind.

Ultimate gratitude to the God for family, friends, life, health and wealth to make this possible.

1 CHAPTER ONE: INTRODUCTION

1.1 Background of the Study

Public health systems utilize various forms of resources to save lives and reduce the burden of illness to the population they serve. Inspired leadership, sound management that is supported by transparent governance makes public health systems efficient. For public health systems to flourish, leadership, management and governance must work together. Leadership is mobilizing others to envision and realize a better future. Governance is steering an organization in a shared strategic direction(MSH, 2016). Leadership, management, and governance are interdependent, overlapping, and mutually reinforcing. All three are needed to support a healthcare system (Rice, Shukla, & Johnson Lassner, 2015).

Good governance creates the conditions in which managers and service providers are more likely to exercise leadership in a health services organization. When managers and service providers are empowered, they deal with change effectively, seek and create opportunities, provide a vision, motivate, inspire, and energize people and develop more leaders like them. Good governance provides purpose, resources, and accountability in support of management, enabling organizations to achieve strategic objectives(Pyone, Smith, & Van Den Broek, 2017). One of the main milestones of the Kenyan constitution of 2010 was the focus on improved leadership and governance. As per the new constitution, Kenya devolved its health services in the year 2013, transferring all functions in public health to the 47 counties. This means that some of the responsibilities of implementing effective leadership and governance at the various levels of the health system fell on the counties.

1.1.1 Mwongozo: The Code of Governance for Public Institutions

Effective leadership in County Health Boards and other state corporations is a key requirement of the new constitution. Accordingly, in 2015, President Uhuru Kenyatta, launched the *Mwongozo*, a code of governance for state corporations aligned to the new constitution, in order to increase efficiency and accountability in the use of scarce resources(Public Service Commission/ State Corporations Advisory, 2015). *Mwongozo*

code is a call by the president to all public institutions to operate effectively and efficiently in order to assist Kenya to realize shared goals. All state corporations are required to comply with the Mwongozo code of ethics.

The code of governance gives guidelines on governance for public institutions in several areas including the constitution of the governing bodies, transparency and disclosure, accountability and ethical leadership by the same. Other areas that involve the governing bodies and covered by *Mwongozo* include stakeholder relationships, sustainability and performance management, and compliance with laws including the constitution. By a guide of the sample board charter on *Mwongozo*, guidelines on the size and composition of the board and appointment of board members is highlighted. Term limits, independence of members and committee formation and delegation of duties is also covered. This study was meant to find out how far Tana River County Health Boards have complied with the requirements of *Mwongozo.*

1.2 Problem Statement

Increased investment and the envisaged 'closer to the people prioritization' objective of devolution has not led to a proportionate improvement in access, quality, cost and responsiveness of public healthcare services in Tana River County. As positive as it may be, the progress made in strengthening the healthcare building blocks has not resulted in proportionate gain in health indicators. There is mounting evidence pointing at erosion of gains made prior to devolution in some health indicators. This is illustrated by the following examples from the County. The county's total health expenditure, as a percentage of total county government expenditure, has increased 10-fold; from 2% in 2013/2014 to 20% in 2016/2017 financial years allocation (Equitable share and Conditional grants from treasury) for Tana River County from 2013 to 2017(CRA, 2017).

This translates to a per capita investment of 2 USD in 2014 to 53 USD in 2016. There are 182 nurses and 9 doctors in Tana River County as of 2017 translating to one nurse to every 1,758 and one physician per 35,556 people, against WHO's recommendation of 1 nurse/physician for every 435 people (World Health Organization, 2010). This is an improvement from 4,384 and 160,000 in 2013. An increase of 16% in the proportion of

pregnant mothers delivering in health facilities has also been recorded, but lower percentage increase in the proportion of mothers attending at least 4 antenatal visits, at 11%. The proportion of women delivering under skilled care has dropped by 3% while the average reporting rates have also dropped by 4%, comparing three years to and three years after devolution (www.hiskenya.org).

Could the increased investment in other blocks of the healthcare system have missed the needs of the community that the system is serving? Could better representation, through enhanced governance, have enabled the health system better identify and respond to the barriers towards improvement of health?

Thus, while there is growing evidence that health indicators have improved in Tana River County as a result of devolution, more improvement against investment in healthcare could be achieved if there was a framework for evaluating and improving governance performance at all levels of the healthcare system in the county. Currently, such a framework does not exist in Tana River County since the *Mwongozo* Code of Governance for State Corporations which would have provided such a framework through guidelines on how to establish institutional boards has not been implemented in the health sector. A 10-fold increase in financial investments in healthcare has not resulted to a proportionate increase in improvement of healthcare indicators in the county. Therefore, this study was set to evaluate the status of healthcare governance in Tana River County and identify challenges to the same.

1.3 Research Objectives

1.3.1 General Objective

The general objective of this study was to assess the extent to which Tana River County has complied with the *Mwongozo* Code of Governance for State Corporations in public healthcare governance.

1.3.2 Specific Objectives

i. To assess general compliance with implementation of the *Mwongozo* Code of Governance (2015) in setting up and operation of health governance bodies in Tana River County
ii. To assess the capacity of the health governance bodies to perform their roles as stipulated in the *Mwongozo* Code of Governance
iii. To assess health governance challenges in healthcare services in Tana River County

1.4 Research Questions

i. Has Tana River County complied with Mwongozo Code of Governance for State Corporations in the setting up and operation of health governance bodies?
ii. Are the governance bodies as currently constituted able to perform their roles effectively?
iii. What are the current challenges and gaps to healthcare governance for healthcare Tana River County?

1.5 Significance of the Study

About 32.3% of Kenya's revenue in the year 2015/2016 was shared out among the 47 counties(Parliament, 2016). In the year 2014/2015, about 20% of devolved funds were used to support public health services. This amounts to about 6.5% of the country's revenue in addition to funds spent to support the national government's ministry of health. The annual allocation to health as a proportion of the total county allocation has increased from 2% in 2013 to 20% in 2017 in Tana River County, translating to about 1.8 billion Kshs (About 180million USD) on healthcare since the year 2013. Though positive results have been achieved, it is upon the healthcare players to provide the answer to whether the output per a unit of investment is optimum.

This study will help Tana River County towards the path of complete compliance with the *Mwongozo* Code of Governance. Compliance will, in turn, ensure that the investment in health translates into commensurate improvement in health indicators. Good governance enhances competitiveness and provides critical infrastructure that enables

health managers to focus and utilize resources towards improvement of the health indicators at the operational level, getting maximum returns on finances, human resources, equipment, and time. To the government, good healthcare governance reduces the fiscal burden/risks, improves access to external sources of finance strengthens transparency and accountability (reduce corruption) and improves economic growth for a country. Good healthcare governance optimizes government's ownership role in public health and enhances financial & fiscal discipline through the building of support & capacity for implementation. To the benefit of the public, governance is the ultimate glue through which all other building blocks in health are held together to improve health outcomes of the populations that health systems serve.

1.6 Scope and Justification of the Study

The study was limited to the county of Tana River and covered Health Boards in Tana River County that have been constituted according to the requirements of the new constitution. Tana River County has the lowest health worker to population ration in Kenya, with only 9 medical officers, three pharmacists, a dentist and 182 nurses to serve the vast county of about 350,000 people. Despite a 10-fold increment of per capita investment in healthcare, most health indicators have not improved proportionate with the increased investment in financing compared to other counties(CRA, 2017).

2 CHAPTER TWO: LITERATURE REVIEW

2.1 The Stewardship and the Agent- Principle Theories of Corporate Governance

Considerable attention has been focused on the state of healthcare under devolution, with special interest of the actors that have been entrusted to delivery healthcare in public institutions on behalf of the government. The debate has included financial efficiency, delivery of services and optimum utilization of human resources for health in resource limited set up and competing priorities. Good governance entails aligning all factors of healthcare delivery to promote public interest (Ferroussier-Davis, 2000). Stewardship can be viewed as a basis for reform of roles and responsibilities of the principal (the government) and agents (providers) in government sponsored health in ensuring accountability and optimization of the resources provided for such services(Dicke, 2002).

Stewardship in health is the ethic that embodies responsible planning and utilization of resources for health to optimize public health outcomes(Robinson, Joe Sam, M. Sami Walid, 2012). The agent can define stewardship as the protection and taking care of the need of the principal's needs. Under the stewardship theory, organizational managers and executives protect the interests of the stakeholders and make decisions on their behalf with their main objective being to create and maintain a successful organization for the sake of the stakeholders (Flynn, 2018).

In the devolved health sector, the management and the health governance bodies are the agents acting for the government (the public). This is in contrast with the agent-principal theory, which focuses on checks and balances where the board of directors is solely meant to check the excesses of the managers to ensure that the interest of stakeholders is not lost as the agents pursue their interests. Unlike the agent-principal theory, the stewardship theory takes in consideration not only the needs of the principal, but also that of the agents, including employees, managers, suppliers, customers and the general public, with the view that no one group of stakeholder is more important than the other(Flynn, 2018). To direct public organizations to act in the interest of the public, the *Mwongozo* Code of Governance for State Corporations was introduced in Kenya in 2015.

2.2 Mwongozo: The Code of Governance for State Corporations in Kenya

Following the promulgation of the new constitution for Kenya in 2010, effective leadership and governance for state institutions have received fresh attention. To address the challenges of governance in State Corporations, the Kenyan government developed Mwongozo as a critical building block in entrenching principles and values of public service and best practices in corporate governance. President Uhuru Kenyatta launched it in 2015. Mwongozo "addresses the matters of effectiveness of Boards, transparency and disclosure, accountability, risk management, internal controls, ethical leadership and good corporate citizenship. These practices are at the core of the values and principles of Public Service as enshrined under Article 232 of the Constitution of Kenya, 2010. Mwongozo further provides a platform for addressing shareholder rights and obligations and ensuring more effective engagement with stakeholders. More importantly, Mwongozo will ensure that sustainability, performance and excellence become the hallmark of management of State Corporations". The Code is being implemented on a "comply or explain" basis, meaning that all state corporations must implement it, or explain reasons why they are not implementing it and show a roadmap toward complete compliance with its implementation. Health governance bodies in the counties are expected to implement the *Mwongozo* Code of Governance for the benefit of the diverse groups of stakeholders. To management, good governance enhances competitiveness and provides critical infrastructure. It also enhances provision of financial, commercial & social services in cost efficient manner. It reduces the fiscal burden/risks, improves access to external sources of finance strengthens transparency and accountability (reduce corruption) and improves economic growth for a country.

To regulators, good governance improves the government's ownership role and enhances financial & fiscal discipline through the building of support & capacity for implementation. To understand the role of health boards in Kenya, as spelt of in the broad Mwongozo Code of Governance guidelines outlined above, it is first necessary to describe the health system within which they operate.

2.3 The Concept of Health Systems

Delivery of health services within a given context is generally described under the concept of a "system" which broadly implies the following components:

- an input component dealing with provision of resources such as human, mechanical, material and financial, a process component, which deals with conversion of these resources in the provision of services to the populations being served to help them prevent ill health, maintain good health or restore good health
- an outputs component which is concerned with good health, defined by the World Health Organization as " a state of complete physical, mental and social well-being" (Zakus and Bhattacharyya, 2007).

The Input and Process requires good governance in order for the desired output (good health) to be achieved. The concept of the health system also implies an "open" system, meaning that the system interacts with internal and external environments that have a bearing on the outputs. These include political, economic, social, technological and physical (Zakus and Bhattacharyya, 2007). Health Systems are one of the several determinants of health.

2.4 Objectives of Health Systems and How to Measure Health System Performance

The World Health Organization (WHO) report of 2000 lists the following as the objectives of Health Systems, and ways to measure health system performance based on each objective based on average level of attainment and the distribution of each objective across the population:

2.4.1 To Improve the Health of the Populations They Serve

This is measured as an average, e.g. life expectancy or maternal mortality as well as the range of life expectancy across subgroups in a population. These subgroups are usually defined by social characteristics such as ethnicity, gender, education, occupation, rural or urban residency, (Braveman, 2003). Normally, these characteristics should not affect

peoples' health in a functional health system. Thus, health systems that consistently neglect certain subgroups in terms of health service delivery may have good average overall performance, but worse performance than those with similar averages which are more evenly distributed across the entire population(Zakus and Bhattacharyya, 2007). The difference if the health status between these groups in a given context, say a country or county, would be minimal in a high performing health system. This reflects the degree of "distributive justice" within the system (Zakus and Bhattacharyya, 2007) part of the overall effectiveness of the systems. Part of the role of good governance by health boards is to ensure that the health system is effective in improving the health of the population being served.

2.4.2 To Respond to the Populations' Expectation

Responsiveness is linked to patients' preferences, which in turn affects service utilization. When most patients show preference towards private health providers as opposed to public health services, there is something wrong the overall governance of the public facilities. This is one of the issues that the *Mwongozo* Code of governance is supposed to address.

2.5 To Provide Financial Protection against the Costs of Ill Health

Fair financing of public health systems is important since health costs are unpredictable and may be catastrophic. The role of good governance is to, among other things; provide oversight on the management of financial resources in health facilities to decrease the financial impact on healthcare costs. This study explored how well this oversight role is played by the different Health Boards in Tana River County.

2.5.1 Functions of a Health System

Figure 2.1 summarizes the key functions of a health system, linking to the objectives of the health system described in section 2.3 above.

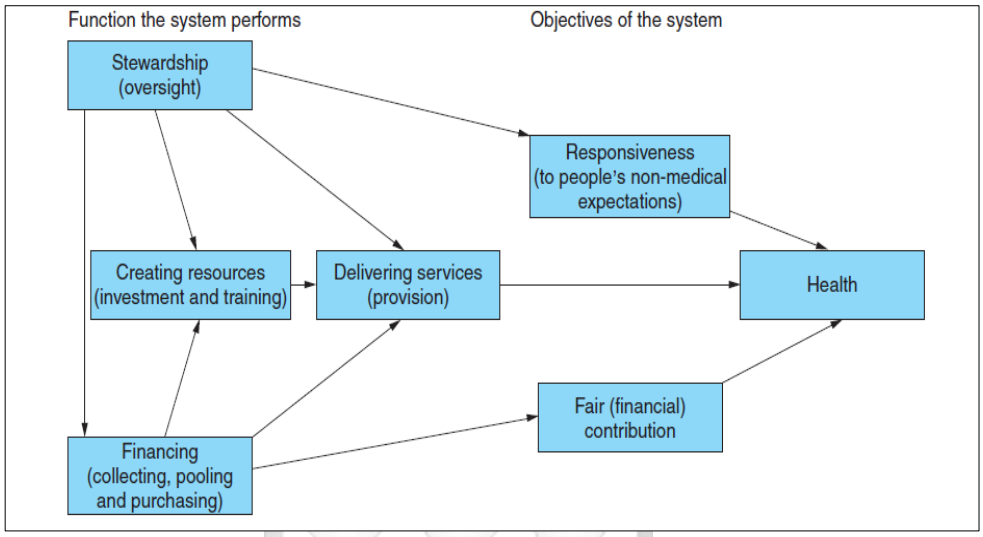

Figure 2.1: Functions of a Health System (Source: WHO Report, 2000)

2.5.2 Stewardship (oversight)

This refers to providing oversight for the other key functions of the health system. This is the main role of health governance bodies in a health system. This role has been neglected by many government in Least and Middle-Income Countries (LMICs) accounting for the general non-functional health systems in these countries. Effective oversight allows for assessment of the other health system functions shown in figure 2.1. The overall objective of this study was to review how well Tana River County has implemented the Mwongozo Code of Governance to create Boards which effective in providing oversight in the health systems within the county.

2.5.3 Creating Resources

This means investing in infrastructure and in attracting, training and retaining healthcare workers. Creating resources to support county health systems is one of the measures of board effectiveness that was evaluated in this study.

2.5.4 Financing the Health System

Funds to finance health systems may come from a) taxes, b) employment insurance schemes, c) private insurance and d), out-of-pocket payments by patients at the point of care. The Health System in Kenya is financed primarily through tax by the government.

Since currently, most of the budgetary allocations are used for recurrent expenditures (mainly staff salaries); little is left to support the key function of health systems which is the provision of quality health services. Effective stewardship (governance) can generate additional resources from other sources, ensure that whatever resources are available are well utilized. This study reviewed the capacity of the health boards in Tana River County to perform this role.

2.5.5 Delivering Health Services

The ultimate function of a health system is to deliver quality, affordable, relevant, accessible and sustainable health services to the populations it serves. A measure of effectiveness of the oversight role of a health board is through the quality of health services being offered by the institution(s) over which the board plays oversight role.

2.5.6 Structure of a Health System

Many LMICs (including Kenya) have been unable to provide quality comprehensive health services to their populations. This has resulted in the emergence of other health service providers, leading to a "pluralistic" health system as shown in Table 2.1. (Zakus and Bhattacharyya, 2007), consisting of a) public health service providers and b) private health service providers, or, for better distinction, a) organized and b) unorganized health services providers. This pluralistic structure broadly reflects the current structure of health systems in Kenya, and this is the structure upon which health boards, both in public and private sector are expected provide oversight. Within this structure, the basic health functions are re-stated as in table 2.1 below, including management of inter-temporal expenditures , i.e., unpredictable and potentially costly health expenses (Standing & Bloom, 2003)

Health-related function	Unorganized health sector		Organized health sector
	Non-marketized	Marketized	
Public health	Household/community environmental hygiene		Government public health service and regulations Public or private supply of water and other health-related goods
Skilled consultation and treatment	Use of health-related knowledge by household members	Some specialized services such as traditional midwifery provided outside market Traditional healers Unlicensed and/or unregulated health workers and facilities Covert private practice by public health staff	Public health services Licensed for-profit health workers and facilities Licensed/regulated NGOs, faith-based organizations etc.
Medical-related goods	Household/community production of traditional medicines	Sellers of traditional and western drugs	Government pharmacies Licensed private pharmacies
Physical support of acutely ill, chronically ill, and disabled	Household care of sick and disabled Community support for AIDS patients and people with chronic illnesses and disabilities	Domestic servants Unlicensed nursing homes	Government hospitals Licensed or regulated hospitals and nursing homes
Management of inter-temporal expenditure	Inter-household/ intercommunity reciprocal arrangements to cope with health shocks	Money lending Funeral societies/informal credit systems Local health insurance schemes	Organized systems of health finance: Government budgets Compulsory insurance Private insurance Bank loans Micro-credit

Figure 2.2: Pluralistic Health Systems (Source: Zakus and Bhattacharyya, 2007)

The importance of each of the sectors shown in Table 2.1 (Organized and unorganized) in a given pluralistic system depends on the history of the health system. In Kenya, this has been made more complicated by the challenges of devolution, as discussed in section 2.6 below. For health, boards to exercise adequate stewardship over such a pluralistic health system, policies should take into account the existing health system structures and utilization of services provided by each sector into account.

2.5.7 Approaches to Improving Performance Health Systems

Approaches to improve health system performance can be broadly divided into three categories (Zakus and Bhattacharyya, 2007): National or regional perspective, local or organizational level and individual perspective. The national level perspective refers to policy measures relating to the locus of decision-making within the system, the structure of the health system, and the degree of integration of its component parts". The local organizational level refers to the management of institutions that provide care while the Individual perspective relates to the engagement or modification of the behavior of health system users and providers.

The national perspective of improving health system performance is concerned with issues such as a) decentralization of health services, regulation of health matters, privatization, public-Private partnerships, contracting and accreditation. Health

governance in Kenya is closely linked to decentralization, hence this section will focus on the challenges of decentralization of health services in Kenya, and how improvement in governance can help address some of these challenges.

2.5.8 Improving Health System Performance through Decentralization

Broadly defined, decentralization means delegation of decision-making powers from the central to local levels of government, through the following (Mitchell & Bossert, 2010).*Deconcentration* involves passing some administrative authority from central government offices to the local offices of central government ministries. *Devolution* involves passing responsibility and a degree of independence to regional or local government, with or without financial responsibility (i.e., the ability to raise and spend revenues).*Delegation* involves passing responsibilities to local offices or organizations outside the structure of the central government such as quasi-public (non-governmental, voluntary) organizations, but with central government retaining indirect control (as in many national Global Fund funded activities).*Privatization* involves the transfer of ownership and government functions from public to private bodies, which may consist of voluntary organizations and for-profit and not-for-profit organizations, with varying degrees of government regulation.

2.5.9 Decentralization of Health Services in Kenya

Several countries in the world, especially the LMICs, have pursued decentralization as a way of economic and political reforms that ensures responsiveness of service delivery to the needs of the diverse needs of their populations (Nyikuri et al 2017). Decentralization can take either of the following two forms: Political or administrative. In political decentralization, citizens or their elected representatives are given more power in public decision-making by having it done at lower levels of the same system of a central government. Its goal is to introduce more participatory forms of governance by giving citizens, or their representatives, more influence in the formulation and implementation of health policies and plans. In administrative decentralization, authority, responsibility and financial resources for providing public services are decentralized from the national

government to local units of government agencies, sub national government or semi-autonomous public authorities or corporation (Saltman et al 2007).

There are three major forms of administrative decentralization: de-concentration (authority is shifted from national to sub-national offices of the same national structures) delegation (authority is transferred to semi-autonomous agencies that carry out functions that were previously carried out by government ministries), and devolution where functions and resources are transferred to local governments (Litvack et al, 1998). This is the case of Kenya. In the year 2010, Kenya promulgated a new constitution whose mainstay was devolution. This led to being of the county governments after the general elections of March 2013. Counties are recognized entities with geographical boundaries over which they exercise authority and within which they perform devolved functions.

Under article 176, the constitution established 47 county governments with two arms: the executive and the legislative. The executive consisting of the governor and the deputy and a 10-member County Executive Committee (CEC) appointed by the governor with the approval of the county assembly. The CEC members have the overall policy and political responsibility over each of the ten County Departments serving the devolved functions, including health. Within each department and working under the CEC member is a Chief Officer (CO), who is a civil servant recruited by the County Public Service Board and appointed by the governor. The county CO is the accounting officer, with overall administrative responsibility over the respective department. The legislative arm is the County Assembly, which is made up of Members of the County assembly (MCAs) representing each electoral ward in the county or as nominated by political parties in the assembly to represent special groups(Kenya Constitution, 2010).

Article 174 of the constitution gives the objectives of devolution as, among others, extending powers of self-governance to the people, enhancing participation of the people in the exercise of the powers of the state and in making decisions affecting them and the right of communities to manage their own affairs to further their development and promote social and economic development and the provision of proximate, easily accessible services; stating that every person has the right to life (article 26) a healthy

environment (article 42), and to the highest attainable standard of health, which includes the right to health care services and reproductive health care (article 43 (1) (A)). Article 53 (1) (c) states that every child has the right to basic nutrition, shelter and health care while 56 (e) states that the State shall put in place affirmative action programs designed to ensure that minorities and marginalized group have reasonable access to health services. Health was among the devolved functions in Kenya, meant to increase access to services, address marginalization and reduce the barrier of bureaucracy in access of services especially procurement of commodities, and to generally increase efficiency in delivery of services by improving access, quality and ensure optimum apportioning and utilization of healthcare resources across the country (Murkomen, 2012).

The fourth schedule, part two of the constitution, mandates the counties to manage all county health facilities and pharmacies, ambulance services, primary health care, licensing and control of undertakings that sell food to the public, veterinary services (excluding regulation of the profession), cemeteries, funeral parlors, crematoria, refuse removal, refuse dumps and solid waste disposal. This devolves healthcare delivery to the counties, save for capacity building and training, policy and national referral facilities. Resources associated with healthcare delivery were devolved to the county governments via the gazette notice number 137 of August 9th 2013.

Effectively, governance of healthcare services was devolved with the counties to the extent of the devolved functions. The Mwongozo code of ethics for state corporations provides a framework for governance that would address the challenges of devolved health services in Tana River County. The main objective of this study is to evaluate the current effectiveness of governance of health services delivery in Tana River County and propose solutions to identified challenges.

2.5.10 Governance and Stewardship of Healthcare Resources: The Challenges for Kenya

With the increased need for better healthcare citizens all over the world, financing of healthcare is increasingly getting recognition the past few decades. In 2005, the World Health Organization (WHO) member states set themselves the target of developing their

health financing systems in order to accelerate and sustain progress towards universal coverage (WHO, 2005). There is no country with limitless resources for healthcare delivery towards universal healthcare, UHC. Most countries, especially LMICs, are battling with diminishing resources with soaring populations. Many of LMICs depend on donor funding, with the same increasingly getting hard to come by. This calls for optimum utilization of healthcare finances.

Other than decreasing funding to healthcare, there is also evidence of inefficiency in the way resources are used, partly because health governance systems are unable to keep pace with the rapid developments in the health sector, and also because of deliberate diversion of health resources to unlawful or unplanned use (Transparency International, 2006).Top sources of inefficiency in healthcare are costs related to weak procurement, distribution and use of medicines, inappropriate or costly staff mix and unmotivated workers, unclear resource allocation guidance; lack of transparency, poor accountability and governance mechanisms and poor informed mix of health interventions (funding high cost low effect interventions) (WHO, 2010). Principles of good governance are underpinned by accountability, transparency, and respect for the rule of law.

Worldwide, it is conservatively estimated that up to 40% of resources for healthcare are wasted (WHO, 2010) with some literature alluding that even in economies with better financial discipline like the United States, as much as 50% of the healthcare budget may be going to waste (The & Turns, 2013). The constitution and the statutes/policies of devolution envision full public participation in setting the county government's financial priorities. Section 87 of the County Government Act 2012 lays this, with the basis of public participation based on timely access to information and the process of formulating and implementing policies, laws, and regulations. It is on this basis that counties decide on the proportion of the devolved funds are invested in public health. However, governments are also not likely to implement public participation in prioritization of expenditure, thus financing may be not responsive to the needs of the stakeholder(Mayeh, 2002).

Due to these challenges, different countries may gain variously per a unit cost of healthcare. The gap between what countries achieve, and what they could achieve with the resources at their disposal could be enormous, especially in growing countries like Kenya that are in unfamiliar governance environment that is devolution. For Kenya, devolution of health services provision has faced many challenges including a) frequent strikes by health workers, b) insufficient funding and infrastructure, c) lack of clear policies on governance, d) skewed distribution of health workers between counties and between urban and rural settings.

2.6 Tana River County

2.6.1 Geography and Demographics

Tana River County is the most northern of the coastal counties of Kenya sharing a long border with the North Eastern county of Garissa. Climatically, the county is more of arid than coastal. Unlike the other coastal counties which are wetter, Tana River is arid. Only 35 KMs of the 536 KMs Kenya's coastline is in Tana River. At 35,375.8 Km^2 it is the fourth largest county in Kenya, and third most sparsely populated county, after only Turkana and Isiolo counties, with 9 people per square kilometers [6]. The county has three sub counties (Garsen, Bura, and Galole) and 15 electoral wards. Hola town, in Galole, is the biggest urban center and headquarters to the county. Peasantry mixed farming along the River Tana's 500km long banks and pastoralism are the major economic activities in the county. The demographic profile of the count is as demonstrated in table 2.2 below.

Table 2-1: Population age groups for Tana River County, 2018 (Source: Kenya National Bureau of Statistics)

Age Group	Population	Percentage
Below 5	60,760	19%
5-24	148,980	46%
25-35	36,703	11%
35-50	38,441	12%
55-80	15,170	5%
Above 80	2,737	1%

Children under the age of 5 years make 19% of the 320,000 (2018) people in the county. Together with the children, young people under 24 years make 65% and women of reproductive age (15-49 years) make about 23 of the population. Literacy level, access to clean water and improved sanitation is low, with only 7% having attended secondary school and above, 22% accessing improved sanitation (toilets/latrines, safe refuse and sewage disposal) and 42 % of people using water from improved sources (protected spring, protected well, protected boreholes, piped and rain water)(KNBS, 2013).

2.6.2 Healthcare in Tana River County

Despite an increase with the advent of devolution, the county grappling with low number of healthcare workers. The county has nine medical officers, three pharmacists, a dentist and 182 nurses as of October 2017. These are the lowest number of the respective cadres in any county in Kenya, based on Ministry of Health Reports in 2017.

There are two 40 bed hospitals and about 50 dispensaries and 3 health centers, superintended by clinical officers and nurses. Save for one health center and 3 dispensaries, health facilities and run and owned by the county government. The distance to health facilities is long, with patients walking for up to 100 kilometers to seek healthcare. The most common causes of mortality and morbidity is as indicated in table 2.3 below(Dpt. of Health TRC, 2014).

Table 2-2: Top causes of mortality and morbidity in Tana River County, 2016/2017

	Top Causes of Morbidity in 2016/2017	**Top Causes of mortality 2016/2017**
1	lower Respiratory Tract Infections	Diarrheal Disease
2	Malaria	Pneumonia
3	Diarrheal diseases	HIV/AIDS

Table 2-3: Distribution of Key Human Resources for health, Tana River County

Cadre	Year: 2017	Population per Worker
Clinical Officers	76	4,211
Nurses	182	1,758
Medical Officers	9	35,556
Pharmaceutical Techs	6	53,333
Laboratory Technicians	41	7,805

2.6.3 Governance Structure of the Health System in Tana River County

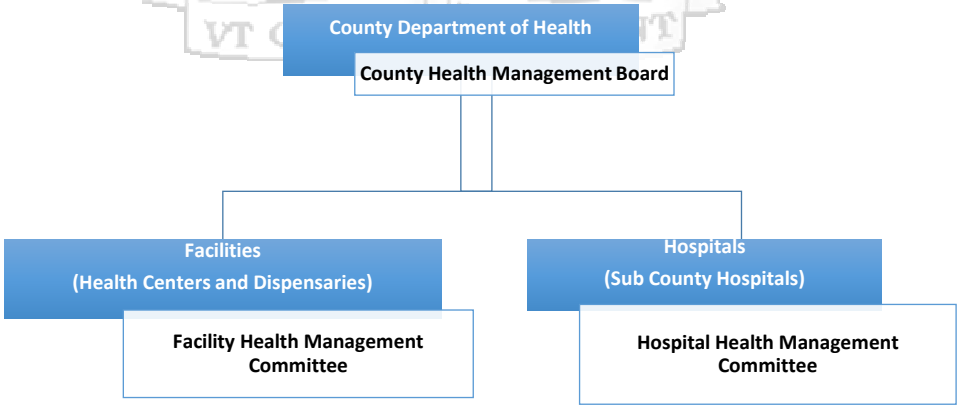

Figure 2.3: Governance structure of the health system in Tana River County:

In Tana River County there is one County Health Management Board, 3 sub county health management committees and 21 facility health management committees. For this study, we are covering the CHMB, three SCHMCs, and 3 FHMCs.

2.6.4 Conceptual Framework for Improving Health Systems Performance through Strengthening Of Governance

The conceptual framework provided by the World Bank (Brinkerhoff & Bossert, 2008), as modified by Management Sciences for Health (Shukla &James, 2015), was used, (Figure 2.2). It states that health governance involves three sets of actors: the state actors (politicians and policy makers), the providers and the public. The linkages between these three actors represent the operational core of healthcare governance. These actors exist in multiple levels of the system. The strength and effectiveness of these linkages influence the ability of the health system to ensure equity, effectiveness, access, quality and sustainability. The independent variables are the people and qualifications of those who are elected to sit in County Boards, and the financial resources allocated to health (decision are political and cannot be changed through this study). The context is the organizational, political and cultural. Drivers are political will and economic incentives. Enablers of good governance include leadership skills, integrity and ethics, performance measurement, use of information, evidence and technology in decision making.

The dependent variables are the health services provided. When the independent variables such as the effectiveness of boards in performing their oversight roles are improved through appropriate interventions), then dependent variable s such as quality of services provided by health service providers (influenced by degree of oversight, supervision and support provided) and responsiveness of health services to the needs of clients/citizens of Tana River County (dependent on types of policies in place) are improved, resulting in improved health outcomes.

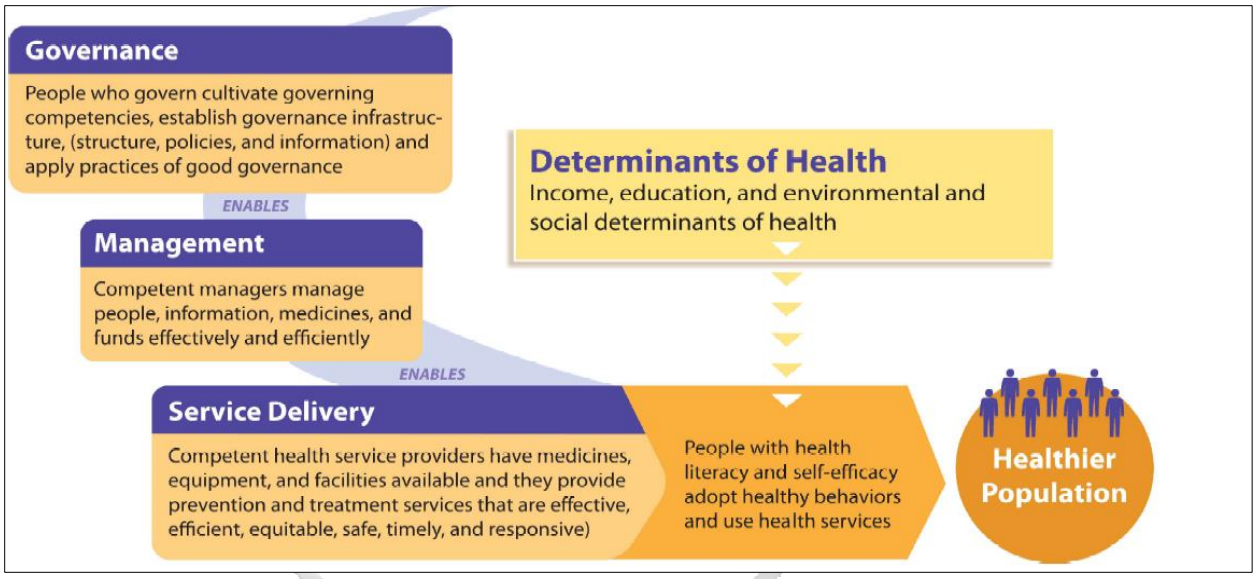

Figure 2.4: Health governance conceptual framework: (Shukla & James, 2015)

This framework allowed the following research questions (RQs) to be addressed, focusing on the independent variables mentioned above:

- Research Question (I): Have the boards and Committees been constituted according the requirements of the *Mwongozo* Code of Governance, to provide policies, directives, oversight and resources to support health systems in Tana River County? The three broad areas of board selection, board function and board evaluation were evaluated.

- Research Question (ii): Are the health governance bodies as currently constituted able to perform their oversight roles effectively (as indicated by the responsiveness and quality of the services provided to the clients/citizens)?

- Research Question (iii): What are the current challenges and gaps to healthcare governance for healthcare Tana River County and how can they be addressed as part of health system strengthening in this county?

2.7 Research Gap

The rationale behind devolution of the health sector was to allow local governments to design health solutions unique to local populations and to encourage effective citizen participation and quick decision making. Although demonstrable efforts have been made towards solving the numerous challenges that have bedeviled this sector since devolution, the role of healthcare governance has not been satisfactorily demonstrated. The net effect lack of assessment and evaluation framework for healthcare governance is the stagnation of healthcare and even a reversal of some gains according to health indicators(Kimathi, 2017).

3 CHAPTER THREE: METHODOLOGY

3.1 Study Design

An observational descriptive research design was used. The respondents were the health governance body members in Tana River County. Health governance body members completed a questionnaire evaluating the establishment and operation of governance bodies in line with the *Mwongozo* Code of Governance for State Corporations 2015.Focus group discussions with various governance bodies were held to respond to the challenges of healthcare governance in Tana River County, and possible solutions to the challenges. This research design was considered appropriate because variables of interest did not involve any manipulation but to establish the current status of the governance for public health services in Tana River County in accordance to the *Mwongozo* Code of Governance for State Corporations 2015.

3.2 Population and Sampling

The population of the study constituted all the members all health governance bodies in Tana River County. A purposive total population sampling was used, targeting five health management boards in Tana River County.

3.3 Data Collection Methods

A purposive sampling approach was used to select respondents for the in-depth interviews. A total of 34in-depth interviews were conducted with current members of health management boards of three two level IV hospitals, one health center and two dispensaries. To address research question one on whether health management bodies have been constituted as guided by the Mwongozo Code of Governance for State Corporations, an informed consent was obtained (Annex 1), a questionnaire (Annex 2) and data was obtained using a questionnaire prepared based on the key requirements established by the Mwongozo Code of Governance was used.

On whether the current governance bodies as currently constituted able to perform their roles effectively, an assessment tool (Annex 3) that was prepared based on a list of competences developed by a consortium set up by the International Hospital Federation

(GCHM, 2015) was used to evaluate the competences of individual board members as evaluated by the CEO of the facility. A focus group was used to discuss the challenges to healthcare governance in Tana River County. The summary of the findings was recorded on a tool (annex 5).

3.4 Data Management and Analysis

A mixed research approach was used, utilizing both qualitative and quantitative techniques. Qualitative approach was used to gather information that cannot be quantified numerically but connected to the theme. Factual elements of the data were collected using quantitative techniques and were presented using descriptive statistics. The data collected was coded, quantified, and analyzed quantitatively and qualitatively. Quantitative data was analyzed using 'R', a programming language and free software environment for statistical computing and graphics that is supported by the R Foundation for Statistical Computing (https://www.r-project.org/). Data so collected from the questionnaires was analyzed by the use of descriptive statistics using R and presented through percentages, proportions and frequencies. The information was displayed by use of horizontal segmented bar charts, prose form and tables. This was done by tallying up responses, computing percentages in response as well as describing and interpreting the data in line with the study objectives and assumptions through use of 'R'.

3.5 Data Validity and Reliability

The tools used to answer research question 2 and research question 2 are well established and based on Mwongozo Code of Governance for State Corporations and can used in any healthcare setting in Kenya, with appropriate modification based on the context. Using the model service charter provided for in the Mwongozo Code of Governance for State Corporations, this tool was created by picking themes relevant to the governance bodies of county health services.

3.6 Ethical Consideration

Ethics review and approval was sought from Strathmore University Research and Ethics department. Permission to carry out research on health systems in Tana River County was granted from the department of health, Tana River County (Annexes 6 &7). Consent (Annex 1) was sought before administering any method of data correction.

4 CHAPTER FOUR: RESULTS

4.1 Response Rate

Of the 53 governance body members, 34 responded, a response rate of 63%

4.2 Demographic Information of the Respondents

Of the 34 respondents, only 2 (6%) had education beyond secondary school. About 21% (7) of the members had not completed primary level of education. Eleven members of governance bodies, (32%) had completed secondary level education. About 79% (27) of the respondents were male.

4.3 Constitution of the Boards According to Mwongozo Code of Governance for Public Corporations

Qualitative analysis was done to understand how the hospital boards and/or committees had been constituted and to assess the views of the members on their capacity to deliver their duties as guided by Mwongozo; the Code of Governance for State Corporations. This evaluated whether the health governance bodies as currently constituted are able to perform their oversight roles effectively (as indicated by the responsiveness and quality of the services provided to the clients/citizens)?"

Twenty-six (26) board/committee members were selected and interviewed on four themes; 1) **Board members selection and appointment** 2) **Board practices responsibilities** 3) **Board operations and procedures** and 4) **Board performance evaluation.**

4.4 Board Members Selection and Appointment

The following subthemes were considered under board selection, as on Mwongozo; Code of Governance for state corporations: awareness of the functions of the board/committee, desirable competencies and personal attributes, term limits, sequence of member appointment to ascertain succession, potential board members' motivation to serve in the board, and entities that board members report to.

Asked about the functions of hospital board/committees, community oversight role/advertisement of the facility services to the community was the most repeated response (17/26), followed by financial management (12/26) and facility infrastructure development (6/26). Planning for hospital services, problem solving at the facility, "*approving and agreeing what the CEO says*", are among the other functions mentioned. On the desirable competencies and personal attributes of the board/committee members, responses were varied from one member to the other; they included understanding their roles and responsibilities, literate, should have "*knowledge of drugs and medical knowledge to assist other villagers*", can have "*any professional*" background and should be able to lobby for more HCWs. Desirable personal attributes mentioned included "*honesty and integrity*", "*listening skills*", "*accountability and interest of the people*" among others.

Majority (17/26) of the respondents supported the idea of having term limits for board membership, with some suggesting a 3-5-year membership term for a member. The reasons for supporting term limits were that it gives room for "*New knowledge*", "*New talent and skills*", and also serves to "*stop bad leadership*". Some respondents were against term limit, associating it with some disadvantages such as diminishing experience in the committee and erasing institutional memory (7/26) and also take away performing members (3/26). Seventeen out of twenty-six (65%) of the respondents were against staggered appointment dates for committee members. They deemed that appointing committee members on the same date improved teamwork and that induction would be easier for the team. According to all the respondents in this study, the motivation for seeking to serve in the board/committee was to serve the community. In majority (17/26) of the boards/committees, members reported that they are answerable to the CEO of the facility. Other members of the board said that they report to the chairman of the committee (3/26) or the SCMOH (3/26).

4.5 Board Practices Responsibilities

The selected board members were questioned on several subthemes to explore their understanding of the board responsibilities and procedures. The first subtheme sought to find out if the board members undergo induction training; to which majority (14/26) said

"*No*", 6/26 had no idea and the rest said yes. Only 6/26 board members said that they have undergone induction training. On whether the board members understand the vision, mission, purpose and core values of health care delivery of the facility where they serve, 14/26 had no idea of the existence of the same, while 12/26 reported that it doesn't exist. Most (23/26) of board members were well aware of some of the key health issues in Tana River County as highlighted in the health strategic plan 2015-2019; these included, "*Shortage in the laboratory service*", outbreaks of diseases such as cholera, malaria, "*Poor referral system*", "*Low financing & untimely fixed budget*" *etc.*

On the frequency of meetings, respondents reported that board meetings are held between twice (6/26) and four times a year (14/26). Notably, none of the boards have a role in the appointment of the facility in charge/CEO; however, majority (17/26) the members reported that they do play an "Oversight" role in the day to day management operations in the facility. Also, on evaluation of the performance of the health facility CEO (facility in charge), all apart from one, responded to never been involved in the evaluation of performance of their health facility CEO. Based on the responses, boards of health in Tana River County do not review the progress of their respective health facilities towards the attainment of targets set out in the 2017/2018 annual work plan for the health facilities and the facility's contribution to the annual work plan of the department of health, Tana River County.

Based on the repeated "No"/ "No idea" response, it appears that the boards do not facilitate the annual financial auditing of the facilities, and do not have a policy on stakeholder engagement for their input towards the attainment of the organization's strategic plans which feed into the county strategic plan in the department of health. The study also revealed that the boards do not have written down mechanisms to guide the board in dispute resolution between the facility and stakeholders. One respondent, however pointed out "*Personal intervention*" and "*Talking to the community*" as possible ways of handling such disputes. When asked about the board's chairman's key functions in the board; "*Calling for meetings*", "*signatory to the accounts of the hospital* and serving as a "*spokesperson of the committee*" were the responses given by the chairmen interviewed. On the key performance indicators for the heads of the health facilities in

Tana River County; the chairman talked about "*Facility delivery*", "*Community relationship*", "*antenatal clinic*", "*Supply of pharmaceuticals*" and "*Financial management*".

4.6 Board Operations and Procedures

More than half (17/26) of the board members represented in this study, are not aware of existence of policies governing the remuneration of the board members. However, there existed some form of reimbursement, *'depending on how our bank account is, as advised by the [officer in charge of the facility]*.None of the board members interviewed was aware of existence of any board committees within their boards. Asked about the set of skills that the respondents bring to the board, current or past occupation, understanding of the communities they represent, ability to establish a working relationship between the community was mentioned by 14 out of 26 respondents as *'... we represent the communities that we come from in matters of health in the facility*. None of the interviewed member is aware of any policy document that any of the boards has helped develop, or is planning to develop during the tenure of any of the board members that were interviewed.

Majority (14/26, 54%) of board members said that the CEO determines the agenda of the meeting. The rest, 12/26 said that the chairman determines the agenda of the meeting. Most (16/26) members reported that the duration of meetings ranged between 1 and 3 hours. However, 6/26 members reported that meetings may take longer; *"...sometimes, we may spend the whole day for a meeting that we thought would take us a few minutes..."*

All respondents (26/26 reported that it is a requirement for the facility CEOs to participate in the board meetings. Some (9/26) board members responded that no action is taken against board members who consistently skip meetings while others (12/26) said that replacements are sought, from the communities that those members come from (replacements are done to represent the village that the ousted member came from). Notably, one member reported that follow-up is done for the members that skip meetings, to encourage them to attend. The meeting minutes are usually either handwritten or typed

by the secretary and printed, and read on the next meeting. The secretary, who is the facility CEO (facility in charge), keeps the minutes.

None of the interviewed members sited any use of technology in board meetings. This included social media networks, dashboards and other forms of technology to aid meetings and decision making. All the interviewed board members said that there is no a replacement policy for members whose terms elapses, with most saying that they have served between 5 to 7 years with no term limits or replacement done during the time that they have been serving in the board. None of the interviewed members reported the existence of a board work plan that would guide their respective board's operations throughout the year.

4.7 Board Evaluation

All the interviewed members reported absence of a written policy for board self-evaluation and thus renewal of the board members terms is not based on performance during the term of office of the board member.

4.8 Results of Research Activities Addressing Research Question (Ii): Ability of Health Governance Bodies to Perform Their Oversight Roles Effectively

On whether the health governance bodies as currently constituted are able to perform their oversight roles effectively (as indicated by the responsiveness and quality of the services provided to the clients/citizens), CEOs sitting in health boards evaluated the capacity of the respective board members of their respective facilities. A total of 34 hospital management board/committee members were evaluated to assess the capability of the governance body to perform their oversight roles effectively as currently constituted.

The evaluated board members came from five health facilities in Tana River County, namely; Hola County Referral Hospital (n=10), Ngao Level IV Hospital (n=8), Garsen Health Centre (n=6), Sera Dispensary (n=6), and Maziwa Dispensary (n=4). The Medical Superintendents of the two hospitals and the facility in charges of the other facilities evaluated individual board members on fiver competences under the themes of leadership skills, communication and relationship management, professional and social

responsibility, health and healthcare environment planning and performance evaluation and business.

4.8.1 Leadership Skills

This evaluated leadership competences, incorporation of management techniques in management, change leadership and driving of innovation. Generally, the CEOs of the respective organizations rate most of their board members poorly in terms of leadership skills. For leadership skills and behavior, CEOs rated 12/34 (35%) and the remaining either fair (19/34), poor (2/34) and sometimes unacceptable (1/34). In regards to the ability of the governance bodies to incorporate management techniques and theories into leadership as well as driving innovation, the CEOs rated 24/34 (71%) board members as lying between fair and unacceptable. They also rated majority (21/34) of the board members as being either fair or poor in terms of ability to lead change in their organizations. The **Table 4.1** and **Figure 1.1** show the distribution of the respondents' views leadership skills.

Table 4-1: Leadership Skills

Competency	Response	Frequency
Leadership skills & behavior	Excellent	2
	Good	10
	Fair	19
	Poor	2
	Unacceptable	1
Incorporation of management techniques and theories into leadership	Excellent	2
	Good	8

	Fair	15
	Poor	8
	Unacceptable	1
Leading change	Excellent	7
	Good	6
	Fair	14
	Poor	7
	Unacceptable	
Driving innovation	Excellent	3
	Good	7
	Fair	16
	Poor	7
	Unacceptable	1

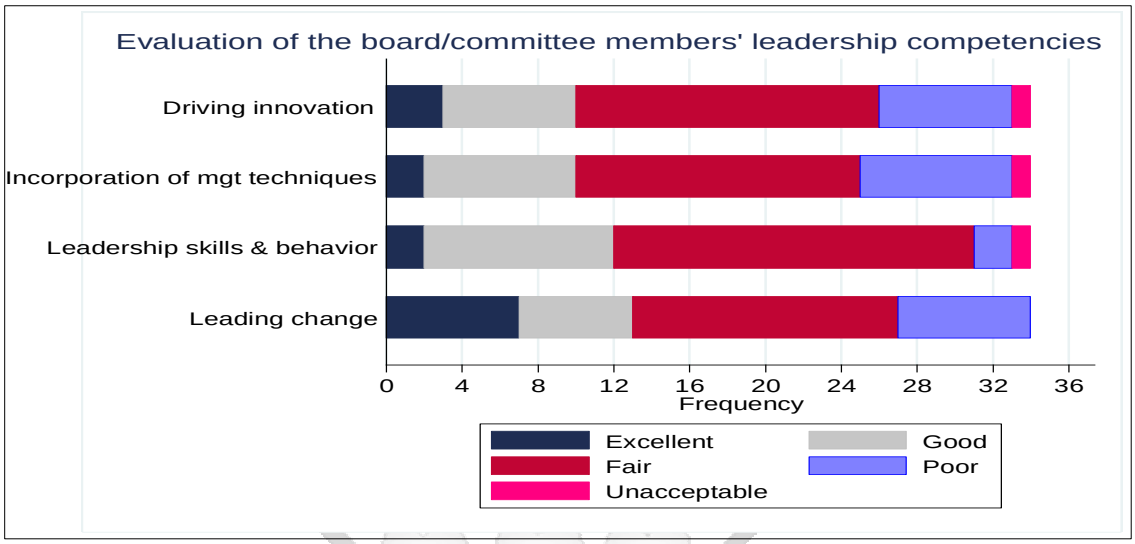

Figure 4.1: Distribution of Respondents' Responses On Board Members' Leadership Competency

4.8.2 Communication and Relationship Management

Generally, the CEOs of studied health centers rate less than 50% of the board members as good or excellent communication and relationship management skills (15/34), relationship management skills (13/34) and facilitation & negotiation skills (13/34). The CEOs judge most of governance body members as being either good, or poor in communication and relationship management (between 19/34 and 21/34).

Table 4.2 and **Figure 4.2** show the distribution of the respondents' views on the governance body members' communication and relationship skills.

Table 4-2: Communications and Relationship Management

Competency	Response	Frequency
Communications skill & engagement	Excellent	2
	Good	13
	Fair	12
	Poor	7
Relationship management		
	Excellent	2
	Good	11
	Fair	14
	Poor	7
Facilitation & negotiation	Excellent	3
	Good	10
	Fair	15
	Poor	5
	Unacceptable	1

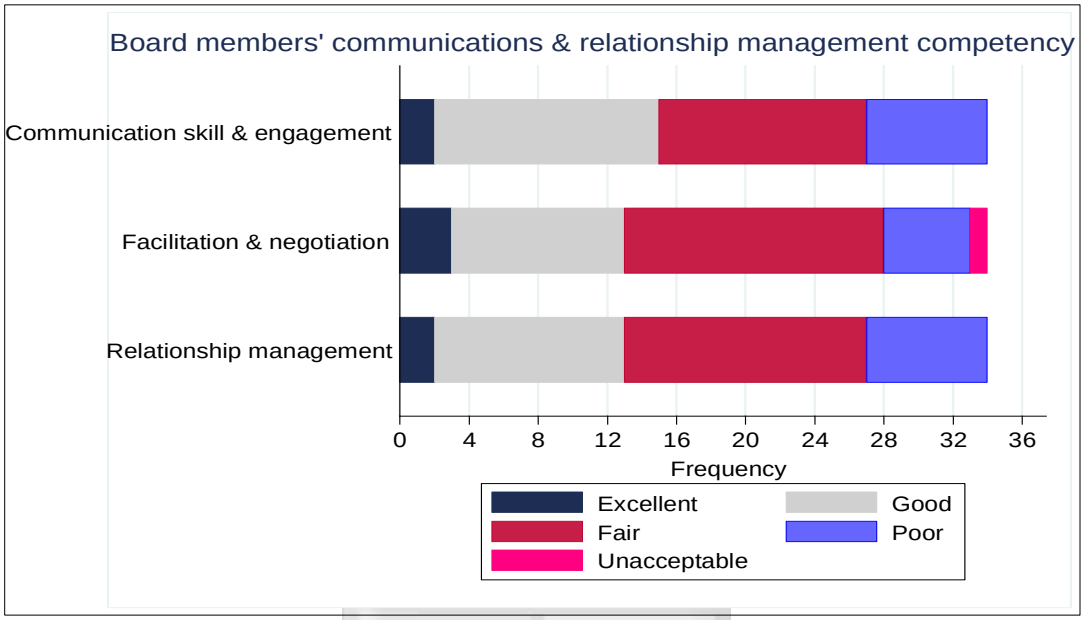

Figure 4.2: Distribution of Respondents' Responses On Board Members' Communication & Relationship Management Competency

4.8.3 Professional and Social Responsibility Competency

Asked about the professional and personal accountability competencies of the board members, CEOs judge most of the governing body members' as being either fair (between 14/34 and 19/34) or poor (between 3/34 and 10/34) and sometimes unacceptable.

Table 4-3: Professional and Social Responsibility Competencies

Competency	Response	Frequency
Personal and professional accountability	Excellent	4
	Good	7
	Fair	19

	Poor	4
Professional development and lifelong learning	Excellent	3
	Good	5
	Fair	14
	Poor	10
	Unacceptable	2
Ethical conduct and social consciousness	Excellent	6
	Good	8
	Fair	16
	Poor	3
	Unacceptable	1

Figure 4.3 shows the distribution of the respondents' views on the committee/board members' professional and social responsibility competency.

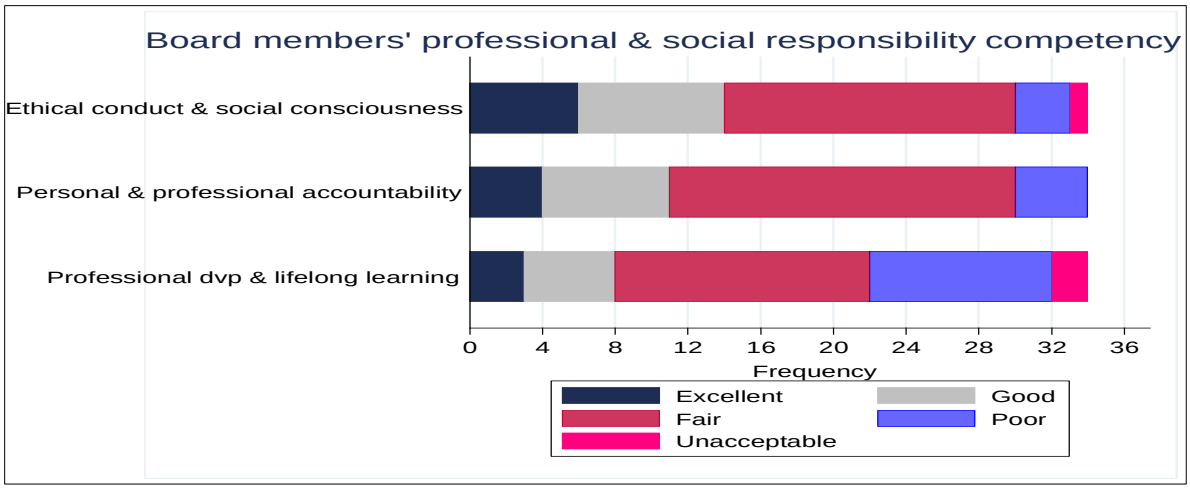

Figure 4.3: Distribution of Respondents' Responses On Board Members' Professional and Social Responsibility Competency

4.8.4 Health and Health Care Environment Competency

Only few of the governing body members were rated as good or excellent in terms of health and health care environment competency by the CEOs of their respective governing bodies **(Table 4.4).**

Table 4-4: Health and Health Care Environment Competencies of Governance Body Members

Competency	Response	Frequency
Healthcare organization structure	Excellent	3
	Good	8
	Fair	8
	Poor	15
Healthcare financing	Excellent	6

	Good	3
	Fair	9
	Poor	14
	Unacceptable	2
Healthcare workforce	Excellent	1
	Good	5
	Fair	11
	Poor	15
	Unacceptable	2
Public health	Excellent	4
	Good	7
	Fair	16
	Poor	6
	Unacceptable	1

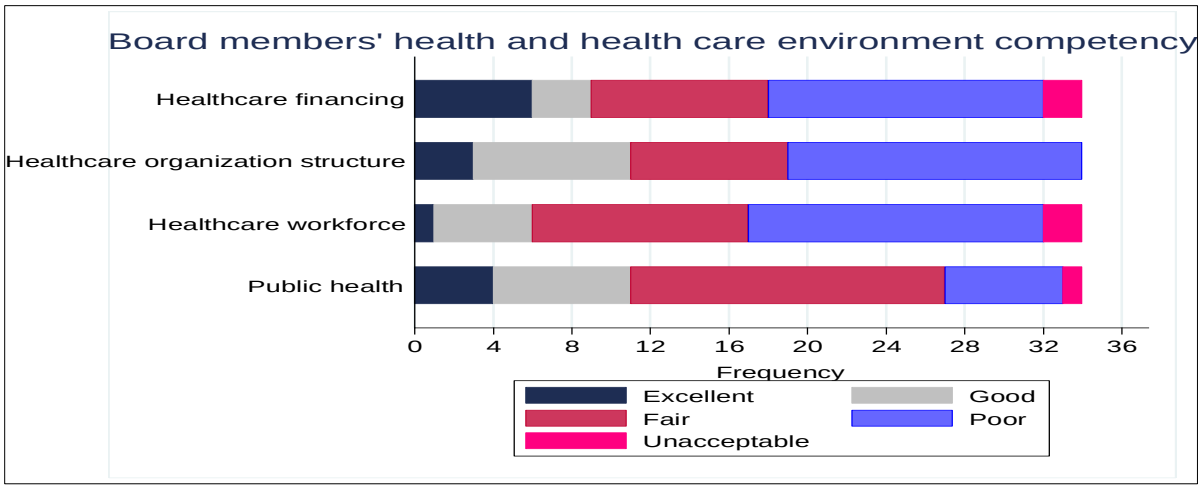

Figure 4.4: Distribution of Respondents' Responses On Board Members' Health and Health Care Environment Competency

4.8.5 Business Competency

When asked about the boards'/committees' competency in planning performance, supply chain, financial management, information management and quality improvement; very few trust on their capability; between 5/34 (15%) and 9/34 (56%) rate them as good or excellent. The rest of the respondents consider them as being fairly good or poor and sometimes unacceptable (**Table 4.5**).

Table 4-5: Business Competency

Competency	Response	Frequency
Planning performance	Excellent	1
	Good	5
	Fair	13
	Poor	12
	Unacceptable	3

	Excellent	4
	Good	5
	Fair	12
	Poor	10
	Unacceptable	3
Information management	Good	5
	Fair	15
	Poor	11
	Unacceptable	3
Quality improvement	Excellent	4
	Good	2
	Fair	15
	Poor	11
	Unacceptable	2

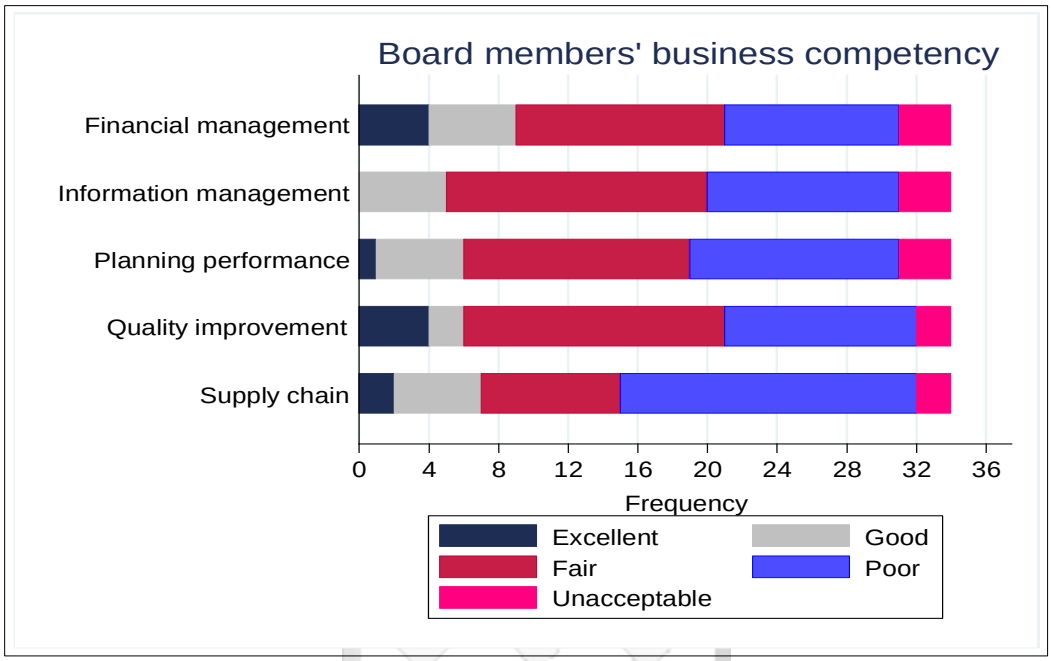

Figure 4.5: Distribution of Respondents' Responses On Board Members' Business Competency

4.9 Results of Research activities on Research Question (iii): Challenges to Healthcare Governance in Tana River County

During focus group discussions, this question was posed to the committees per facility in the five facility boards that were selected. Two subsequent focus group discussions were held, comprising of all the five facility board members. The table below summarized the recurrent themes in terms of challenges and possible solutions to governance bodies.

Table 4-6: Major Challenges and Proposed Solutions to Healthcare Governance in Tana River County

Challenge	Suggested Solution
1. Shortage of **resources** to run meetings and communication for governance bodies	Power to boards to influence allocation to governance bodies to carry out their functions
2. Member **competency** in finances, health environment and general management	1. Policy on recruitment to have minimum qualifications to board members 2. Member training and induction 3. Performance evaluation and continuous improvement policy to be developed at the count level, applicable to all boards in the county
3. Little oversight powers	1. Role in recruitment and evaluation of the CEO 2. Defined tenure and clear rules on terms limits 3. Policy on health governance at the county level
4. Non-Involvement in strategic leadership	1. Forum for health leaders and stakeholders for governing bodies to contribute their input to strategic plans for health facilities

5 CHAPTER FIVE: DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Discussion of Findings

In this chapter, the findings are discussed, conclusions drawn based on the findings and recommendations for the various stakeholders and further research suggested in the gaps identified by the study.

5.2 Constitution of Governance Bodies In Compliance With the Mwongozo Code of Governance

To gauge whether the current board are constituted according to thirty-four (34) board/committee members were selected and interviewed on four themes; 1) Board members selection and appointment 2) Board practices responsibilities 3) Board operations and procedures and 4) Board performance evaluation using a standard qualitative questionnaire that is based on the board charter provided by the *Mwongozo* code of governance for state corporations.

Board members may not have been selected based on competences in line with the functions of the facilities that they serve as the majority do not understand what should be the competencies of potential board members. Most board members believed that membership to the facility board was more to represent the village or the ethnic sub group that they come from, sometimes at the expense of technical capacity, skills and experience that is appropriate for board members for health facilities.

They view the CEO as the person they are answerable to, eroding the oversight function that is the function of the board, especially on the CEO. The boards have no role in the appointment or evaluation of the facility's CEO or the audit of the financial performance of the facilities that they serve.

For the past couple of years, no new board members have been hired as evidenced by long serving members. There seemed to be no mechanism to renew terms of existing boards or appointing new ones. Board members generally do not understand the

importance of term limits. Most members were self-driven to serve the community, as minimal financial support was available in the boards.

There was minimal training of board members on the functions of the board, with most members not aware of the general direction that the health system of the facilities they serve in is taking. Board members had pedestrian knowledge on the specific challenges that the health facilities faced and the priorities of these facilities.

Boards serve as a dispute resolution mechanism between the local community and the facilities, but rarely enhanced the performance of the facilities through engagement of stakeholders beyond the common members of the public at the village level. There was no mention of board members interacting with political and other leaders, health implementing partners or religious leaders whose interaction would increase the performance of the health facilities that the boards serve.

On the procedures of the boards, remuneration of the board members was unstructured and at the discretion of the CEO who decides and communicates what is available for the same. Boards are not involved in formulation or approval of any facility policy documents (annual work plans and strategic plans). They also do not have any form of work plan for the operation of their respective boards. Members could skip several meetings without repercussions in most boards, while the CEO takes, keeps and avails minutes on board meetings. None of the interviewed boards have self-evaluation and continuous improvement mechanisms in place.

5.3 Capacity of the Health Governance Bodies as Currently Constituted to Perform Their Roles

Through the opinion of the CEO that serve in the facilities with the boards, governance bodies were evaluated on whether they are able to perform their oversight roles effectively, citing their opinion on the capacity of individual board members on areas of leadership and leadership skills, communication, relationship management, professional competencies, healthcare environment and business competencies.

CEOs do not look up to board members for general leadership of their health facilities, based on the CEO's faith in the leadership skills of their boards including in change and innovation management towards the mission and the vision of the facilities. However, most members are good communicators and relationship managers with the communities that they come from. The relationship skills do not extend to stakeholders beyond the local communities from which the members come from.

The board members have generally low professional and technical standing. They are thus not able to give technical guidance to the CEOs and the managers of the healthcare system. Boards have poor knowledge in terms of how the human resources for health, health financing, commodity security, health organizational structure and service delivery interact to supply services. They also have little capacity to make meaningful contribution in performance planning for the facilities, quality management, supply chain planning, information and financial management.

5.4 Challenges and Gaps to Healthcare Governance in Tana River County

To identify what challenges that exist in the current health governance bodies, the boards held focus group discussions.

Counties have done little to provide financial resources for healthcare governance, with boards operating at the mercy of the CEOs. There are also no structures to empower health management boards, with little effort from county authorities to formerly recruit governing bodies. There is no policy on qualification, hiring and operation of board members.

Health governance bodies have no role in the strategic direction of the health systems, with no interaction between the county governance bodies and technical managers for healthcare facilities and the county health management team, the CEC health or the Chief Officer health.

5.5 Conclusion

The findings of this study reveal that healthcare governance bodies in Tana River County have not been constituted and do not operate as guided by *Mwongozo*, the code of governance for state corporations. They do not have capacity to carry out effective governance for healthcare services to ensure access to quality and cost-effective healthcare services that are responsive to the needs of the community that they serve.

5.6 Recommendations

To improve healthcare governance so that it improves alongside with the other pillars of healthcare systems, the study recommends that the CEC member for health constitutes a team of governance experts and county health leaders to put in place a governance policy that defines the terms of reference for recruiting of members of the health governance bodies in line with the recommendations of *Mwongozo*, the Code of Governance for Public Corporations. The health governance bodies should include the County Health Management Board, Hospital Management Boards for the two level four hospitals and Facility Management Boards for all the facilities in the county. The study also recommends that the governor appoints the members of the health governance bodiesandgives them such financial support and legitimacy that is necessary to effectively carry out their oversight and strategic directing roles.

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Annexes

Annex 1: Questionnaire on State of Governance

Adopted from Mwongozo, the Code of Governance for State Corporations Kenya 2015

GOVERNANCE ITEM	INTERVIEW QUESTIONS
1. BOARD SELECTION	1.1. In your terms of reference, what are the functions of the health management board or committee in which you are currently serving?
	1.2. What should be the desirable competences, personal attributes and qualifications of the board or committee members so that they are able to serve the people of Tana River County and meet their expectations in terms of health services provision?
	1.3. Should board/committee members have term limits? What are the pros and cons of term limits for board members?
	1...4 Should board/committee members all appointed on the same date? If the answer is "no", please explain
	1.5. What were your motivations for seeking to serve in the board/committee you are in?

	1.6Who does the board report to? Is it the nominating authority?
2. BOARD PRACTICES AND RESPONSIBILITIES	2.1. What are the collective responsibilities of the board? Have board/committee member undergone an induction training?
	2.2. What are the vision, mission, purpose and core values of health care delivery facility in which you are serving as a board/committee member in Tana River County?
	2.3. Are you conversant with the key health issues of the Tana River County as highlighted in the county health strategic plan 2015-2019?
	2.4. (To be answered by the chairman) What are your key functions as the board chairman?
	2.5. (To be answered by the chairman) What are the key performance indicators for the heads of the health facilities in Tana River County against which they should be evaluated by the boards/committees?
	2.6. How many times in a calendar year do you hold board meetings?

	2.7. Has the board been involved in the evaluation of performance of any of the CEOs of the health facilities in Tana River County?
	2.8. A) What is the progress in attainment of targets set out in the 2017/2018 annual work plan by this facility; b) Does the board review, on quarterly or annual basis, the attainment of targets that facilities set out in the annual work plans?
	2.9. Does the board have a role in the appointment of the facility in charge/CEO?
	2.10 Do you play any role in the day to day management operations in the facility?
	2.11 Does the board facilitate the annual financial auditing of the facilities? Is there a report of such an audit for the 2017/2018 financial year?
	2.12 Does the board have a list of stakeholders? Is there a policy on how to engage the stakeholders for their input towards attainment of the organization's strategic plan?
	2.13 When there is a dispute between the facility and the stakeholders, is there a mechanism for the stakeholders to report this to the board? Is there a formal way that the board

	resolves such disputes?
Board Operation and Procedures	2.14 Is there a policy on how the board members are remunerated?
	2.15 Please name the committees that are in the board you currently serve in. Are you a member of any of these committees??
	2.16 What is the set of skills that you bring to the board or board committees from your current occupation/job? What is your current job?
	2.17 Please list 3 examples of policy documents that the board has helped to develop or is planning to develop during your tenure as a board/committee member
	2.18 Who determines the agenda for board meetings
	2.19 Describe how a typical board meeting is conducted, and how long it generally lasts
	2.20 Does anyone from management attend board meetings, and if so, what is their role? (illustrate your answer with examples)

	2.21 Is it a requirement for the CEO of the facility to attend an ALL board meetings?
	2.22 What happens to board members who consistently fail to attend board meetings?
	2.23 How are board meetings minutes recorded, approved and circulated to members?
	2.24 How are board members invited to board meetings, and how are important documents shared with board members before the meetings?
	2.25 Can a board member participate in a board meeting via Skype?
	2.26 In case the term of a board member elapses, is there a replacement plan/policy in place to ensure board activities are not disrupted?
	2.27 Is there a work plan that guides the operations of the board throughout the year? If yes, what are the contents of the work plan?
3.BOARD EVALUATION	3.1. Is there a written policy for board (self) evaluation, and if so, has this ever been implemented during your tenure as a board member?

	3.2. Is the report on evaluation of individual board members taken into account when renewing the tenure of board members?

Annex 2: Leadership Competencies for Individual Board/Committee Members

Name of Organization/Facility:

_____

Name of the Board Member:

_____

Name of respondent:

_____

Instructions

This questionnaire assesses the competencies of each board member on five governance competences (leadership, communication and relationships, professional development and life learning, health and healthcare environment and business competences).

Please rate the level of competency for each board member on the five areas of competency.

Governance Body Member Bio data

Age _____

Level of Technical Education

No education ☐

Primary School ☐

O Levels ☐

Diploma ☐

Degree ☐

Post Graduate ☐

Management Training

None ☐

Short Management Course ☐

Post Graduate ☐

1. Leadership Competencies

A. Leadership Skills and Behavior

Articulate and communicate the mission, objectives and priorities of the organization to internal and external entities

Incorporate management techniques and theories into leadership activities

Analyze problems, promote solutions and encourage decision making

1= Unacceptable ☐ | 2= Poor ☐ | 3= Fair ☐ | 4= Good ☐ | 5= Excellent ☐ | Not Applicable ☐

B. Engaging Culture and Environment

• Create an organizational climate built on mutual trust, transparency and a focus on service improvement that encourages teamwork and supports diversity

• Encourage a high level of commitment from employees by establishing and communicating a compelling organizational vision and goals

• Hold self and others accountable to surpass organizational goals

1= Unacceptable ☐ | 2= Poor ☐ | 3= Fair ☐ | 4= Good ☐ | 5= Excellent ☐ | Not Applicable ☐

C. Leading Change

• Promote ongoing learning and improvement in the organization

• Respond to the need for change and lead the change process

1= Unacceptable ☐ | 2= Poor ☐ | 3= Fair ☐ | 4= Good ☐ | 5= Excellent ☐ | Not Applicable ☐

D. D. Driving Innovation

• Encourage diversity of thought to support innovation, creativity and improvement

1= Unacceptable ☐ | 2= Poor ☐ | 3= Fair ☐ | 4= Good ☐ | 5= Excellent ☐ | Not Applicable ☐

2. Communications and Relationship Management Competencies:

A. Relationship Management

• Demonstrate effective interpersonal relationships and the ability to develop and maintain positive stakeholder relationships

• Practice and value transparent shared decision making and understand its impacts on stakeholders (internal and external)

• Demonstrate collaborative techniques for engaging and working with stakeholders

1= Unacceptable ☐ | 2= Poor ☐ | 3= Fair ☐ | 4= Good ☐ | 5= Excellent ☐ | Not Applicable ☐

B. Communication Skills and Engagement

• Exercise cultural sensitivity in internal and external communication

• Demonstrate strong listening and communication skills

• Present results of data analysis in a way that is factual, credible and understandable to the decision makers

• Prepare and deliver business communications such as meeting agendas, presentations, business reports and project communication plans

Demonstrate understanding of the function of media and public relations

1= Unacceptable ☐ | 2= Poor ☐ | 3= Fair ☐ | 4= Good ☐ | 5= Excellent ☐ | Not Applicable ☐

C. Facilitation and Negotiation

• Manage conflict through mediation, negotiation and other dispute resolution techniques

• Demonstrate problem solving and problem-solving skills

• Build and participate in effective multidisciplinary teams

1= Unacceptable ☐ | 2= Poor ☐ | 3= Fair ☐ | 4= Good ☐ | 5= Excellent ☐ | Not Applicable ☐

3. Professional and Social Responsibility Competencies:

A. Personal and Professional Accountability

• Advocate for and participate in healthcare policy initiatives

• Advocate for rights and responsibilities of patients and their families

• Demonstrate an ability to understand and manage conflict-of-interest situations as defined by organizational bylaws, policies and procedures

• Practice due diligence in carrying out fiduciary responsibilities

• Commit to competence, integrity, altruism and the promotion of the public good

• Promote quality, safety of care and social commitment, in the delivery of health services

1= Unacceptable ☐ | 2= Poor ☐ | 3= Fair ☐ | 4= Good ☐ | 5= Excellent ☐ | Not Applicable ☐

B. Professional Development and Lifelong Learning

• Demonstrate commitment to self-development including continuing education, networking, reflection and personal improvement

C. Contributions to the Profession

• Contribute to advancing the profession of healthcare management by sharing knowledge and experience

• Develop others by mentoring, advising, coaching and serving as a role model

• Support and mentor high-potential talent within both one's organization and the profession of healthcare management

1= Unacceptable ☐ | 2= Poor ☐ | 3= Fair ☐ | 4= Good ☐ | 5= Excellent ☐ | Not Applicable ☐

C. Contributions to the Profession

• Contribute to advancing the profession of healthcare management by sharing knowledge and experience

• Develop others by mentoring, advising, coaching and serving as a role model

• Support and mentor high-potential talent within both one's organization and the profession of healthcare management

1= Unacceptable ☐ | 2= Poor ☐ | 3= Fair ☐ | 4= Good ☐ | 5= Excellent ☐ | Not Applicable ☐

D. D. Self- Awareness

• Be aware of one's own assumptions, values, strengths and limitations

• Demonstrate reflective leadership by using self- assessment and feedback from others in decision making

1= Unacceptable ☐ | 2= Poor ☐ | 3= Fair ☐ | 4= Good ☐ | 5= Excellent ☐ | Not Applicable ☐

E. Ethical Conduct and Social Consciousness

• Demonstrate high ethical conduct, a commitment to transparency and accountability for one's actions

Use the established ethical structures to resolve ethical issues

• Maintain a balance between personal and professional accountability, recognizing that the central focus is the needs of the patient/community

1= Unacceptable ☐ | 2= Poor ☐ | 3= Fair ☐ | 4= Good ☐ | 5= Excellent ☐ | Not Applicable ☐

4. Health and Healthcare Environment Competencies:

A. Health Systems and Organizations

• Demonstrate an understanding of system structure, funding mechanisms and how healthcare services are organized

• Balance the interrelationships among access, quality, safety, cost, resource allocation, accountability, care setting, community need and professional roles

• Assess the performance of the organization as part of the health system/healthcare services

• Use monitoring systems to ensure legal, ethical, and quality/safety standards are met in clinical, corporate and administrative functions

• Promote the establishment of alliances and consolidation of networks to expand social and community participation in health networks, both nationally and globally

1= Unacceptable ☐ | 2= Poor ☐ | 3= Fair ☐ | 4= Good ☐ | 5= Excellent ☐ | Not Applicable ☐

B. Health Workforce

• Demonstrate the ability to optimize the healthcare workforce around local critical workforce issues, such as shortages, scope of practice, skill mix, licensing and fluctuations in service

1= Unacceptable ☐ | 2= Poor ☐ | 3= Fair ☐ | 4= Good ☐ | 5= Excellent ☐ | Not Applicable ☐

C. Person- Centered Health

• Effectively recognize and promote patients and their family's/caregiver's perspectives in the delivery of care

• Include the perspective of individuals, families and the community as partners in healthcare decision- making processes, respecting cultural differences and expectations

1= Unacceptable ☐ | 2= Poor ☐ | 3= Fair ☐ | 4= Good ☐ | 5= Excellent ☐ | Not Applicable ☐

D. Public Health

• Establish goals and objectives for improving health outcomes that incorporate an understanding of the social determinants of health and of the socioeconomic environment in which the organization functions

• Use vital statistics and core health indicators to guide decision making and analyze health trends of the population to guide the provision of health services

• Manage risks, threats, and damage to health during disasters and/or emergency situations

• Evaluate critical processes connected with the public health surveillance and controls systems and communicate relevant surveillance information to increase response to risks, threats, and damage to health

• Recognize the local implications of global health events to understand global interconnectivity and its impact on population health conditions

1= Unacceptable ☐ | 2= Poor ☐ | 3= Fair ☐ | 4= Good ☐ | 5= Excellent ☐ | Not Applicable ☐

5. Business Competencies:

A. General Management

• Demonstrate knowledge of basic business practices, such as business plans, contracting, and project management

• Collate relevant data and information, and analyze and evaluate this information to support or make an effective decision or recommendation

• Seek information from a variety of sources to support organizational performance, conduct needs analysis and prioritize requirements

1= Unacceptable ☐ | 2= Poor ☐ | 3= Fair ☐ | 4= Good ☐ | 5= Excellent ☐ | Not Applicable ☐

B. Laws and Regulations

• Abides by laws and regulations applicable to the work of the organization

1= Unacceptable ☐ | 2= Poor ☐ | 3= Fair ☐ | 4= Good ☐ | 5= Excellent ☐ | Not Applicable ☐

C. Financial Management

• Effectively use key accounting principles and financial management tools, such as financial plans and measures of performance (e.g., performance indicators)

• Use principles of project, operating and capital budgeting

• Plan, organize, execute and monitor the resources of the organization to ensure optimal health outcomes and effective quality and cost controls

1= Unacceptable ☐ | 2= Poor ☐ | 3= Fair ☐ | 4= Good ☐ | 5= Excellent ☐ | Not Applicable ☐

D. Human Resource Management

• Provide leadership in defining staff roles and responsibilities, developing appropriate job classification/grading systems and workforce planning

• Effectively manage departmental human resource processes, including scheduling; performance appraisals; incentives; staff recruitment; selection and retention; training and education; motivation, coaching and mentoring; and appropriate productivity measures

1= Unacceptable ☐ | 2= Poor ☐ | 3= Fair ☐ | 4= Good ☐ | 5= Excellent ☐ | Not Applicable ☐

E. Organizational Dynamics and Governance

• Demonstrate knowledge of governmental, regulatory, professional and accreditation agencies

• Effectively apply knowledge of organizational systems theories and behaviors

• Interpret public policy, legislative and advocacy processes within the organization

• Manage within the governance structure of the organization

• Create and maintain a system of governance that ensures appropriate oversight of the organization

• Demonstrate knowledge of the role of leadership within governance structure

1= Unacceptable ☐ | 2= Poor ☐ | 3= Fair ☐ | 4= Good ☐ | 5= Excellent ☐ | Not Applicable ☐

F. Strategic Planning and Marketing

• Lead the development of key planning documents, including strategic plans, business service plans and business cases for new services

• Plan for business continuity in the face of potential disasters that could disrupt service delivery

• Develop and monitor operating-unit strategic objectives that are aligned with the mission and strategic objectives

• Apply marketing principles and tools to develop appropriate marketing to the needs of the community

• Evaluate whether a proposed action aligns with the organizational business/strategic plan

1= Unacceptable ☐ | 2= Poor ☐ | 3= Fair ☐ | 4= Good ☐ | 5= Excellent ☐ | Not Applicable ☐

G. Information Management

• Use data sets to assess performance, establish targets, monitor indicators and trends, and determine if deliverables are met

• Ensure that applicable privacy and security requirements are upheld

• Ensure optimal use of information and trend analysis within the organization through the use of business intelligence, information management, clinical, and business systems

• Promote the effective management, analysis and communication of health information

1= Unacceptable ☐ | 2= Poor ☐ | 3= Fair ☐ | 4= Good ☐ | 5= Excellent ☐ | Not Applicable ☐

H. Risk Management

• Effectively use risk management principles and programs, such as risk assessment and analysis and risk mitigation

1= Unacceptable ☐ | 2= Poor ☐ | 3= Fair ☐ | 4= Good ☐ | 5= Excellent ☐ | Not Applicable ☐

I. Quality Improvement

• Develop and implement quality assurance, satisfaction, and patient safety programs according to national initiatives on quality and patient safety

• Develop and track indicators to measure quality outcomes, satisfaction and patient safety, and plan continuous improvement

1= Unacceptable ☐ | 2= Poor ☐ | 3= Fair ☐ | 4= Good ☐ | 5= Excellent ☐ | Not Applicable ☐

J. Systems Thinking

• Demonstrate an understanding of the interdependency, integration, and competition among healthcare sectors

•Connect the interrelationships among access, quality, cost, resource allocation, accountability and community

1= Unacceptable ☐ | 2= Poor ☐ | 3= Fair ☐ | 4= Good ☐ | 5= Excellent ☐ | Not Applicable ☐

K. Supply Chain Management

• Effectively manage the supply chain to achieve timelines and efficiency of inputs, materials, warehousing, and distribution so that supplies reach the end user in a cost-effective manner

• Adhere to procurement regulations in terms of contract management and tendering guidelines

• Effectively manage the interdependency and logistics of supply chain services within the organization

1= Unacceptable ☐ | 2= Poor ☐ | 3= Fair ☐ | 4= Good ☐ | 5= Excellent ☐ | Not Applicable ☐

Annex 3: Focus Group Discussion Data Tool

Data Collection Tool for Research Question 3

(What are the current challenges and gaps to healthcare governance for healthcare Tana River County (capacity, resources, oversight activities, communication flow) and how can they is addressed as part of health system strengthening in this county?)

Focus Group Discussion Summary Tool

Topic: What are the challenges of healthcare governance? What are the proposed recommendations towards improvement of healthcare governance in your facility/Tana River County?

Summary of Challenges

1. _____
2. _____
3. _____
4. _____
5. _____

Summary of Recommendations

1. _____
2. _____
3. _____
4. _____
5. _____

Annex 4: Participant Information and Consent Form

SECTION 1: INFORMATION SHEET–HEALTH PERSONNEL

Investigator: Dr. Mwenda Nicholas, Tana River County

Institutional Affiliation: Strathmore Business School (SBS), 2018

SECTION 2: INFORMATION SHEET–THE STUDY

2.1: Why is this study being carried out?

This study is being carried out as contribution to the betterment of delivery of health services in Tana River County and as a requirement for completion of the Master of Business Administration, Healthcare Management, at the Strathmore Business School, 2018.

2.2: Do I have to take part?

No. Taking part in this study is entirely optional and the decision rests only with you. If you decide to take part, you will be asked to complete a questionnaire to get information on structures and capacity of health governance (Health Management Committees, the County Health Management Board and Facility Management Committees) in Tana River County. If you are not able to answer all the questions successfully the first time, you may be requested to sit through another informational session after which you may be requested to answer the questions a second time.

You are free to decline to take part in the study from this study at any time without giving any reasons.

2.3: Who is eligible to take part in this study?

- Members of the County Health Management Board, Tana River County
- Members of the Facility Health Management Committees, Garsen Health Center, Madogo Health Centre
- Members of the Hospital Health Management Committees in Bura Hospital, Ngao Hospital and Hola Hospital.

2.4: Who is not eligible to take part in this study?

Anyone who is not a member of the boards/committees described in 2.3 above is not eligible to take part in this study.

2.5: What will be taking part in this study involve for me?

You will be approached and be requested to take part in the study. If you are satisfied that you fully understand the goals behind this study, you will be asked to sign the informed consent form (this form) and then taken through a questionnaire to completion.

2.6: Are there any risks or dangers in taking part in this study?

There are no risks in taking part in this study. All the information you provide will be treated as confidential and will not be used in any way without your express permission.

2.7: Are there any benefits of taking part in this study?

The information will be used to improve the effectiveness of public healthcare leadership and governance in Tana River County, thus contributing in improving health service delivery.

2.8: What will happen to me if I refuse to take part in this study?

Participation in this study is entirely voluntary. Even if you decide to take part at first but later change your mind, you are free to withdraw at any time without explanation.

2.9: Who will have access to my information during this research?

All research records will be stored in securely locked cabinets. That information may be transcribed into our database but this will be sufficiently encrypted and password protected. Only the people who are closely concerned with this study will have access to this information. All your information will be kept confidential.

2.10: Who can I contact in case I have further questions?

You can contact me, Dr. Nicholas Mwenda, at SBS, or by e-mail (nickmwenda@yahoo.com), or by phone (+254721101586). You can also contact my supervisor, Prof. Gilbert Kokwaro, at the Strathmore Business School, Nairobi, or by e-mail (gkokwaro@strathmore.edu) or by phone (0722323651)

I, _____, have had the study explained to me. I have understood all that I have read and have had explained to me and had my questions answered satisfactorily. I understand that I can change my mind at any stage.

Please tick the boxes that apply to you;

Participation in the research study

☐ I AGREE to take part in this research

☐ I DO NOT AGREE to take part in this research

Storage of information on the completed questionnaire

☐ I AGREE to have my completed questionnaire stored for future data analysis

☐ I DO NOT AGREE to have my completed questionnaire stored for future data

analysis

Participant's Signature:

Date: _____/_____/_____

_____

DD /MM / YEAR

Participant's Name:

Time: _____ /_____

_____

(Please print name) ***HR / MN***

I, _____ (Name of person taking consent) certify that I have followed the SOP for this study and have explained the study information to the study participant named above, and that she has understood the nature and the purpose of the study and consents to the participation in the study. She has been given opportunity to ask questions which have been answered satisfactorily.

Investigator's Signature:

Date: _____/_____/_____

_____

DD /MM / YEAR

Investigator's Name:

Time: _____ /_____

_____

(Please print name) ***HR / MN***

Annex 5: Budget for the study

Item	Number	Unit Cost	Total Cost
Fuel (Liters)	150	100.00	15,000.00
Data Clerks	4	5,000.00	20,000.00
Airtime	1	1,000.00	1,000.00
Accommodation	4	6,500.00	26,000.00
Transport for Board Members	45	1,000.00	45,000.00
			107,000.00

Annex 6: Ethical Clearance

Strathmore UNIVERSITY

7th May 2018 SU-IRB 0225/18

MWENDA NICHOLAS MWIKAIRI
P.O Box 38 70101
Hola, Tana River
Nairobi
Kenya.

Email: nickmwenda@yahoo.com

Dear Mwenda,

REF **Student Number:** MBA-HCM/83147/16 **Protocol ID:** SU-IRB 0225/18
An Assessment of the state of Public Healthcare Governance in Tana River County, Kenya

We acknowledge receipt of your application documents to the Strathmore University Institutional Ethics Review Committee (SU-IERC) which includes:

1. Study Proposal dated January 2018
2. Participant Information and Consent form dated January 2018
3. Study Questionnaires dated January 2018
4. Study Budget
5. CV

The committee has reviewed your application, and your study *"An Assessment of the state of Public Healthcare Governance in Tana River County, Kenya."* has been granted **approval**.

This approval is valid for one year beginning **7th May 2018** until **6th May 2019.**

In case the study extends beyond one year, you are required to seek an extension of the Ethics approval prior to its expiry. You are required to submit any proposed changes to this proposal to SU-IERC for review and approval prior to implementation of any change.

SU-IERC should be notified when your study is complete.

Thank you

Sincerely,

Amina Salim

Regulatory Affairs Fellow

STRATHMORE UNIVERSITY APPROVED INSTITUTIONAL REVIEW BOARD

Annex 7: Clearance - County Government of Tana River

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COUNTY GOVERNMENT OF TANA RIVER
DEPARTMENT OF HEALTH
County Director of Medical Services

REF: TRC/HEALTH/CDMS 0104-2018 Jan 4, 2018

To:

Dr. Mwenda Nicholas,
County Government of Tana River

RE: CLEARANCE TO CARRY OUT A STUDY ON HEALTH GOVERNANCE IN TANA RIVER COUNTY

The County Health Management Committee, Tana River, is in receipt of your request to carry out this study that will involve visit to subject facilities and interviewing hospital and facility committee members.

This team has reviewed your study protocol and is pleased to give greenlight on the same.

Good luck and best wishes.

Dr. Oscar O. Endekwa,
County Director of Medical Services
TANA RIVER

1

Appendices

Appendix 1: Allocation to the Department of Health

Tana River County (2013/2014 to 2016/2017 financial years) and the ministry of health (2009 to 2012) in Millions of USDs Source: http://ifmis.go.ke

	2013/14	2014/15	2015/16	2016/17	4-year period
Total County Allocation (Millions USD)	3,118,81	3,599.93	4,155.86	4,592.14	12,347.93
Total on Development		45.04	382.45	383.74	811.24
Total on Recurrent		18.98	339.19	536.74	894.91
Health Exp. (Recurrent and Development)		64.02	721.64	920.48	1,706.14
% invested in health		2%	17%	20%	14%
Population Estimate (KNBS)		293,701	302,217	310,982	320,000
Per Capita Investment in KSHs		217.99	2,387.82	2,959.91	5,331.70
Per Capita Investment in Health in USDs		2.18	23.88	29.6	53.32