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Factors influencing implementation of the safe motherhood, maternal and neonatal health component of the National Reproductive Health Policy (2007) in Nairobi County

Jessica K. Mbae
Strathmore Business School (SBS)
Strathmore University

Factors Influencing Implementation of the Safe Motherhood, Maternal, and Neonatal Health Component of the National Reproductive Health Policy (2007) in Nairobi County

Jessica Karimi Mbae

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Strathmore Business School

Strathmore University

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DECLARATION

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, the thesis contains no material previously published or written by another person except where due reference is made in the thesis itself.

Jessica Karimi Mbae

Signature: ..... Date 24/6/20.....

Approval

The thesis of Jessica Karimi Mbae was reviewed and approved for examination by the following:

Dr. Ben Ngoye

Signature..... Date 24/06/2020.....

Strathmore Business School

Strathmore University

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DEDICATION

I dedicate this research project to my parents, Mr. Bernard Mbae and Dr. Josephine Kibaru-Mbae who have supported me throughout this whole process.

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ABSTRACT

This study investigated factors influencing the implementation of the safe motherhood, maternal, and neonatal health component of the National Reproductive Health (NRHP) (2007) in Nairobi County using Mazmanian and Sabatier's policy implementation framework. The investigation sought to determine the extent to which human resources, financial resources, hierarchical integration, and stakeholder involvement influenced the implementation of these components of the Policy. A mixed-methods approach consisting both qualitiative and quantitative methods was applied. The 101 public health facilities in Nairobi County were the units of analysis and the unit of observation was senior health officials in the facility. The sample size was established as 80 respondents. A structured questionnaire was used to collect primary data, which was supplemented by literature review. The qualitative and quantitative data was analyzed using content and thematic analysis and statistical methods respectively. The quantitative findings are presented in figures and tables. These findings show positive and significant correlations for financial resources, hierarchical integration, and formal access by outsiders; and positive and non-significant correlations for human resources. The composite model (human resource, financial resources, hierarchical integration, and formal access by outsiders) had a 40.8 % effect on implementation of this component of the NRHP and the model was a good fit for the data given the positive F statistic ($F = 12.291$) at significance level $p < 0.05$. Linear regression analysis showed that formal access by outsiders (stakeholder participation) had the largest and only statistically significant effect on implementation of safe motherhood, maternal and neonatal health component of the NRHP (2007). The study thus recommends more concerted efforts toward stakeholder participation if implementation towards achieving the goals of the NHRP (2007) is to be realized. This calls for strategic stakeholder mapping and analysis, and for increased consultations with stakeholders including global health organizations such as WHO and UNICEF. The study was however limited to Nairobi County, and to this particular policy, and so the findings may not necessarily be generalizable.

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ABBREVIATIONS AND ACRONYMS

CBO	Charity Based Organisation
FBO	Faith Based Organisation
FCTC	Framework Convention on Tobacco Control
GDP	Gross Domestic Product
KDHS	Kenya Demographic Health Survey
KNBS	Kenya National Bureau of Statistics
MDAs	Ministries, Departments, and Agencies
MDG	Millennium Development Goals
NEPAD	New Partnership for Africa's Development
NRHP	National Reproductive Health Policy
NGOs	Non-Governmental Organisations
RHS	Reproductive Health Services
SDGs	Sustainable Development Goals
SPSS	Statistical Package for Social Sciences
UN	United Nations
UNICEF	United Nations International Children's Fund
WHO	World Health Organisation

CHAPTER 1: INTRODUCTION TO THE STUDY

1.1 Introduction

In the quest for development, countries draft policies to guide strategies that will enable the country to reach specific desired ends. Successful implementation of policies is however an issue of concern in all countries, both developed and developing (Ajulor, 2018). In general, public policy is described as a set of governmental actions taken to resolve the problems faced by a Nation (Ajulor, 2018). Making public policy is more than a technical function of state but is a complicated web of interactive processes determined by different natures of ecnvironmental, social, and political forces (Ajulor, 2018). Accordingly, public policies in low income nations possess specific particularities of their personal virtues of the influence of an unstable social and poltical environment (Ajulor, 2018). Malnutrition, illetracy, unemployment, poor standards of living, poverty, and ill health and other common problems facing these nations have also influenced policy development and implementation (Osman, 2002).

Notwithstanding, scholars and researchers have described the public policy process differently. For example, Howlett and Ramesh (2003) identified five stages formulation of policy, setting the agenda, decision making, evaluation, and adoption. Rossi, Lipsey and Freeman (2004) identified five stages that include policy evaluation, adoption, formulation, execution, and identifying the problem. Fixsen et al. (2009) described a six-phase process beginning from adoption and exploration, full operation, sustinability, innovation, installation of the programme, and initial execution.

This dissertation concentrates on implementation of policy which is a key component of public policy process, where associations and organizations get involved assigning each agency their part of the responsibility towards achievement of the policy (O'Toole, 2004). In this stage, intimate communication and coordination between different actors are needed and part of the implementation is executed by various agencies and departments (Fixsen et al., 2009). In implementing public policy, there is a mixing of machine, material, human, and money is quite significant (Mbieli, 2006).

Mazmanian and Sabatier (1983, p. 20) defined implementation as undertaking a fundamental policy decision often included in a decree that can also be presented in terms of court decisions or decree-law. Sabatier and Mazmanian (1983) lists policy implementation as the first phase of the political system's amendment of the novel policy; the actual impact of the decisions; the compliance of internal and external target groups with those decisions; the policy outputs, or decisions, or departments; and the perceived impact of the decisions (Elson, 2006).

O'Toole (2004, 266) defined policy implementation as processes on-going during the formulation of an intent on the part of a state to take an action or stop doing something and the final effect of these actions." Thus, Mbieli (2006) explains that execution of policy is significant to policy success because it is in the core of the policy process. This consists policy identification of programmes, projects, plans, activities, definition of unique roles of implementing agencies or firms; details of necessary and strategic links and matching mechanisms; as well as human, financial, technology, utilization, material, and data acquisition (Mbieli, 2006).

Moreover, countries have different approaches and peculiarities in policy implementation with differing issues leading to lack of implementation of policies. For example, in Pakistan, policy implementation has three elements, the problems, its players and their policies (Khalid, Mushtaq, & Navee, 2016). In this sense, the problem is the identified subject which needs to be addressed while the players are individuals who need to deal with the issue which has been identified (Khalid et al, 2016). The practice of public policy making in Pakistan further suggested that the country was never able to espouse an appropriate system for making its public policy as it did not involve the public. Policies were introduced without public consent and essential information on the ground (Khalid et al., 2016).

In Africa, Bolaji, Gray, and Campbell-Evan (2015) found policy implementation problems in Nigeria to be related to an absence of continuity, corruption,, and insufficient material and human resouces, all of which frequently result to a gap in implementation that creates a wide distance amid the policy aims and achievement of the scheduled aims concluding that though

policies are often built in developing countries, most times the policies did not reach the desired results for these same reasons (Bolaji et al., 2015).

Further South, Landsberg's review of South Africa's "Africa Agenda" argued that several Non Governmental Organizations have hailed the New Partnership for Africa's Development (NEPAD) bottom-down arrangement by governments and leaders which exlcuded civil society actors from NEPAD processes (Landsberg, 2014). Ggoobi (2016) in Ajulor (2018) attributed policy implementation failure to the marginalization of rural areas and complete policy planning and design deprived of appropriate management and stakeholder involvement and considerations on whether it met the needs of the people or not.

In Kenya, Ndua (2013) found that actors in any sector operated solely within their respective legal and institutional framework. Each institution or agency operated independently of each other although their tasks and responsibilities were generally similar. The study established that the sector acts and policies overlapped and duplicated each other and therefore drew efforts in various directions (Ndua, 2013). The study also established that other challenges included a limited awareness of acts and policies within the sector, inadequate sector funding and inadequate human resource to manage the sector among others (Ndua, 2013).

1.2 Background to the study

1.2.1 The Reproductive Health Care Sector in Kenya

The 2030 Agenda for United Nations Sustainable Development Goals consists of seventeen (17)SDGs and one hundred and sixty-nine (169) associated targets. Sustainable Development Goal three (SDG 3) addresses all significant health priorities and calls for enhancing maternal, child, and reproductive health. In 2015, the WHO developed strategies aimed at Ending Preventable Maternal Mortality (EPMM) that outlined global strategies and targets for lessening maternal mortality under the SDGs. The goal is that by 2030, all nations ought to show a reduction by two-thirds of Maternal Mortality Ratio (MMR) of their 2010 baseline level. The regular worldwide target is an MMR of less than 70/100, 000 live births, with the state target being an MMR less than 140/100, 000 live births by 2030 (WHO, 2015).

The data from 2003 to 2014 KDHS indicates that among of mothers that reported ANC from a health professional grew between 2003 to 2014 from 88 % to 96 %. Skilled assistance during delivery increased from 42% in 2003 to 62% in 2014.Facility-based deliveries increased from 40% in 2003 to 61% in 2014. The percentage of mothers receiving post natal care increased from 10 percent in 2003 to 50 percent in 2014. The MDG target for ANC by skilled provider is 100%. Kenya is close to reaching this goal. The MDG target for skilled assistance during delivery is 90% (Mungai, 2015).

In line with these aspirations, the government and its partners initiated programmes aimed at reducing Maternal Mortality. For example, in 2013 the Government did away with the fees charged for delivery in all state owned health facilities with the objective of enhancing health facility delivery service use and lessen mortality related to pregnancies (Gitobu, Gichangi, & Mwanda, 2018). However, Gitobu et al. found that despite abolishment of the fees, there was still a need to all together address other determinants that influence pregnancy-related deaths. More recently, the 'Beyond Zero' campaign was launched by the Kenyan First lady in 2014 to partner with the Government of Kenya to lessen child and maternal mortality.

The campaign focused on five key areas: on child and maternal health services while providing recognition, accountability, and accelrating the achievement of HIV, child, and maternal health targets; engaging communities to deal with barriers to accessing HIV treatment; prompting investment in high effect actions to promote child and maternal health and HIV control; mobilizing men as agents of change, partners, clients, and engaging communities to deal with constraints to HIV, maternal, and child services (Mwangi & Mberia, 2018). Nonetheless, despite these policy initiatives and programs, maternal and neonatal mortality rates have not reduced (Wasuna, 2015).

1.2.2 National Reproductive Health Policy, 2007

The NRHP aims to standardize, plan, implement, evaluate, and monitoring of Reproductive Health (RH) services given by the Faith Based Organisations (FBOs), private-for-profit sectors, Non-Governmental Organisations (NGOs), state, Community Based Organizations (CBOs), and Kenyan communities. The policy's four components of RH are family planning,

gender issues, reproductive and sexual rights, adolescent/youth sexual and reproductive health, neonatal and maternal health, and safe motherhood (Ministry of Health, 2007).

The policy's aim is to improve the reproductive health situation by quality improvement, enhancing responsiveness to client needs, effectiveness and efficiency of service delivery at all stages, enhancing equitable access to reproductive health services (RHS). This policy gives priority to four mechanisms of RH founded on significance and degree of the problem: neonatal and maternal health, safe motherhood, family planning, youth/adolescent reproductive and sexual health, and gender issues. Additional significant mechanisms of RH spoken in the policy are cancers of reproductive organs reproductive tract infections, and RH for the elderly, HIV/AIDS, and infertility, (Ministry of Health, 2007).

Additionally, the policy identified major challenges to neonatal, maternal, safe motherhood health in terms of health system weaknesses from care quality, utlisation and demand for RH services, redefining roles of Community-Owned Resource Persons (CORPs) such as Traditional Birth Attendants (TBAs) in terms of registration of births and postnatal care, complication referrals, poor access to better care for newborns, comprising facilities for thermal regulationm promotion of exlusive and early breastfeeding, infection prevention, and resuscitation facilities. Other challenges include poor access to RH data, skilled care during the pregnancy period, post-partum, and postnatal periods (Ministry of Health, 2007).

1.2.3 Public Policy Implementation Frameworks

There is no grand theory for policy implementation; however, Public Policy literature shows that there are three major approaches for examining policy implementation from a synthesis approach, bottom-up method, and hierarchical approach (Khan & Khandaker, 2016). This study aims to use the hierarchical method to examine the factors influencing the implementation of the NRHP (2007). Russell (2015) argued that a hierarchical method was more valuable when objectives and goals are clearer and guidelines are aimed in a complete way. Accordingly, we intend to use the Mazmanian and Sabatier (1983) framework, which is firmly situated within the top-down approach school, to systematically analyze the policy implementation process, and identify variables which contribute to achieving the aims or outcomes of the policy at hand.

In detail, Mazmanian and Sabatier (1983) note that the important function of analyzing policy execution is to find the variables that influence reaching the policy objectives during the public policy process. The variables can be grouped into three categories that consist of the problems being addressed, a diversity of contextual variables that uphold the policy, and the structural dimensions that contribute to the process of implementation. These variables are experienced in the five phases of policy execution as shown in Figure 1.1.

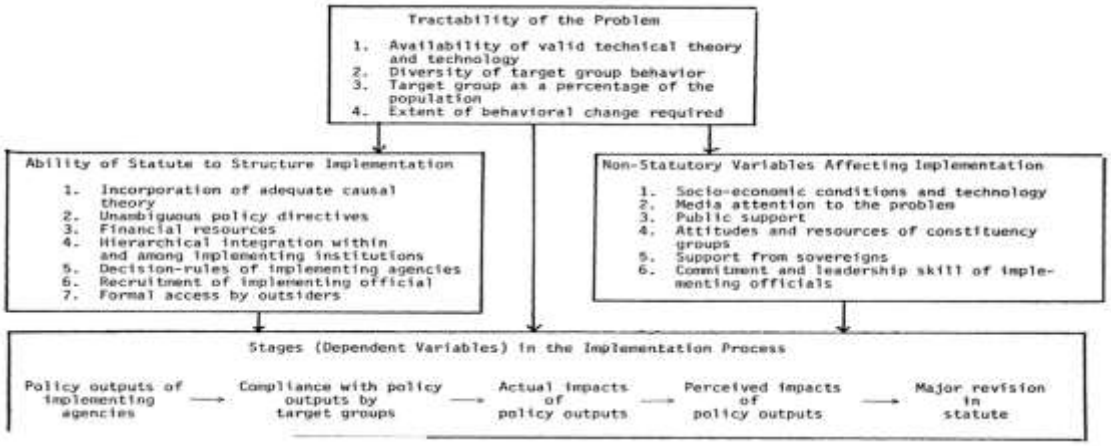

Figure 1.1: Mazmanian and Sabatier (1983) Policy Implementation Framework

There are several motivations for adopting the Mazmanian and Sabatier (1983) Policy Implementation Framework. First, there is need for more effort in empirical and conceptual exploration of the relationship between personal behavior, legal, economic, and political context. Second, the current frameworks overlook the capacity of a decree to assemble the process of implementation. Although most variables discuss the significance of consistent and clear policy goals, needed financial resources, and to a less degree, the motivation given for compliance, but neglect the ability of a decree to establish the number of clearance/veto points, the formal access of different actors to the process of implementation and to some degree the likely policy dispositions of implementing officials (Xua & Gao, 2017). Mazmanian and Sabatier's framework addresses these concerns. Third, none of the available frameworks (save for Mazmanian and Sabatier's framework) openly speak on the "tractability" or solvability of the problem(s) addressed by a public policy (Xua & Gao, 2017).

Consequently, the framework championed by Mazmanian and Sabatier (1983) provides us with a robust platform for conducting the study. This dissertation concentrates on influence of structural variables on implementation of the maternal and neonatal health component of the NRHP (2007) in Nairobi County. Specifically, the study selected four (4) from the seven (7) structural variables identified in the Mazmanian and Sabatier (1983) Policy Implementation Framework: human resources, financial resources, hierarchical integration, and stakeholder involvement. These variables were selected as they are pertinent to Kenya's health sector which has often suffered from human resource, financial resources, hierarchical integration, and stakeholder participation challenges over the years (Kimathi, 2017).

1.3 Problem Definition

The First Medium Term Plan 2008-2012 of the Vision 2030 target of reducing the MMR from 410 to 147 per 100,000 live births did not materialize. In its place, the MMR increased to 488 in 2012. This target was subsequently adjusted to 300 per 100,000 live births by 2015 (the Republic of Kenya, 2014). However, the 2014 DHS reported that the MMR stood at 362 per 100,000 live births whilst the neonatal mortality rate (NMR) stood at 22 per 1,000 live births (KNBS, 2014) despite having the policy in place. In brief, the desired outcomes have not materialized.

The NRHP 2007 was explicit in what actions were needed to enhance service delivery in maternal services and a reduction of maternal and neonatal deaths. The effective implementation of policies results in positive outcomes. For instance, Kibui et al. (2015) established that the Kenya Health Policy Framework (KHPF) 1994-2010 policy execution led to a large investment in public health programmes and poor investments in medical services which resulted to increased indicators of health in relation to infectious diseases and child health.On the other hand, there is evidence to indicate that Kenya has a history of poor implementation of policies. For example, Maina and Ongut's (2014) study on the effective implementation of the new health financing policies found that there was ineffective implementation with lack of resources and noncompliance, as factors that contributed to this situation.

Ndua's (2013) study on policy implementation constraints in Kenya's cultural industry found that limited awareness of Acts and policies, duplication and overlap of roles, inadequate sector funding, similar tasks and responsibilities, and inadequate human resource were some of the challenges. Wangila (2017) measured the barriers to policy execution of the Early Childhood Development and Education Policy established that financial resources, poor learning and teaching resources, and lack of state good will were some of the challenges facing its implementation. Mohamed, Juma, Asiki, and Kyobutungi's (2018) qualitative study found that allocation of resources was a facilitator and also a barrier of implementing tobacco control policies and also found that poor human resources was a barrier to policy implementation.

This dissertation evaluates execution of the NRHP of 2007. There is minimal evidence of research that has focused on implementation of this policy. Moreover, none of the studies mentioned and none of those in our literature review have made use of Sabatier's robust framework to structure their analysis of the problems of policy execution. As a result, the entirety of factors, and in particular structural factors, and their influence on policy implementation in Kenya remains unknown. Consequently, the study aims to conduct empirical research using this established public policy implementation framework and adopting specific variables as relevant to the health sector.

1.4 Research Objectives

1.4.1 General Objective

The main objective of the study was to systematically assess influence of specific structural factors on implementation of the safe motherhood, maternal, and neonatal health component of the NRHP (2007) in Nairobi County.

1.4.2 Specific Objectives

The specific objectives of the study were:

i. To determine the influence of human resources on implementation of the NRHP 2007
ii. To determine the effect of financial resources on implementation of the NRHP 2007

iii. To determine the influence of hierarchical integration within and among implementing agencies on implementation of the NRHP 2007

iv. To determine the influence of formal access by outsiders on implementation of the NRHP 2007

1.5 Research Questions

The study aimed to answer the following questions:

i. To what extent did human resources influence the implementation of the NRHP 2007?

ii. To what extent did financial resources influence the implementation of the NRHP 2007?

iii. To what extent did hierarchical integration influence the implementation of the NRHP 2007?

iv. To what extent does formal access by outsiders influence the implementation of the NRHP 2007?

1.6 Scope and limitations of the study

This study aimed to assess implementation of the NRHP, 2007 in maternal and neonatal health care in Kenya. The study used the Mazmanian and Sabatier (1983) model to examine the implementation of the policy. The model describes three categories of variables that influence the implementation process. However, this study uses one category, the structural variables, to understand the implementation of the policy. The study adopted four of the seven structural variables: financial resources, human resources, hierarchical integration, and stakeholder involvement.

The non-statutory variables (technology, socio-economic conditions support from the soverign, media attention to the problem, and public support) are not investigated in this study as these are external factors while the study was interested in internal factors, that is, factors that could be said to be within the policy-making institution's sphere of control. The study collected data from government officials and hospital officials.

1.7 Significance of the study

The study is of significance to policy and decision makers in the Reproductive Health sector as the study assesses the achievements that have been made to improve maternal and neonatal health under the NRHP, 2007. The results will show whether and how the identified structural factors influenced maternal and neonatal health. This will allow inferences to be made that can inform recommendations which if implemented, will contribute to improved maternal and neonatal health and achievement of the SDG 3 to reduce maternal mortality to less than 140/100, 000 live births. The study will also be significant to health service providers as it will establish the problem areas that need more effort to enhance maternal and neonatal health in their facilities. The study will also be beneficial to the public as it will provide an opportunity to give feedback on Reproductive Health Services (RHS) offered from public health facilities. The study is also of importance as contributed to knowledge and suggested areas of further study on policy making and implentation for maternal and neonatal care in Kenya.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter presented the literature review for the study. The sub-sections in the chapter are the theoretical foundation, the literature selected variables, a review summary, and research gaps, conceptual framework, and definition of study variables.

2.2 Theoretical Foundations

The policy implementation process can be understood in three major approaches that have been proposed by scholars. These are the hybrid (synthesis) approach, bottom-up approach, and top-down approach. In the hierarchical approach, the "higher-ups" are at the peak of making legislation and the views of the citizenry are not sought in this decision-making process. This view supports the notion that policies are based on the wants of hierarchy levels and superiors along with the top leadership of an organization of government who are the actors in making decisions (deLeon, & deLeon, 2002).

In the hybrid approach, elements of the bottom-up and to-down approaches are used together in an effort to strengthen each of the approaches whilst lessening the inherent weaknesses in either of these approaches. The policy actors are more engaged in the policy implementation process within the bottom-up approach. Here, there exist implicit and explicit negotiations between the two parties and thus policies created through this approach possess the wishes and hopes of the public and lower officials (Paudel, 2009).

This study assumed the hierarchical model of public policy execution. One of the most popular top-down theories of public policy execution is the Sabatier and Mazmanian (1983) model which identified several variables in the public policy process. These variables are grouped into three (3) main groups: material variables (A1-A4), background/contextual variables (C1-C5) and structural variables (B1-B7) as seen in Figure 2.1.

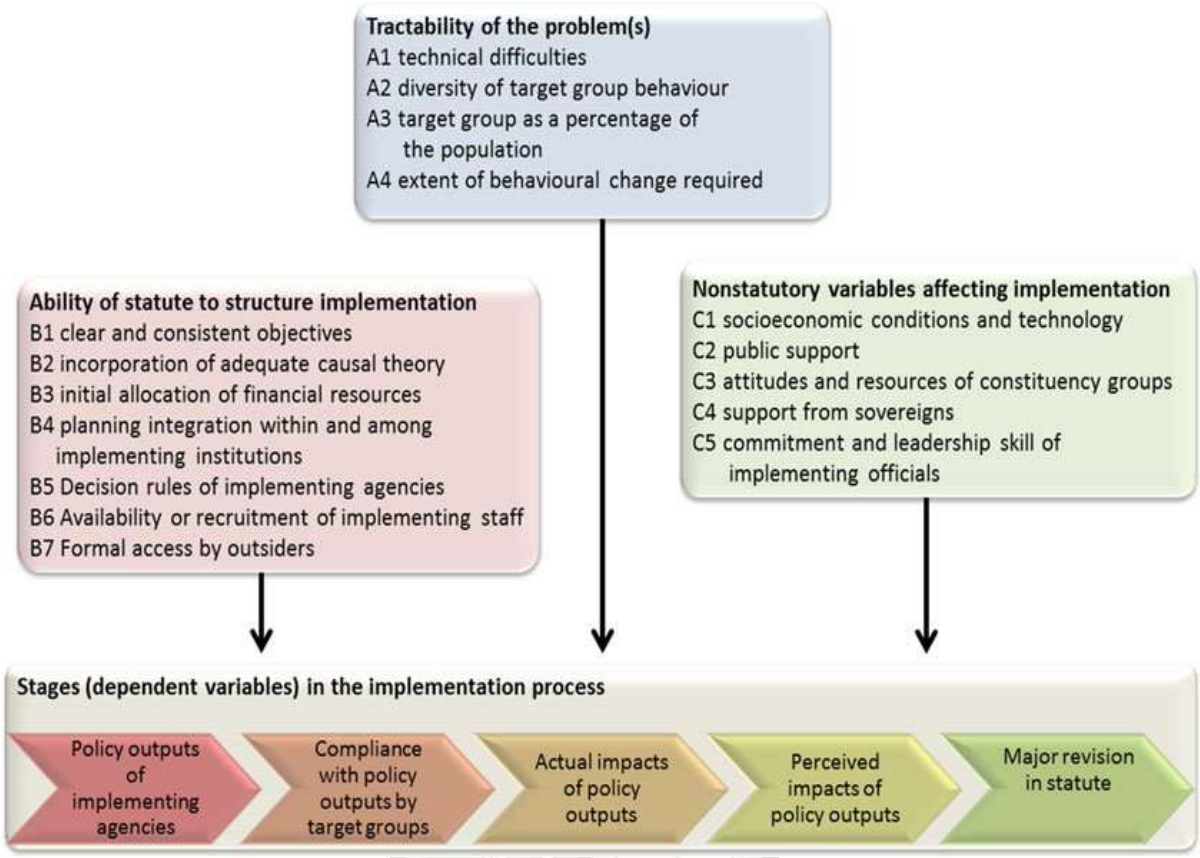

Figure 2.1: Sabatier and Mazmanian (1983) Model of Public Policy Implementation

The well-defined and small changes are easy to politically support and have a larger opportunity of attaining triumph. Additional complex and significant variations required less-focused rules and let officials implementing the policy have much more discretion (Mazmanian & Sabatier, 1983). Socioeconomic technology and conditions, resources and attitudes of constituency groups, public support, and leadership and commitment skills of officials executing the policy are the contextual variables of the model (Elson, 2006). Hierarchical integration, allocation of financial resources, decision rules of agencies implementing the policy, consistent and clear objectives, outsider access, and inclusion of adequate causal theory are the structural variables of the model (Mazmanian & Sabatier, 1983).

Paudel (2009) acknowledges that the hierarchical tactic to policy implementation suffers from some criticisms. One of the assumptions by the top-down approach is that it is a simple action to evaluate progress in achieving goals. Furthermore, the top-down model uses a statutory language as the beginning point of policy making. The hierarchical approach suffers from absence of deliberation of the tasks that are performed early in the policy-making process. The proponents of top-down have been challenged that they view execution as an exclusive organizational process and they ignore the political factors of attempting to eliminate them. Lastly, top-down proponents have emphasized on decrees as major actors.

Despite these criticisms, the top-down approach and the Sabatier and Mazmanian (1980) model remains the most used public policy framework in the literature. Meier and McFarlane (1996) evaluated the Mazmanian and Sabatier model by using a number of resourceful parameters and established that most of the assumed associations were statistically significant. The Mazmanian and Sabatier model fit this study's research goal, which was to establish the implementation of the NRHP (2007) from problem identification to the actual steps taken to deal with the issues at hand. The model is also useful in the identification of the significance of internal variables on the execution of policy. To this end, the study focused on the following variables: recruitment, finances, hierarchical integration, and formal access by outsiders. We provide further detail in the sub-sections below.

2.3 Empirical Literature

2.3.1 Human Resource and Policy Implementation

The process of policy implementation relies on staffing levels for oversight. As a result, the effect of policy execution will be influenced by the quality of the executive. Highly professional executives will actively implement policies and will be working to ensure those policies are implemented effectively, however, less qualified and irresponsible executives can be perfunctory towards activities required of them under a particular policy, resulting to a failure in policy execution. Thus the qualifications of executives are one major factor of policy execution, such as professional knowledge, basic skill, high responsibility and reliability (Xu & Goa, 2017).

Mthethwa (2012) argues that after strategies are determined, the organizations implemented require mobilizing and estimating the material, human, financial resources needed to implement policies effectively. New policies consist of new strategies and firms may need to abandon or modify old actions and perform new tasks. In most cases, this means that actors in policy implementation can be engaged in training on policy content and needed skills. For instance, a policy that aims to expand the group of healthcare workers to provide family planning services and use of intra-uterine devices would need personnel and other nurses in reproductive health to undergo some form of training to attain the aims of the policy.

Makinde's (2005) research on policy implementation in Nigeria by different governments since independence found that there were several implementation problems from inadequate material and human resources, absence of permanency in government policies, and corruption resulted to gaps in execution. This means that there is a wider gap between policy goals and the achievement of planned goals. It was the study's conclusion that policies created often in low income nations, in most cases, rarely achieve the desired results partly because of this human resource factor.

Tummers, Vermeeren, Steijn, and Bekkers (2012) reported that most public professionals are in most cases not willing to implement public policies that are proposed by the state. The authors gave an example of insurance doctors in the Netherlands faced significant moral and professional concerns when they were required to implement new policies aimed at re-looking at the welfare of clients. These concerns resulted to a strike by 240 doctors against the new policy while others quit their jobs. Unwilling public sector professionals in implementation of public policies results to major consequences. One, the interaction quality between citizens and professionals can be affected and also influence the output legitimacy of state but it can also decrease significantly the policy implementation effectiveness.

In Nigeria, Ugwuanyi and Chukwuemeka, (2013) examined the problems of policy execution effectiveness and public bureaucracy in low income countries. The study showed the problem of inadequacy in human resources where public bureaucracy in Nigeria and did not have the numbers of staff required over the total numbers and more significantly in relation to precise

areas of professional managerial or technical expertise and competence. The author argues that this was biased as the capacities of bureaucracy in governments in terms of skill and expertise determined to a larger degree policy execution failure or success.

Ndua (2013) examined the constraints that policy implementation faces in the cultural industry in Kenya. One of the challenges identified was the inadequate human resources needed to implement policy. Officers interviewed indicated that their workload far surpasses their human resource capacity. They described their situations as 'hectic, tedious, overwhelming and one of chronic understaffing. Senior staff indicated having less the number of staff required to implement policy and existing staff were overworked and overstretched.

Mohamed et al. (2018) research on tobacco control policies in Kenya adopting a case study approach which combined interviews and document reviews as data collection methods. The respondents for the study were stakeholders from civil society, government, private sector, and academia. The allocation of resources was found to be a facilitator and also as a barrier. An absence of staff assets was listed as a major issue in policy execution as the Ministry of health did not have a sufficient number of staff in their control units and high staff reassignment or turnover further affected policy implementation.

2.3.2 Financial Resources and Policy Implementation

According to Sabatier and Mazmanian (1980) implementing agencies must have financial and organizational resources available to ensure successful implementation of their policies. Gerston (2010) clarified that sufficient financial resources contribute to the sustainability of planning, policy operationalization, finishing objectives, and making staff arrangements. Timely disbursement of adequate assets and a well-organized management is significant to the achievement of policy objectives and goals. Xu and Goa (2017) opined that no matter how specific the policy is, if the organization and personnel who are responsible for policy implementation have inadequate financial resources, policy implementation cannot achieve the stated goals of the policy. All policy execution requires an appropriate amount of human, material and financial resources.

Imurana, Haruna, and Annin-Bonsu (2014) evaluated public policy implementation in Africa and the major conclusion was that corruption and bribery is a persistent problem in Africa. The policy making process accounted for most of the challenges experienced to the policy implementation phase. The actors in policy at the top hierarchy and in the field often drain off financial resources for personal benefits. Institutions and agents have been put in place to make sure that officials are accountable may be exposed to bribery to make false reports and manipulate their findings. Conclusively, this results to a weakened system and the policies formulated are not able to reach their goals and objectives.

O'Toole (2004) found that several issues interfered with implementation of policy from management of financial resources. The lack of resources limits policy implementation effectiveness and hindered policy-making. Without resources, the implementation of policy which is the effective phase may never happen. Furthermore, policies may not be declared as effective neither can they be executed in their simple statement, this means, that policies are not self-implementing with a skeleton staff, authority, and access to information (Marume, Mutongi, & Madziyire, 2016).

Kolawole, Williams, and Wasiu (2018) noted that within the internal environment of policy implementation, economic factors consist of the financial resources, nature of the economy, per capita income, and type of economic system. Financial resources are essential to effectively implement public policies and therefore its availability is vital when formulating public policies. When financial resources are unavailable, public policies will not be implementable, no matter how brilliantly formulated they are.

Ugwuanyi and Chukwuemeka (2013) examined the problems to policy implementation effectiveness by the public bureaucracy in low income nations. The findings indicated that a significant determinant of policy implementation effectiveness of policies was institutions and agencies were mandated to implement policies was the inadequate financial and staff resources to be able to effectively implement policy. In other times, the state does not provide an adequate budget to allow for the process of policy bureaucracy to correctly implement formulated policies.

In a study that investigated the barriers and facilitators of the tobacco policy in Kenya, Mohamed et al. (2018) indicated that inadequate funding was a main issue that contributed to a longer process of placing the policy and sluggish process in policy execution. A World Health Organization Framework Convention on Tobacco Control (WHO – FCTC) study showed that there was a poor allocation of financial resources as the fund set up to control tobacco did not receive any budgetary allocations form the ministry of finance to implement the policy.

2.3.3 Hierarchical Integration within and among implementing agencies and Policy Implementation

The process of public policy implementation always involves more than one department or agency (Xu & Goa, 2017). The fruitful execution of policy is more likely to be achieved if the agencies engaged in implementing are integrated in one hierarchical structure. The extent of hierarchical integration amid agencies implementing policies depends on the amount of actors who had the chance to prevent policy objectives being reached and on the ability of sanctions and inducements to make sure that actors act in agreement with objectives of a policy (Reslow, 2015). The hierarchical integration within and amongst implementing institutions should be based on a sound mechanism for coordinating the actions of implementing agencies and actors. In this vein the extent of integration if loose will result in substantial difference in the extent of behavioral agreement amongst implementing officials and other actors (Bempah & Kanmiki, 2017).

Sabatier and Mazmanian (1995) define hierarchical integration as the extent to which the actors leading a public policy implementation use an adequate system of sanctions and incentives and the other activities and actors engaged in the implementation of the policy. Sørensen (2006) stated that mechanisms of hierarchical integration may not apply to settings in which the importance is based on the capacity of self-determining actors. In its place, state authorities are recommended to rely more on elusive forms of governance which allow public officials to lessen their grip on policy implementation without losing control.

In China, Xu and Goa (2017) noted that the major problems arise in this area as follows: the central government and local governments lack coordination; departments within the same level of government lack coordination. Additionally, the functions of all implementing subjects are unclear, intersect, overlap and dislocation leading to messy situations where some implementing subjects pass the buck, blame each other. Moreover, there exist multiple executions which can result to policy implementation interruption.

Carter, Weible, Siddiki, Brett, and Chonaiew (2015) described hierarchical integration as the degree that government agencies control the decisions producing outputs. This consists of recognizing sanction points where those subjected to regulation can hinder achievement of policy and distinguish the motivations that influence compliance. These veto points are circumstances in the casual perspective that agencies implementing may not have full control as when policy actors delay or fail to meet compliance with actions needed to produce policy outcomes. Sanctions and inducements are the motivation that an agency may adopt to coerce or encourage obedience with policy and astound sanction points and enhance enforcement and monitoring effectiveness.

According to Elson (2006), the hierarchical integration of implanting agencies is influenced by the degree to which the support policy aims have sanctions and incentive to promote compliance. The second is the number of clearance and veto points engaged in execution of policy aims. The clearance and veto points are described as situations when an in-between have capabilities to hinder progress (Mazmanian & Sabatier, 1981, 1983). This is an important variable which focuses on the leadership commitment and institutional support of officials implementing policy (Elson, 2006).

2.3.4 Formal access by outsiders and Policy Implementation

A successful policy implementation needs democratic involvement where the public and policy makers are engaged in exchange of information which examined the costs for basic values and share the benefits and burdens. Various stakeholders should be engaged to lessen political burdens on the state. Policy stakeholders consist of individuals or groups are liable for implementation. People negatively or positively had an effect by the lack of implementation

(or implementation), professionals, officials who are answerable for reaching policy objectives (Mthethwa, 2012).

The fruitful participation of diverse collections within civil society, private society, and private industry is significant to implementation since every sector makes a contribution of special perspectives resources and skills. Private sector engagement can create an impetus for improving the efficient logistic systems and quality of care and complementing public sector services. Civil society actors can also participate in advocating specific strategies and monitoring implementation by acting as watchdogs to make sure that adequate findings are allotted and suitable actions are undertaken (Bhuyan Jorgensen, & Sharma, 2010).

According to Schalk (2015), there are two dominant theoretical approaches that can have positive stakeholder engagement to performance of policy in terms of access to resources and information and creating policy support. First, access to information and assets is a significant motivation for states to involve stakeholders in the policy-making procedure. Second, creation of policy support is a motivation for nations to involve stakeholders in formulation of policy process. States depend on the contribution and cooperativeness of stakeholder to implementation and policy design. Despite the significance of stakeholder participation in policy making, the evidence shows that the brief, one-off consultation of target populations often used in policy-making does not guarantee more effective policy implementation. It is suggested that exchanges with beneficiaries and other key stakeholders should go through each phase of public policy process, from the time a policy problem is recognized to policy implementation (Kelly, Garvey, & Palcic, 2016).

Matthews, Pulver, and Ring's (2008) research on health policy for indigenous population in research showed the importance of including the target population in all the policy formulation phases and state levels. Matthews et al. advocated for increased participation of health organizations controlled by Indigenous communities in the policymaking process. In the United States, Hanks (2006) evaluated a huge federal nutrition programme which underscored the significance of public health policymakers and practitioners participating with the target population so as to learn from each other during the policy process.

In the Netherlands, Bijlsma, Bots, Wolters, and Hoekstra (2011) examined the effect of stakeholder engagement on developing substance in policy formulation, more so the framing of the policy issue, policy design and analysis, and the making and knowledge use. The research established the view that stakeholder participation in advancement of policy resulted to an increase in the quality of the knowledge base. Secondly, stakeholder engagement contributed to a wider frame includes significant stakeholder criterion and other additional options.

In Indonesia, Hutahaean (2016) conducted research on the prominence of stakeholder's method in public policy building in the environment sector. The study found that the problem was the approach used in formulation of regional rules. Most local rules are discussed and compiled with the elite engaged in policy making such as the legislature members and state officials. The stakeholder communities who are the target population of a policy are less often engaged in coming up with local rules.

Ndua's (2013) research on policy implementation in the cultural sector in Kenya found that links between policy implementation agents and stakeholders in implementation of policy was missing. The study established that even though the department used committees at the level of community to disseminate and coordinate the goals of the department to implement policy. The findings further indicated that financial and human resources to make sure that there are adequate links and coordination of activities and programs at this level.

Mohamed et al. (2018) did a qualitative investigation on the barriers and facilitators in the implementation of formulation of tobacco control policies in Kenya and found that stakeholder passion and commitment was a facilitator for policy implementation. The study participants also revealed that shared goals and comprehension, vision and interests were significant determinants, and once the stakeholders identified their characters, it was much easier for the stakeholders to take actions towards a shared objective.

2.4 Literature Review Summary and Research Gaps

The cited literature indicates that there is indeed a plethora of research focusing on factors influencing policy execution. The literature was conducted along the study independent

variables (financial resources, human resources, hierarchical integration, and stakeholder involvement) on policy execution. The research agrees that these factors are indeed important for policy implementation and the degree to which these factors are careful in policy process would lead to better results of policy execution.

Majority of the studies, however, have investigated the problem by focusing on the obstacles and challenges of policy execution. Most of the studies examined in the literature review did not use any of the public policy implementation models (such as Sabatier's Framework/Model) that are available. This is one research gap that the study intends to fill by using selected variables from an established theoretical model – Mazmanian and Sabatier – to determine how these mix of variables influences public policy implementation. This study goes further by using objectivity to select four variables from the Mazmanian and Sabatier (1980) as variables which have been found to be important in Kenya's health sector. Furthermore, the study is limited to structural (statutory) variables whilst other studies adopting the framework have used contextual (non-statutory) and statutory variables.

There is evidence of studies that have been conducted on policy implementation in different sectors in Kenya. These are: Ndua (2013) research in the cultural sector, Mohammed et al. (2018) study in the tobacco sector, Wangila (2017) research in the education sector. However, there is less research that has examined the health sector; and none that has focused on Safe Motherhood, Maternal, and Neonatal Health which are a core focus of the SDGs, a research gap needed to be filled by the dissertation.

2.5 Conceptual Framework

Conceptual frameworks are a graphical depiction that explains the main indicators to be researched in a study and the important factors, variables, or concepts and the assumed relationships between (Miles & Huberman, 1994). Figure 2.2 shows independent variables are human resources, financial resources, hierarchical integration, and stakeholder participation. Implementation of the 2007 NRHP policy is the dependent variable.

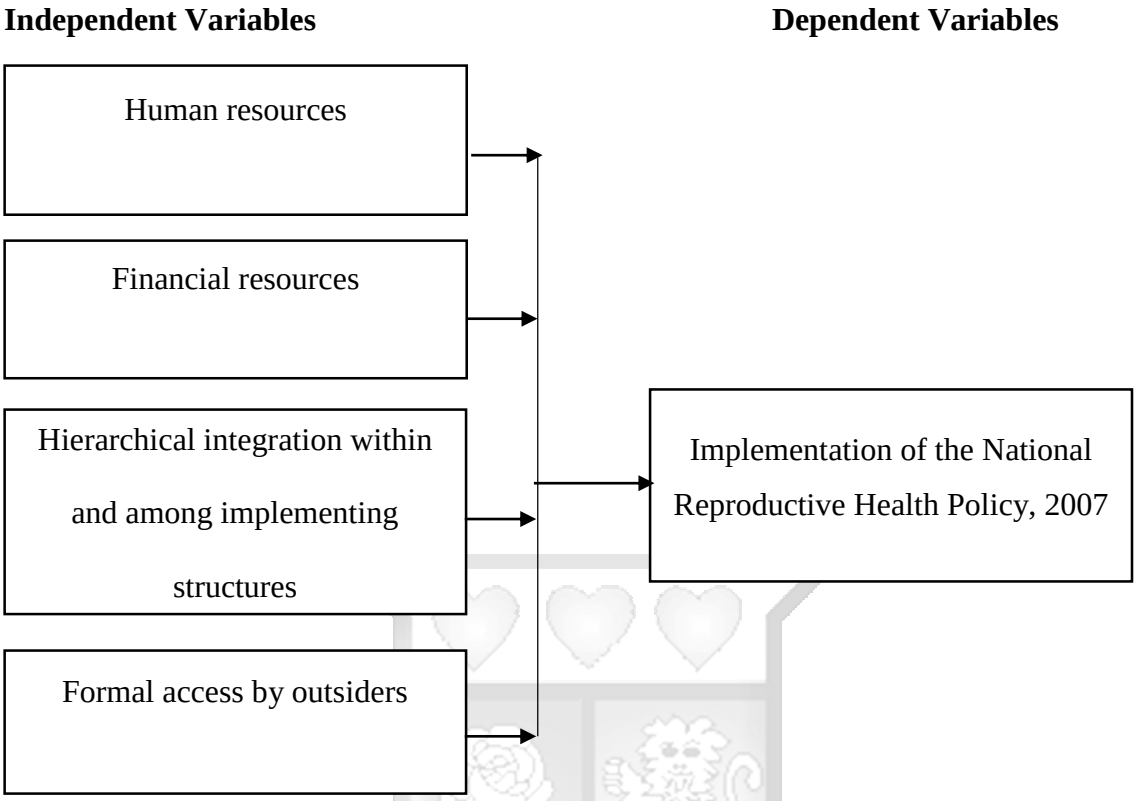

Figure 2.2: Conceptual framework

Source: Researcher (2020)

2.6 Definition of Variables

Table 3.1: Operationalization of variables

	Variable	Indicators
Independent variables	Human resources	• Recruitment • Skills • Training • Number of staff • Staff deployment
	Financial resources	• Budget allocation • Fund disbursements • Financial management • Donor support • Financial utilization
	Hierarchical integration within and among implementing structures	• Institutional support • Commitment and leadership of officials • Coordination between agencies • Inducements and sanctions • Compliance/noncompliance
	Stakeholder Involvement	• Stakeholder analysis • Stakeholder mapping • Stakeholder identification • Stakeholder participation regulations • Stakeholder participation activities
Dependent variable	Policy implementation	• Policy outputs, decisions, or choices of departments • Compliance of internal/external beneficiaries of decisions • Genuine influences of decisions • Apparent influences of decisions • Political system's amendment of novel policy

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents the research methods that the study intends to utilize to undertake this study. The chapter is a presentation, discussion, and rationalization of the research techniques chosen by the study.

3.2 Research Design

A research design is a description of a link between empirical information to a dissertation's research objectives in a systematic manner and to the eventual inferences of a dissertation (Yin, 2003). A research design is a framework that gives a blueprint of the study. The research design precisely addressed by different scientific approaches, scientific paradigms, research methods, research approaches, research strategy, and data gathering methods and the strategy of analysis (Lopez-Fernandez & Molina-Azorin, 2014).

A mixed method research was adopted. Fetters and Molina-Azorin (2017) define mixed methods research as the different mix of techniques that involve using more than one approach in data collection. The mixed method approach involves integrating the quantitative and qualitative research methods in research (Leech & Onwuegbuzie, 2009). According to Tashakkori and Teddlie (2010), results achieved from these integrated method improves and enriches understanding the problem under research and create new ideas about the problem so as to provide solutions to questions that are had to answer by utilizing a single approach.

The mixed method approach provided an opportunity for research to use diverse data collection techniques to enrich the quality of data and make meaningful analysis, discussions, recommendations, and conclusions that can inform the practice of public policy execution. The study used several data sources ranging from questionnaires, key informant interviews, secondary data and this makes mixed methods an adequate approach.

3.3 Population and sampling

Krieger (2012) defined population as collective of the units or people from where a sample is chosen and to which the findings of an analysis are applied. A hundred and one Nairobi County public health facilities were the units of analysis and the observation and public health officials

from these facilities were units of analysis. In addition to this population, the study also includes officers from non-governmental organizations (NGO), community based organizations (CBO), development partner organisations, and the Ministry of Finance. These officers are key informants of the study and information they provide was used to support the quantitative (survey) data.

Sampling is the choosing of units, persons, and/or settings to be studied (Patton, 2001). Sampling can be distinguished as either probability or non-probability sampling techniques. Delice (2010) defined probability sampling as the procedures of selecting elements that are selected randomly and every unit has a non-zero and recognized opportunity to be chosen. On the other hand, non-probability is widely applied in studies that researchers apply their judgements to choose a sample (Teddlie & Yu, 2007).

Non-probability sampling was adopted which is an approach that is based in the researcher's discretion in selecting a sample. Specifically, the research applied a quota sampling technique which is a form of non-probability sampling approach. According to Teddlie and Yu (2007), the stratified elements of the sampling technique features probability sampling but the relatively smaller number of cases which are selected using the technique is a feature of purposive sampling. Comparable to stratified sampling, quota sampling required the investigator to select the subgroups and amount of members of the population which is followed by a selection of respondents influenced by her/his judgement and convenience to fill each strata/quota.

This approach is appropriate as the population of interest fits into different categories that are responsible for implementation of the 2007 NRHP. The researcher identified the different agencies involved in executing the policy and select participants from these groups to make up the sample of the study. Yamane's (1967) sample size formula was utilized to determine the sample size of 80 respondents.

$$n = \frac{N}{1+N\,(e^2)}$$

Where;

n = sample size

N = study population (101 facilities)

e = tolerance at the preferred level of confidence (0.05 at 95% confidence)

Consequently,

$n = 101/ (1 + 101 (0.05)^2$

$= 101 / 1.25$

$= 80$

3.4 Data Collection Methods

A mixed method approach consisted both qualitative and quantitative methods of data collection. Quantitative data is that which can be interpreted to numbers which can be analyzed and displayed mathematically and is considered as "hard". Qualitative data is often considered "soft" suggesting that it may not always be possible to reduce it to something certain (Osang et al., 2013). The study adopted primary and secondary sources of data where the former are directly collected by a study, secondary data refers to existing and has been collected for an entirely different purpose but is relevant to the current study (Lowry, 2015). A structured questionnaire was implemented to gather primary data whilst secondary data was sourced from the reviewed literature.

3.4.1 Questionnaire

A sequence of questions an investigator presents to subjects thereby asking for their responses is referred to a questionnaire (Osang et al., 2013). The study used a structured questionnaire to collect data from a portion of the respondents. The questionnaire comprised of close-ended and open-ended questions and was interview administered. A 5 point Likert scale was designed and used multiple items to measure the study variables. A Likert scale is a score scheme intended to evaluate people's attitudes, opinions, or perceptions (Joshi, Kale, Chandel, & Pal, 2015). The questionnaires were administered to health officials/professionals in the sampled health facilities by the research assistants.

3.4.2 Key Informant Interviews

Key informants are participants giving detailed opinions and information on a specific subject based on their knowledge of an issue. Key informant interviews are one-on-one interviews conducted with key informants (Kun, Kassim, Howze, & MacDonald, 2013). This approach was included as a data collection technique to provide an in-depth and wide-ranging source of information with a selected few participants who have expert knowledge and experience with the subject under study. However, the Covid-19 outbreak affected the collection of this qualitative information due to the curfew and lockdowns imposed by the government which restricted personal interaction between members of the public. These guidelines hindered the conduct of personal interviews which were to be done through face to face interactions.

3.5 Data analysis

The procedure of cleaning, inspecting, transforming, modeling, and retrieval of significant data which aids to support in making decisions and to make conclusions is referred to as data analysis. Data analysis can either qualitative or quantitative. Qualitative data analysis is an exploration for over-all statements on associations between groups of data (Marshall & Rossman, 1990). Quantitative data analysis involves summarizing a vast amount of data to provide richer data and interpretations (Onwuegbuzie & Combs, 2011).

The quantitative data was coded first and entered into a statistical package for analysis. Descriptive statistical analysis was conducted to observe trends in the data using frequency distributions. Pearson correlation and linear regression analysis were used to analyze the data. In presenting the quantitative data, charts and tables were used. The data was presented along study's research objectives and was done to complement each other. The proposed linear regression model was;

$$Y_1 = \alpha + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \beta_4 X_4 + \varepsilon_i$$

Where:

Y_1 = Policy implementation

α = Constant

$\beta_1, \beta_2, \beta_3, \beta_4$, = Coefficients

X_1 = Human resources

X_2 = Financial resources

X_3 = Hierarchical integration

X_4 = Formal access by outsiders

ε_i = error term

3.6 Research Quality - Validity, Reliability and Objectivity of the Research

Validity is the extent to which an assessment fulfills the functions for which it is being used (John, 2015). In an attempt to establish the validity of the study instruments, a detailed literature review was done to identify indicators and formulate questions to be used in collecting data. There is no statistical test to establish the validity of an instrument; this content validity is dependent on expert judgments in the field (Mohajan, 2017). The investigator engaged peers, experts, university supervisors, and professionals in health public policy to review the data collection instrument before the data collection process.

The extent to which an instrument continuously measures whatever it measures is defined to as reliability (John, 2015). Twelve respondents from Kiambu County were recruited into the pilot study whereby the internal consistency of the survey was determined by using Cronbach Alpha as Likert scale items were used to measure variables. The respondents were selected from Kiambu County so as to avoid contamination of respondents. George and Mallery (2003) suggest that if alpha values are >0.9 = Excellent, >0.8 =Good, >0.7 = Acceptable, >0.6 = Questionable, >0.5 =Poor, and <0.5 = Unacceptable. Table 3.1 indicates overall reliability for the instrument was 0.8 which is adequate while human resources variable reliability was poor but passed the unacceptable threshold.

Table 3.1: Reliability Statistics

Items	Cronbach's Alpha	N of Items
Human Resources	0.553	5
Financial resources	0.759	5
Hierarchical Integration	0.928	5
Formal access by outsiders	0.862	5
Policy Implementation	0.898	5
Overall Reliability	**0.800**	**25**

3.7 Ethical Issues in Research

Research ethics is a strand of applied ethics of well-defined guidelines and rules that describe their conduct (Akaranga & Makau, 2016). Voluntary and informed consent of subjects to partake in the dissertation was adhered to by clarifying to study participants on the purpose of the study and guaranteeing the privacy of study participants by observing anonymity. The researcher affirmed to respondent on the willingness or voluntary consent to partake in the dissertation with no consequences. Anonymity of participants was assured by not asking for any personal identification information. Documentation necessary to certify the ethical threshold of the study included an ethical review from Strathmore University Institutional Ethics Review Committee (SU-IERC), approval for the study from NACOSTI and an approval from the Nairobi City County.

CHAPTER 4: PRESENTATION AND ANALYSIS

4.1 Introduction

This chapter is a presentation of the analyzed data. The data is presented in figures and tabular formats in sections that consist of respondent and facility information, descriptive statistics results for each of the study variables, a section on correlation analysis and regression analysis.

4.2 Respondents Information

This section provides a summary of the respondents' and facility information from the participants' work experience, professional background, level of education, and level of health facilities reached in the sample.

4.2.1 Position in Health Facility

The results summarized in Table 4.1 show that nurses were most of the participants in this investigation accounting for 52.5 % of the sample followed by clinical officers standing at 16.3 % of the sample, and pharmacists represented by 7.5 % of the sample. Other positions of interviewed respondents were nutritionist, antenatal and neonatal nurses, nurse officer I and III, a Pharmaceutical Technologist, Laboratorist, and head of department.

Table 4.1: Respondents' Position at Health Facility

Position at health facility	Frequency	Percent
Antenatal Nurse	2	2.5
Clinical Officer	13	16.3
Head of Department	1	1.3
Laboratorist	1	1.3
Medical Officer	3	3.8
Nutritionist	3	3.8
Pharmacist	6	7.5
Pharmaceutical Technologist	1	1.3
Nurse	42	52.5
Nurse Officer I	1	1.3
Nurse Officer III	2	2.5
Nurse in-Charge	2	2.5
Officer In-Charge	2	2.5
Neo-Natal Nurse	1	1.3
Total	**80**	**100**

4.2.2 Respondents' Work Experience

Figure 4.2 shows the distribution of study participants' work experience in the number of years worked where 47.50 % had worked in the health sector for 4-7 years, 38.75 % had worked in the sector for less than 3 years, 7.50 % had worked between 8-11 years, with those working for more than 12 years accounting for 6.25 % of the sample.

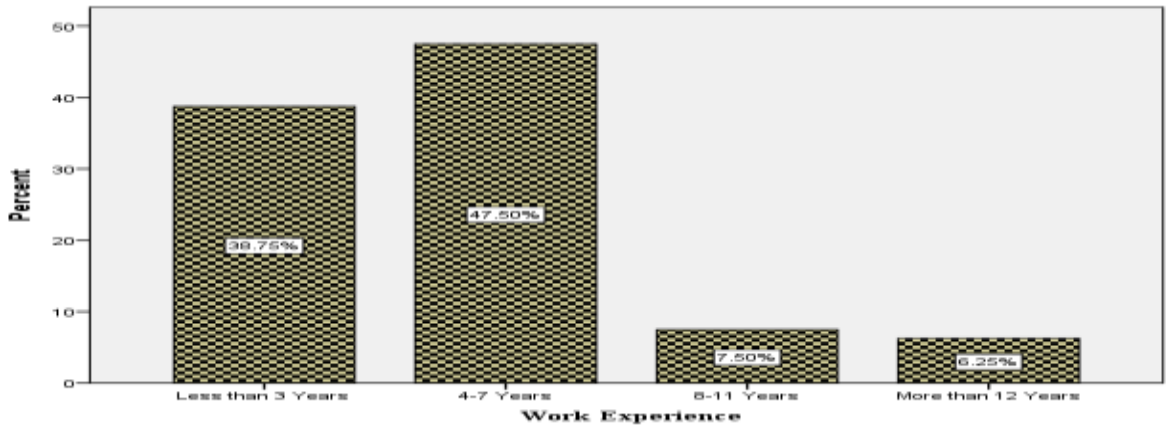

Figure 4.2: Respondents' Work Experience

4.2.3 Professional Background

In terms of their professional background, 50.00 % of the sample was nurses, 31.25 % were clinicians, and 6.25 % were medical officers, 5.00 % were reproductive health officers, 2.50 % were specialists and pharmacists, with social workers and pharmaceutical technologists accounting for 1.25 % of the sample as summarized in Figure 4.3.

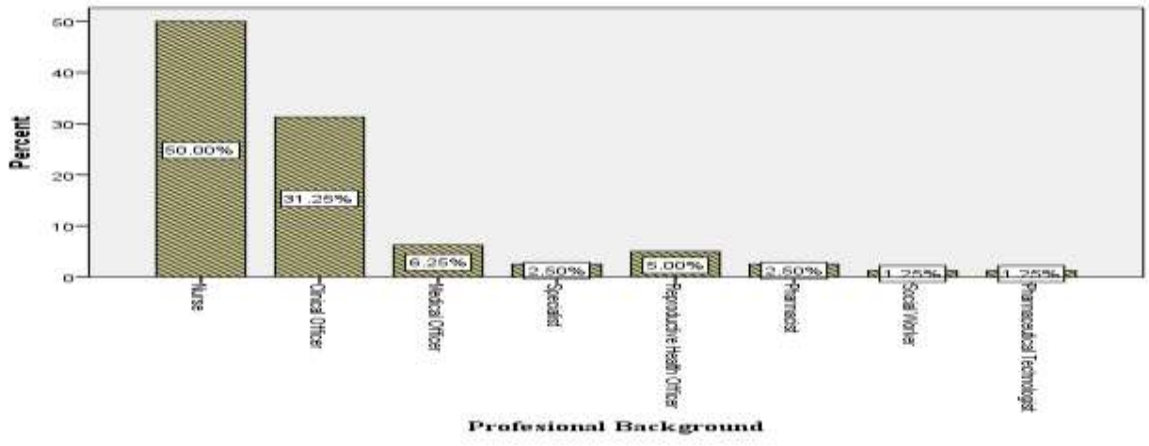

Figure 4.3: Respondents' Professional Background

4.2.4 Level of Education

Figure 4.4 presents the distribution of study participants' level of education where 51.25 % had a Diploma level of education, 46.25 % had a Bachelor's degree, and 2.50 % having a Higher Diploma.

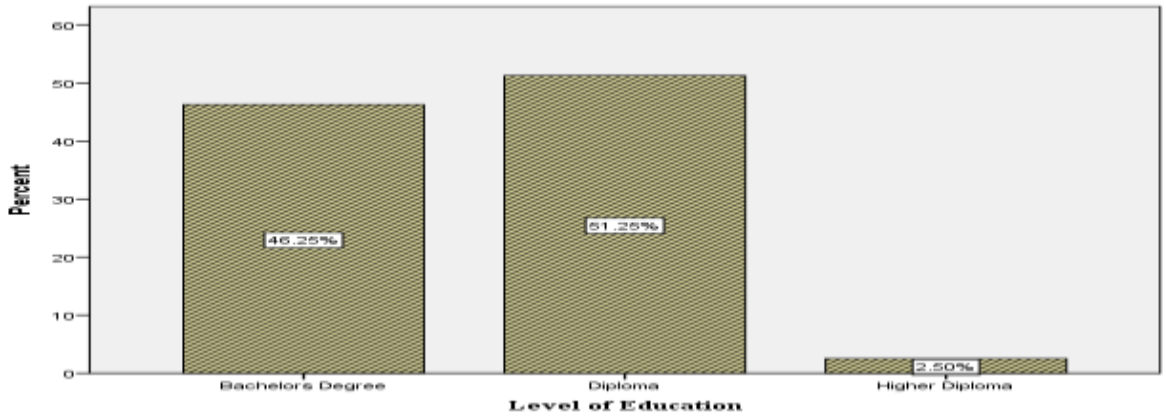

Figure 4.4: Respondents' Level of Education

4.2.5 Health Facility Level

The results indicate that majority of the study participants were from health centers, maternity homes, and nursing homes and accounted for 70.00 % of the sample, this was followed by dispensaries at 27.50 % of the sample, and community level health facilities accounting for 2.50 % as seen in Figure 4.5.

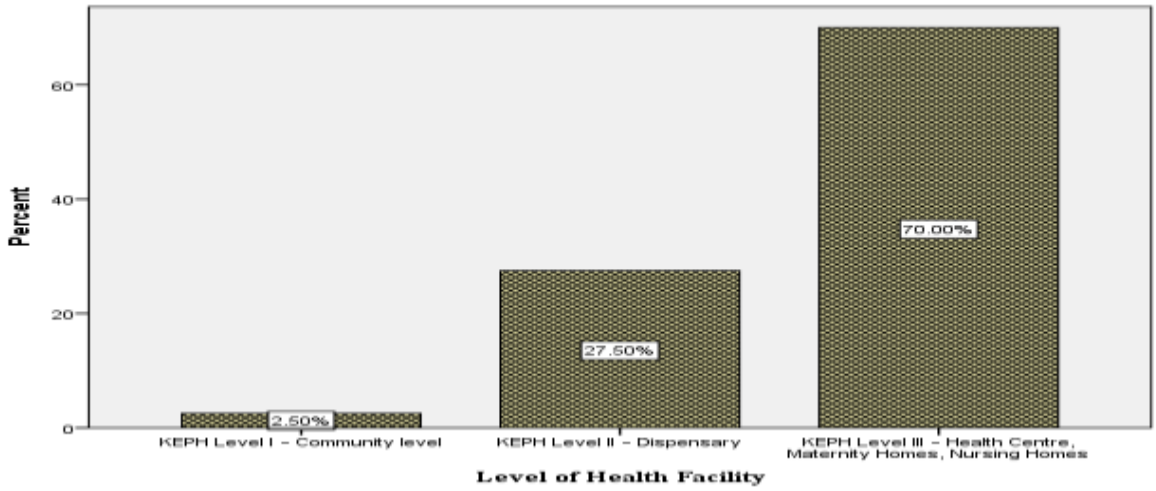

Figure 4.5: Level of Sampled Health Facility

4.3 Implementation of Safe Motherhood, Maternal, and Neonatal Health Component

The dependent variable for the investigation was implementation of NRHP 2007 which was indicated by five statements to which the respondent indicated their level of agreement

Table 4.2: NRHP Policy Implementation Descriptive Statistics

NRHP Policy implementation	N	Mean	Mode	Std. Deviation
Women, including adolescents/youth have access to reproductive health information, counselling and services	80	4.15	4	.858
There is increased access to comprehensive and basic emergency obstetric care to meet minimum international standards	80	3.88	4	.905
Women have access to skilled care throughout pregnancy, delivery, postpartum, postnatal periods and care of the newborn	80	4.00	4	.900
Communities are involved in measures to promote 'women-and baby-friendly' maternity services and assisting with transport.	80	3.74	4	.951
Referral networks across public and non-public facilities have been promoted & strengthened	80	3.56	4	.926

1 indicated strong disagreement, 2 indicted disagreement, 3 indicated Neutrality, 4 indicated Agreement, and 5 indicated Strong agreement. The results shows respondents agreed that women had access to reproductive health information, services, and counselling (M=4.15, SD=0.858) and this was also observed in regard to Women having access to skilled care throughout pregnancy, postpartum, delivery (M=4.00, SD=0.900) as seen in Table 4.2.

4.4 Human Resources

The respondents were asked to indicate their level of agreement with the human resource statements where 1 indicated strong disagreement, 2 indicted disagreement, 3 indicated Neutrality, 4 indicated Agreement, and 5 indicated Strong agreement. The descriptive statistics for the statements on human resources variable are shown in Table 4.3 where most of the mean scores for the statements are below the midpoint thus indicating disagreement of respondents with these statements. The results show respondents disagreement that the health sector is consistently recruiting staff for maternal and neonatal care (M=2.23, SD=1.079), that government Ministries, Departments and Agencies (MDAs) allocate adequate number of maternal and neonatal care staff (M=2.40, SD=0.963), and that there exists deployment of service providers skilled in sexual and reproductive health care at all levels in line with the Health Sector Strategic Plan (M=2.91, SD=0.917).

Table 4.3: Human Resources Descriptive Statistics

Human resources	N	Mean	Mode	Std. Deviation
The health sector is consistently recruiting staff for maternal and neonatal care	80	2.23	2	1.079
The government MDAs allocate adequate number of maternal and neonatal care staff	80	2.40	2	.963
There exists deployment of service providers skilled in sexual and reproductive health care at all levels in line with the Health Sector Strategic Plan	80	2.91	3	.917
There is consistent training and supervising service providers at all levels using standardized procedures	80	3.21	3	.852
There are actual transferring clinical skills through on-job-training and certification processes	80	3.40	4	.821

4.5 Financial Resources

The respondents were asked to indicate their level of agreement with financial resource statements where 1 indicated strong disagreement, 2 indicted disagreement, 3 indicated Neutrality, 4 indicated Agreement, and 5 indicated Strong agreement. The financial resources variable descriptives are summarized in Table 4.4 where the results show that most responses were below the midpoint suggesting poor ranking of the financial resources factors. The results indicate that there was no timely fund disbursements to maternal and neonatal care as allocated in the health budgets as respondents disagreed with this statement (M=2.45, SD=0.856). The participants further disagreed that the government continuously increased budgetary allocations for maternal and neonatal care (M=2.55, SD=0.967).

Table 4.4: Financial Resources Descriptive Statistics

Financial Resources	N	Mean	Mode	Std. Deviation
The government has continuously increased budgetary allocation for maternal and neonatal care	80	2.55	2	.967
There are timely fund disbursements to maternal and neonatal care as allocated in the health budgets	80	2.45	2	.856
There are coordination and harmonization of financial resources to plan and predict for maternal and neonatal care	80	2.94	3	.891
There are established mechanisms for tapping financial resources from non-public sectors and donors	80	3.28	4	.900
There is an improvement in efficiency in resource utilization for maternal and neonatal care	80	2.94	3	1.035

4.6 Hierarchical Integration

The respondents were asked to indicate their level of agreement with hierarchical integration statements where 1 indicated strong disagreement, 2 indicted disagreement, 3 indicated Neutrality, 4 indicated Agreement, and 5 indicated Strong agreement. Table 4.5 presents the descriptives for the variable of hierarchical integration where most responses were in the midpoint of the scale. The findings show that respondents were neutral on government MDAs use of inducements and sanctions in implementing the NRHP (M=3.21, SD=0.867). There are

sufficient commitment and leadership of senior public officials in implementing NRHP (M=3.36, SD=0.767), There is smooth coordination between public health agencies in implementing NRHP (M=3.38, SD=0.877), that government MDAs were responsive towards compliance and non-compliance of the NRHP 2007 in regard to maternal and neonatal care (M=3.50, SD=0.857), and that there was a continued institutional support from government MDAs to implement the NRHP (M=3.50, SD=0.779).

Table 4.5: Hierarchical Integration Descriptive Statistics

Hierarchical integration	N	Mean	Mode	Std. Deviation
There is a continued institutional support from government to implement the NRHP	80	3.50	4	.779
There are sufficient commitment and leadership of senior public officials in implementing NRHP	80	3.36	4	.767
There is smooth coordination between public health agencies in implementing NRHP	80	3.38	3	.877
The government MDAs use inducements and sanctions in implementing the NRHP	80	3.21	4	.867
The government MDAs are responsive towards compliance and non-compliance of the NRHP 2007 in regard to maternal and neonatal care	80	3.50	4	.857

4.7 Formal Access by Outsiders

The participants were asked to indicate their level of agreement with hierarchical integration statements where 1 indicated strong disagreement, 2 indicted disagreement, 3 indicated Neutrality, 4 indicated Agreement, and 5 indicated Strong agreement. Table 4.6 shows the descriptives which suggest that respondents had a neutral attitude towards the statements. The respondents were neutral on government MDAs encouragement of stakeholders to promote

research and exchange of information between researchers and the end-users of research results (M=3.63, SD=0.802) and that government MDAs had provided protocols and procedures for stakeholder participation in reproductive health (M=3.65, SD=0.797).

Table 4.6: Formal Access by Outsiders Descriptive Statistics

Formal access by outsiders	N	Mean	Mode	Std. Deviation
The government MDAs conducted a reproductive stakeholder analysis and mapping for maternal and neonatal care	80	3.55	3	.745
The government MDAs encourage stakeholders to promote research and exchange of information between researchers and the end-users of research results	80	3.63	4	.802
The government MDAs have provided protocols and procedures for stakeholder participation in reproductive health	80	3.65	4	.797
Reproductive health stakeholder facilitates greater public participation and involvement in the planning and implementation of reproductive health programmes.	80	3.55	4	.899
The government MDAs have provided for stakeholder participation activities in maternal and neonatal care	80	3.59	4	.807

4.8 Correlation Analysis

Table 4.7 shows correlation coefficients between the independent variables and the dependent variable where positive correlation coefficients were observed between all the variables indicating positive associations between the variables. The findings show that human resources (r = 0.127, p = 0.261) had a positive but insignificant association with policy implementation of the NRHP (2007). The results further revealed that financial resources (r = 0.370, p = 0.001), Hierarchical integration (r = 0.421, p = 0.000), and Formal access by outsiders (r = 0.616, p = 0.000) had positive and significant association with implementation of the NRHP (2007). The findings suggest that involvement of stakeholders, followed by hierarchical integration, and financial resources were linked with the successful implementation of the NRHP policy.

Table 4.7: Correlation Coefficients

	Human resources	Financial resources	Hierarchical integration	Formal access by outsiders
Human resources	1			
Financial Resources	.339**	1		
	.002			
Hierarchical Integration	.165	.576**	1	
	.144	.000		
Formal access by Outsiders	.039	.367**	.532**	1
	.729	.001	.000	
Policy Implementation	.127	.370**	.421**	.616**
	.261	.001	.000	.000

**. Correlation is significant at the 0.01 level (2-tailed).

4.9 Regression Analysis

Table 4.8 shows the coefficient of determination ($R^2 = 0.408$) value which indicates variables in the model had a 40.8 % variation on implementation of the NRHP (2007).

Table 4.8: Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.639[a]	.408	.376	.52997

b. Predictors: (Constant), Formal access by outsiders, Human resource, Financial Resources, Hierarchical Integration

The results in Table 4.9 show F statistic and significance columns which are important in predicting the fitness of the model. A positive F statistic (F=12.921, DF = 4.75) and significance < 0.05 (p = 0.000) means that the model was a good fit of the data.

Table 4.9: ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	14.517	4	3.629	12.921	.000[b]
	Residual	21.065	75	.281		
	Total	35.582	79			

a. Dependent Variable: Policy Implementation

b. Predictors: (Constant), Formal access by outsiders, Human resource, Financial Resources, Hierarchical Integration

The results from the regression coefficients summarized in Table 4.10 show that human resources (β = 0.057, p = 0.560), financial resources (β = 0.122, p = 0.291), and hierarchical integration (β = 0.061, p = 0.655) had a positive but insignificant effect on implementation of the NRHP (2007) as they all had significance levels greater than 0.05. Formal access by outsiders (β = 0.587, p = 0.000) was the only variable that had a positive and significant effect on implementation of the NRHP (2007). This means that formal access by outsiders had the greatest effect on execution of the policy and this was significant. The proposed model thus becomes;

Policy implementation = 1.044 + Human resource 0.057 + Financial Resources 0.122 + Hierarchical Integration 0.061 + Formal access by outsiders 0.587

Table 4.10: Coefficients[a]

Model	Unstandardized Coefficients		Standardized Coefficients	T	Sig.
	B	Std. Error	Beta		
(Constant)	1.044	.452		2.309	.024
Human resource	.057	.097	.056	.585	.560
Financial Resources	.122	.115	.122	1.062	.291
Hierarchical Integration	.061	.135	.054	.448	.655
Formal access by outsiders	.587	.115	.541	5.116	.000

a. Dependent Variable: Policy Implementation

CHAPTER 5: SUMMARY, DISCUSSION, CONCLUSION, AND RECOMMENDATIONS

5.1 Introduction

This chapter gives the summary, discussion, conclusion, and recommendations of the study. The summary gives a synopsis of the study, discussion shows the comparing and contrasting the findings of this study against past studies, conclusions of the study and recommendations for action and areas of further studies are given.

5.2 Summary

The dissertation investigated factors influencing implementation of the safe motherhood, maternal, and neonatal health component of the NRHP (2007) in Nairobi County using Mazmanian and Sabatier's policy implementation framework. The overall objective of the study was to determine whether and how structural variables of human resource, financial resources, hierarchical integration, stakeholder involvement influenced implementation of maternal and neonatal health components of the NRHP. The investigation sought to answer to what extent do human resources, financial resources, hierarchical integration, and stakeholder involvement influenced implementation of maternal and neonatal health components of the NRHP.

A mixed method approach was applied which consisted of using both qualitiative and quantitative methods. The 101 public health facilities in Nairobi County were the units of analysis and the unit of observation was senior health officials in the facility. The sample size was established as 80 respondents who were administered the questionnaire. Supplementary qualitative information was sought from Ministry of Health officials, maternal and neonatal officers, and officers from an NGO, CBO, development partner, and Ministry of Finance to enrich quantitative data. A structured questionnaire, key informant interviews, and document analysis were used to collect data. The qualitative and quantitative data was analyzed using content and thematic analysis and statistical methods respectively. The findings were presented in figures and tables for quantitative data and in prose and verbatim for qualitative data.

The findings showed positive associations between human resource, financial resources, hierarchical integration, and formal access by outsiders, and implementation of NRHP (2007). This correlation was positive for financial resources, hierarchical integration, and formal access by outsiders' variables but non-significant for human resources. The model (human resource, financial resources, hierarchical integration, and formal access by outsiders) had a 40.8 % effect on implementation of this component of the NRHP and the model was a good fit for the data given the positive F statistic ($F = 12.291$) and the significance level ($p < 0.05$) in the ANOVA results. However, the linear regression analysis showed that formal access by outsiders (stakeholder participation) had the largest and only statistically significant effect on implementation of NRHP (2007).

5.3 Discussion

5.3.1 Influence of human resources on implementation of the NRHP 2007

Determining influence of human resources on implementation of NRHP (2007) was the first goal of this dissertation. The respondents disagreed with human resources statements indicating that there was a lack of consistent recruitment of staff for maternal and neonatal care, lack of adequate number of staff in maternal and neonatal care, and poor deployment of skilled sexual and reproductive health care personnel. The correlation findings indicate a positive but non-significant association between human resources and implementation of the policy. The linear regression analysis indicated positive and insignificant effect of human resources on policy implementation of this component of the NRHP.

This finding agrees with that of Ndua (2013) research which found that increased workloads due to lower number of staff to implement policy was one of the barriers to policy implementation in Kenya. The situation was also similar in Nigeria where Ugwuanyi and Chukwuemeka, (2013) found that the bureaucracy of government capabilities in relation to skills and expertise that influence in a large way the execution of policy failure or success. The findings also indicated that there was lack of consistent training which is important for successful implementation of policy.

Mthethwa (2012) asserted that in a situation that a policy calls for an expansion of healthcare workers who have the ability to undertake family planning services from inserting an intra-uterine device, personnel or nurses require adequate training if the policy is to attain the goal. The findings from the inferential analysis go against previous studies that have found that human resources affected execution of policy. These include Mohamed et al. (2018) qualitative research on the barriers and facilitators in execution and formulation of policies in Kenya which established that human resources was a hindering factor in implementation of policy.

5.3.2 Effect of financial resources on implementation of the NRHP 2007

Determining the effect of financial resources on implementation of NRHP (2007) was the second objective of the study. An examination of the findings from the statements indicates respondents' disagreement with timely fund disbursements to maternal and neonatal care as allocated in the health budgets and government's continued increase in budgetary allocation for maternal and neonatal care. The results from the correlation analysis show that financial resources and policy implementation had a positive and statistically significant association but the effect of financial resources on policy implementation although positive, was non-significant.

The findings from the statements support past studies which have found similar results. The study participants indicated that there was no increase in the budgetary allocations for the implementation of the NRHP. This finding is agreeable to that of Mohamed et al. (2018) which found that tobacco control policies did not receive monetary resources from the government and this contributed to poor execution of the policy. This scenario was also observed in Nigeria where Kolawole, Williams, and Wasiu (2018) reported that some agencies and institutions saddled with the responsibility of formulating and implementing given policies do not possess the requisite manpower and financial resources to effectively implement them.

5.3.3 Influence of hierarchical integration within and among implementing agencies on implementation of the NRHP 2007

The third objective of the study was to establish the influence of hierarchical integration on implementation of the safe motherhood, maternal and neonatal health component of NRHP

(2007). The descriptives from the variable statements show that respondents were neutral towards all the statements representing this variable. The study participants were neutral on the continued institutional support from government to implement the NRHP, government MDAs were responsive towards compliance and non-compliance to the NRHP, and existence of smooth coordination between public health agencies in implementing NRHP. There was a positive and statistically significant association between hierarchical integration and implementation of the NRHP but the effects of hierarchical integration were positive but insignificant.

The importance of hierarchical integration variable is the collaboration and coordination between the central and county governments in implementing health policies which has become a contentious issue in Kenya. According to Kibui et al. (2015), the county government is also required to recognize the right of its county communities to manage their health affairs, protect, and promote the health interests of the special groups. In addition, county governments should ensure easy access to health services and equitable sharing of the national and local health resources and service delivery to all people in the country. This also entails improving the capacity of the national and county governments to efficiently deliver required health services according to their particular authorizations.

The findings do not support earlier studies which found positive effects of hierarchical integration on implementation of policy. In China, for example Xu (2017) research on the cause analysis of public policy implementation deviation found that deviation from policy implementation in the republic could be alleviated with more coordination of hierarchical integration within and among implementing institutions. In a similar vein, Mendes and Aguiar (2017) study on implementation of public health policy and its challenges in the digital age in brazil concluded that in order to achieve effective results, policy implementation required working with a proper hierarchical integration

5.3.4 Influence of formal access by outsiders on implementation of the NRHP 2007

This research aimed to determine the influence of formal access by outsiders on implementation of the safe motherhood, maternal and neonatal health component of NRHP

(2007). The descriptive results show that respondents' had a moderate attitude towards formal access by outsiders' statements. The findings show respondents felt neutral attitudes towards the government's stakeholder analysis and mapping in the reproductive sector, provided a space and environment for stakeholder participation in neonatal and maternal care, and encouraging stakeholders to promote research and exchange of information within the reproductive health sector. A positive and significant association was established between policy implementation and formal access by outsiders who were also positive and statistically significant on the effects of formal access by outsiders on policy implementation.

The results indicated that there was formal access to outsiders on NRHP policy implementation although this was indicated moderately when the statements were examined. The inferential statistics also indicated that this variable of involving stakeholders in the policy implementation process had the largest and statistically significant effect. The findings agree with past studies that found effects of stakeholder participation on policy implementation. For instance, Ntombura (2019) research on effects of public participation on policy implementation in case of Elgeyo Marakwet County which found positive and statistically significant effects of representation, exchange, and stakeholder on implementation of policy.

5.4 Conclusion

5.4.1 Influence of human resources on implementation of the NRHP 2007

The findings revealed that human resources did not have a statistically significant effect on implementing the Safe Motherhood, Maternal, and Neonatal Health Component of the NRHP.

5.4.2 Effect of financial resources on implementation of the NRHP 2007

The results found that there was no relationship between financial resources and implementation of the safe motherhood, maternal and neonatal health component of the NRHP in Nairobi County.

5.4.3 Influence of hierarchical integration within and among implementing agencies on implementation of the NRHP 2007

The findings indicated that there was no statistically significant relationship between hierarchical integration and implementation of the Safe Motherhood, Maternal, and Neonatal Health Component of the NRHP in Nairobi County.

5.4.4 Influence of formal access by outsiders on implementation of the NRHP 2007

The findings of the study revealed that formal access by outsiders (stakeholder participation) had a positive and significant effect on implementing the Safe Motherhood, Maternal, and Neonatal Health Component of the NRHP in Nairobi County.

5.5 Recommendations

5.5.1 Recommendations for Action

The findings indicated that stakeholder involvement had a positive and statistically significant effect on implementation of the safe motherhood, maternal and neonatal health component of the NRHP (2007). The study recommends for more concerted efforts for stakeholders to participate in implementing the NRHP (2007). This calls for strategic stakeholder analysis and mapping for increased consultations between international health organizations such as WHO and UNICEF.

5.5.2 Areas of Further Research

This study was an investigation on the factors influencing implementation of the safe motherhood, maternal and neonatal health component of the NRHP (2007) in Nairobi County. The study recommends that future studies should distinguish research between maternal and neonatal health components in different studies. The study was limited to Nairobi County and thus the findings may not be generalizable to other counties and thus there is need to conduct similar studies in different counties.

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APPENDICES

APPENDIX 1: LETTER OF INTRODUCTION

Jessica Karimi Mbae

P. O. Box 174-00202

Nairobi

0711175135

Dear Respondent,

REF: Participation in Data Collection for Postgraduate Studies

I am a postgraduate student at the Strathmore Business School. In partial fulfillment of the requirements for Degree of Master of Public Policy and Management at Strathmore University, I am undertaking a research project ***"Factors Influencing Implementation of the Safe Motherhood, Maternal, and Neonatal Health Component of the National Reproductive Health Policy (2007) in Nairobi County."***

You have been selected to form part of the study. I therefore kindly request you to assist me in filling out the attached questionnaire. The information provided will be used exclusively for the purpose of this research and will be treated in strict confidence. A copy of the final report will be availed to you on request.

Your co-operation will be highly appreciated. Please contact the researcher in case of any query.

Yours sincerely

Jessica Mbae

Email: jessicambae@gmail.com

APPENDIX 2: INFORMED CONSENT FORM

PARTICIPANT INFORMATION AND CONSENT FORM

Research title: Factors Influencing Implementation of the Safe Motherhood, Maternal, and Neonatal Health Component of the National Reproductive Health Policy (2007) in Nairobi County

SECTION 1: INFORMATION SHEET

Investigator: Jessica Mbae

Institutional affiliation: Strathmore Business School (SBS)

SECTION 2: INFORMATION SHEET–THE STUDY

2.1: Why is this study being carried out?

This study is being undertaken to evaluate the implementation of the National Reproductive Health Policy (2007). Specifically, this study aims to determine the extent to which the Safe Motherhood, Maternal, and Neonatal Health Component of the policy has been achieved in public health facilities in Nairobi County.

2.2: voluntary participation

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 Safe implementation of the **Safe Motherhood, Maternal, and Neonatal Health.** If you are not able to answer all the questions successfully the first time, you may be asked to sit through another informational session after which you may be asked 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?

- Public health officers in listed public health facilities sampled in this study

- Employees and officers of organisations that are involved in implementation of the Safe Motherhood, Maternal, and Neonatal Health Component of the National Reproductive Health Policy (2007).

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

You will be approached and 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 complete.

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 from this study will be used to improve implementation of the **Safe Motherhood, Maternal, and Neonatal Health component of the National Reproductive Health Policy (2007).**

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

All research records and information will be securely stored by the researcher under lock and key and also in password protected files. Only the researcher, research assistants, and university supervisor will have access to your information. All your information will be kept confidential.

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

You can contact me, **Jessica Karimi Mbae** at SBS, or by e-mail (**jessicambae@gmail.com**), or by phone (**0711175135**). You can also contact my supervisor, **Dr. Ben Ngoye,** at the Strathmore Business School, Nairobi, or by e-mail (BNgoye@sstrathmore.edu) or by phone (0715395882)

If you want to ask someone independent anything about this research please contact:

The Secretary–Strathmore University Institutional Ethics Review Board

P. O. BOX 59857, 00200,

Nairobi, email ethicsreview@strathmore.edu Tel number: +254 703 034 375

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 NDON'T AGREE to take part in this research ☐

Investigator's Signature: Date: _____/_____/_____

_____

DD / MM / YEAR

Investigator's Name: Time: _____ /_____

_____

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

APPENDIX 3: QUESTIONNAIRE

Section 1: Demographic Information

1. What is your position in health facility?

   ……

2. How long have you held this position?

   Less than 3 years ( )

   4-7 years ( )

   8-11 years ( )

   More than 12 years ( )

3. What is your professional background?

   Nurse ( )

   Nursing officer ( )

   Medical officer ( )

   Specialist ( )

   Other (Specify) …….

4. Please indicate the level of your hospital?

   KEPH Level I – Community level ( )

   KEPH Level II – Dispensary ( )

   KEPH Level III – Health Centre, Maternity Homes, Nursing Homes ( )

   KEPH Level IV – Primary Hospital ( )

   KEPH Level V – Secondary Hospital ( )

   KEPH Level VI – Tertiary Hospital ( )

Section 2: Human Resources

The following table consists of human resources statements in regard to implementing the NRHP component of maternal and neonatal care. Please indicate your level of agreement with these statements.

Statements		**Strongly disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly agree**
1	The health sector is consinstentllly recruiting staff for maternal and neonatal care					
2	The government Ministries, Departments and Agencies (MDAs) allocate adequate number of maternal and neonatal care staff					
3	There exists deployment of service providers skilled in sexual and reproductive health care at all levels in line with the Health Sector Strategic Plan					
4	There is consistent training and supervising service providers at all levels using standardized procedures					
5	There are actual transferring clinical skills through on-job-training and certification processes					

Section 3: Financial resources

The following table consists of financial resources statements in regard to implementing the NRHP component of maternal and neonatal care. Please indicate your level of agreement with these statements.

Statements		**Strongly disagree**	**Disagree**	**Neurtral**	**Agree**	**Strongly agree**
1	The government has continuously increased budgetary allocation for maternal and neonatal care					
2	There are timely fund disbursements to maternal and neonatal care as allocated in the health budgets					
3	There are coordination and harmonization of financial resources to plan and predict for maternal and neonatal care					
4	There are established mechanisms for tapping financial resources from non-public sectors and donors					
5	There is an improvement in efficiency in resource utilization for maternal and neonatal care					

Section 4: Hierarchical integration within and among implementing structures

The following table consists of Hierarchical integration statements in regard to implementing the NRHP 2007 component of maternal and neonatal care. Please indicate your level of agreement with these statements.

Statements		**Strongly disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly agree**
1	There is a continued institutional support from government ministries, departments, and agencies (MDAs) to implement the NRHP					
2	There are sufficient commitment and leadership of senior public officials in implementing NRHP					
3	There is smooth coordination between public health agencies in implementing NRHP					
4	The government MDAs use inducements and sanctions in implementing the NRHP					
5	The government MDAs are responsive towards					

	compliance and non-compliance of the NRHP 2007 in regard to maternal and neonatal care					

Section 5: Formal access by outsiders

The following table consists of Hierarchical integration statements in regard to implementing the NRHP 2007 component of maternal and neonatal care. Please indicate your level of agreement with these statements

Statements		**Strongly disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly agree**
1	The government MDAs conducted a reproductive stakeholder analysis and mapping for maternal and neonatal care					
2	The government MDAs encourage stakeholders to promote research and exchange of information between researchers and the end-users of research results					
3	The government MDAs have provided protocols and procedures for stakeholder participation in reproductive health					
4	Reproductive health stakeholder facilitates greater public participation and involvement in the planning and implementation of					

	reproductive health programmes.					
5	The government MDAs have provided for stakeholder participation activities in maternal and neonatal care					

Section 6: Implementation of Safe Motherhood, Maternal, & Neonatal Health

The following table consists of statements in regard to Safe Motherhood, Maternal, and Neonatal Health Component. Please indicate your level of agreement with these statements.

	Statements	**Strongly disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly agree**
1	Women, including adolescents/youth have access to reproductive health information, counselling and services					
2	There is increase access to comprehensive and basic emergency obstetric care to meet minimum international standards					
3	Women have access to skilled care throughout pregnancy, delivery, postpartum, postnatal periods and care of the newborn					

4	Communities are involved in measures to promote 'women-and baby-friendly' maternity services and assisting with transport.					
5	Referral networks across public and non-public facilities have been promoted & strengthened					

APPENDIX 4: LIST OF FACILITIES

S/No.	Facility	Level
1.	Mowlem Health Center	Level 2
2.	Mihang'o Community Dispensary	Level 2
3.	Nairobi County Beyond Zero Clinic	Level 2
4.	KTTID Dispensary	Level 2
5.	Kenya Institute of Special Education Dispensary	Level 2
6.	United States International University VCT	Level 2
7.	Starehe Boys Centre School Clinic	Level 2
8.	Kamiti Maximum Clinic	Level 2
9.	Korogocho Health Centre	Level 3
10.	Wellness Program KWS Hq	Level 2
11.	CID HQS Dispensary	Level 2
12.	Uthiru Muthua Dispensary	Level 2
13.	KEMRI Mimosa	Level 2
14.	Mukuru Health Centre	Level 3
15.	Nairobi Earc St Anne Medical Clinic	Level 2
16.	Afya House Dispensary	Level 2
17.	The Co-Operative University College of Kenya Dispe	Level 2
18.	Innoculation Centre	Level 2
19.	Mary Mission	Level 3
20.	Lungalunga Health Centre	Level 3
21.	Mama Lucy Kibaki Hospital - Embakasi	Level 4
22.	Lunga Lunga Health Centre	Level 3
23.	Rhodes Chest Clinic	Level 2
24.	NASCOP VCT	Level 2
25.	Pumwani Maternity VCT Centre	Level 2
26.	Kmtc Dispensary	Level 2
27.	Kayole II Sub-District Hospital	Level 4
28.	Mbagathi District Hospital	Level 4
29.	Ngong Road Dispensary	Level 2
30.	Upendo Dispensary	Level 2
31.	Nairobi West Men's Prison Dispensary	Level 2
32.	State House Dispensary (Nairobi)	Level 2
33.	Gsu Hq Dispensary (Ruaraka)	Level 2
34.	Gsu Dispensary (Nairobi West)	Level 2
35.	Port Health Dispensary (Langata)	Level 2
36.	Kibera D O Dispensary	Level 2
37.	Bomas of Kenya Dispensary	Level 2

38.	Dod Mrs Dispensary	Level 2
39.	Dog Unit Dispensary (O P Kenya Police)	Level 2
40.	Dsc Karen Dispensary (Armed Forces)	Level 2
41.	Kenyatta University Dispensary	Level 2
42.	Babadogo Health Centre	Level 3
43.	Njiru Health Centre	Level 3
44.	Nairobi Remand Prison Health Centre	Level 3
45.	Kariobangi Health Centre	Level 3
46.	Amurt Health Centre	Level 3
47.	Kasarani Health Centre	Level 3
48.	Redemeed Health Centre	Level 3
49.	Karen Health Centre	Level 3
50.	Jericho Health Centre	Level 3
51.	Riruta Health Centre	Level 3
52.	Loco Dispensary	Level 2
53.	Mathari Hospital	Level 6
54.	Kabete Barracks Dispensary	Level 2
55.	Kabete Approved School Dispensary	Level 2
56.	Lower Kabete Dispensary (Kabete)	Level 2
57.	Lagos Road Dispensary	Level 2
58.	Mathare Police Depot	Level 2
59.	Huruma Lions Dispensary	Level 2
60.	Dandora II Health Centre	Level 3
61.	South B Police Band Dispensary	Level 2
62.	Mow Dispensary	Level 2
63.	Kaloleni Dispensary	Level 2
64.	Mutuini Sub-District Hospital	Level 4
65.	Ministry of Education (Moest) VCT Centre	Level 2
66.	Single Mothers Association of Kenya (Smak)	Level 2
67.	Kemri VCT	Level 2
68.	Langata Women Prison Dispensary	Level 2
69.	University of Nairobi Dispensary	Level 2
70.	Ngaira Rhodes Dispensary	Level 2
71.	Pangani Dispensary	Level 2
72.	Pumwani Majengo Dispensary	Level 2
73.	Uhuru Camp Dispensary (O P Admin Police)	Level 2
74.	Mji Wa Huruma Dispensary	Level 2
75.	Eastleigh Health Centre	Level 3
76.	Dandora I Health Centre	Level 3

77.	Kahawa Garrison Health Centre	Level 3
78.	7Kr Mrs Health Centre	Level 3
79.	GSUTraining School	Level 3
80.	Mathare North Health Centre	Level 3
81.	Kahawa West Health Centre	Level 3
82.	Garrison Health Centre	Level 3
83.	Ngara Health Centre (City Council of Nairobi)	Level 3
84.	Bahati Health Centre	Level 3
85.	Westlands Health Centre	Level 3
86.	APTC Health Centre	Level 3
87.	Karura Health Centre (Kiambu Rd)	Level 3
88.	Ruai Health Centre	Level 3
89.	Langata Health Centre (Mugumo-Ini)	Level 3
90.	Chandaria Health Centre	Level 3
91.	Nsis Health Centre (Ruaraka)	Level 3
92.	Jkia Health Centre	Level 3
93.	Waithaka Health Centre	Level 3
94.	Kangemi Health Centre	Level 3
95.	Embakasi Health Centre	Level 3
96.	Kamiti Prison Hospital	Level 4
97.	Memorial Hospital	Level 4
98.	Pumwani Maternity Hospital	Level 4
99.	Moi Air Base Hospital	Level 4
100.	National Spinal Injury Hospital	Level 6
101.	Kenyatta National Hospital	Level 6

APPENDIX 5: KEY INFORMANT INTERVIEW

Human resource

1. How does the human resource factor influence implementation of the maternal health component of the national reproductive health policy?
2. What role does your organisation play in terms of addressing the human resources for implementation of this policy?
3. How can the human resource factor be used to improve implementation of the maternal health component of the national reproductive health policy?

Financial resources

4. How does the financial resource factor influence implementation of the maternal health component of the national reproductive health policy?
5. What role does your organisation play in terms of addressing the financial resources for implementation of this policy?
6. How can the financial resource factor be used to improve implementation of the maternal health component of the national reproductive health policy?

Hierarchical integration within and among implementing structures

7. How does integration of the different department and agencies influence implementation of the maternal health component of the national reproductive health policy?
8. What role does your organisation play in terms of addressing the human resources for implementation of this policy?
9. How can the departmental/agency integration be used to improve implementation of the maternal health component of the national reproductive health policy?

Formal access by outsiders

10. As a stakeholder, what role have you played in implementation of the maternal health component of the national reproductive health policy?
11. How would you explain the access that your organisation has in implementation of the maternal health component of the national reproductive health policy?
12. How can stakeholder participation be used to improve implementation of the maternal health component of the national reproductive health policy?

APPENDIX 6: ETHICAL CLEARANCE

Strathmore UNIVERSITY

17th May 2019

Mbae Jessica
P.O.Box 174 -00202
Nairobi
jessicambae@gmail.com

Dear Jessica,

REF Protocol ID: SU-IERC0466/19

FACTORS INFLUENCING IMPLEMENTATION OF THE SAFE MOTHERHOOD, MATERNAL, AND NEONATAL HEALTH COMPONENT OF THE NATIONAL REPRODUCTIVE HEALTH POLICY (2007) IN NAIROBI COUNTY

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

1. Study Protocol submitted 8th May 2019
2. Cover letter listing all submitted documents 8th May 2019
3. Proposal declaration page signed by supervisors 8th May 2019

The committee has reviewed your application, and your study *"Factors Influencing Implementation of the Safe Motherhood, Maternal, and Neonatal Health Component of the National Reproductive Health Policy (2007) in Nairobi County"* has been granted **approval**.

This approval is valid for one year beginning **17th May 2019** until **17th May 2020**

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,

for

Prof Florence Oloo
Secretary
Strathmore University Institution Ethics Review Committee

STRATHMORE UNIVERSITY INSTITUTIONAL ETHICS REVIEW COMMITTEE (SU-IERC)
17 MAY 2019
TEL: +254 (0)703 034 000
P. O. Box 59857 - 00200
NAIROBI - KENYA

APPENDIX 7: RESEARCH AUTHROIZATION

NAIROBI CITY COUNTY

egrams: "PRO-MINHEALTH", Nairobi
ephone: Nairobi 217131/313481
: 217148
ail: pmonairobi@yahoo.com

COUNTY HEALTH OFFICE
NAIROBI
NYAYO HOUSE
P.O. Box 34349-00100
NAIROBI

en replying please quote

f. No. CMO/NRB/OPR/VOL1-2/2020/21

COUNTY HEALTH SERVICE

Jessica Mbae,

Strathmore Business School

Strathmore University

NAIROBI

20/03/2020

RE: RESEARCH AUTHORIZATION

This is to inform you that the Nairobi City County Operational Technical Working group reviewed the documents on the study titled, ***"Factors Influencing Implementation of safe Motherhood, Maternal, and Neonatal Health Component of the National Reproductive Health Policy (2007) in Nairobi County."***

I am pleased to inform you that you have been authorized to undertake the study in Nairobi County.

The researcher will be required to adhere to the ethical code of conduct for health research in accordance to the Science Technology and Innovation Act, 2013 and the approval procedure and protocol for research for Nairobi County

On completion of the study, you will submit one hard copy and one copy in PDF of the research findings to our operational research technical working group.

Raphael Muli

FOR COUNTY DIRECTOR HEALTH SERVICES

FOR COUNTY DIRECTOR OF MEDICAL SERVICES

CC: **Medical Superintendent, Mbagathi Hospital Mama Lucy Hospital, Pumwani Hospital**

Medical officer in-charge: Kibera South Hospital, Karen Hospital and St. Mary's Hospital

All. Sub County MOH's

APPENDIX 8: RESEARCH PERMIT

REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Ref No: **745381**

Date of Issue: **11/June/2020**

RESEARCH LICENSE

This is to Certify that Ms., JESSICA KARIMI MBAE of Strathmore University, has been licensed to conduct research in Nairobi on the topic: Factors Influencing Implementation of the Safe Motherhood, Maternal, and Neonatal Health Component of the National Reproductive Health Policy (2007) in Nairobi County for the period ending : 11/June/2021.

License No: **NACOSTI/P/20/5166**

745381

Applicant Identification Number

Director General
NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Verification QR Code

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