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## AN ASSESSMENT REPORT

# READINESS OF SELECTED COUNTIES TO DELIVER HEALTHCARE SERVICES IN A DEVOLVED GOVERNANCE STRUCTURE, KENYA

AUGUST 12, 2014



**AFRICAN INSTITUTE FOR HEALTH & DEVELOPMENT**

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## LIST OF ABBREVIATIONS AND ACRONYMS

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AfDP	African Development Bank
AIHD	African Institute for Health and Development
AMPATH	Academic Model for the Prevention and Treatment of HIV
CAA	County Appropriation Act
CEC	County Executive Committee
CHC	County Health Capacity
CHEW	Community Health Extension Worker
CHMT	County Health Management Team
CHS	County Health Services
CHW	Community Health Extension Worker
CIDP	County Integrated Development Plan
CO	Clinical Officer
CoK	Constitution of Kenya
CRA	Commission on Revenue Allocation
CSO	Civil Society Organisation
DHIS	District Health Information System
GoK	Government of Kenya
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
IDI	In-depth Interview
IDSR	Integrated Disease Surveillance Report
IPPD	Integrated Payroll and Personnel Database
KDHS	Kenya Demographic Health Survey
KEMSA	Kenya Medical Supplies Agency
KIHBS	Kenya Integrated Household Budget Survey
KII	Key Informant Interviews
KMPDU	Kenya Medical Practitioners, Pharmacists and Dentist Union
KNBS	Kenya National Bureau of Statistics
M&E	Monitoring and Evaluation
MCA	Member of County Assembly
MDGs	Millennium Development Goals
MoH	Ministry of Health
NASCOP	National AIDS & STI Control Programme
NCDs	Non-communicable Diseases
NCPD	National Council for Population and Development
NGO	Non-Governmental Organisation
NHIF	National Hospital Insurance Fund
PHC	Primary Health Care
PSC	Public Service Commission
STI	Sexually Transmitted Infection
TA	Transition Authority
TB	Tuberculosis
URTI	Upper Respiratory Tract Infection
USAID	United States Agency for International Development
WHO	World Health Organization

## EXECUTIVE SUMMARY

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The delivery of health services was devolved to the County Governments in 2013, putting into focus the County governments' capacities to offer the highest attainable standards of health to their people as provided in the Constitution of Kenya (CoK) 2010. Although it had been acknowledged that the right to health would be progressive and incremental, the transfer of functions to the County Governments during the transition and moving forward calls for their capacity to deliver healthcare to the people in their jurisdiction. In this regard African Institute for Health and Development (AIHD), conducted the assessment that was aimed at assessing the achievements and challenges faced by the Counties in the performance of their health care delivery functions and document best practices that could be scaled up or replicated among counties. The Fourth Schedule specifically defined roles that both National and County Governments must fulfil.

The objective of the assessment was to determine the pointers of readiness of the selected counties in providing quality health care in line with the Constitutional provisions as set out in fourth schedule. Specifically, the assessment sought to: i) map the County public health facilities by examining the population distribution and disease burden; ii) identify the strengths and challenges of health service delivery in the selected Counties; iii) document perceptions towards the capacity of the Counties to deliver healthcare services; and iv) document best-practices and success stories. The assessment was conducted between February and March, 2014 in eight selected Counties, namely: Baringo; Kakamega; Mandera; Meru; Nyamira; Trans Nzoia; Uasin Gishu; and West Pokot.

In this assessment both qualitative and quantitative approaches were used for data collection. The mode of data collection was exit interviews with clients and enriched with in-depth information gathering through focus group discussions as well as key informants. Due to the nature of system issues various documents were also reviewed and selective audit and pipelining in procedures and operations were verified and reviewed leading to consensus if the inference being made reflected the true situation as of the time of the assessment. The people interviewed were purposively selected on the basis of their expertise knowledge and the management leadership role they play as well as strategic oversight in the operation in the health service delivery. Some of those interviewed were in management and administration, technical operations, head of various units and decentralised health facilities. The assessment looked at both software and hardware issues - systems to improve efficiency in terms of availability of appropriate human resource for health, health commodities and equipments being used to offer services, speedy programmatic monitoring, decision making, preparedness in planning and tracking of processes. It also assessed perception in outcomes of services received, financial allocation and resources devoted to health care and challenges that may exist.

It should be noted that the key result areas in this assessment have valuable information that County governments can utilise to support the planning processes or subject to further probing. These result areas are that the public services are heavily utilised by women as evidenced by the respondents who participated in the exit interview in the proportion of female respondents (71%) and male respondents (21%). A significant proportion (76%) of respondents reported having received all the services they had sought. Majority had indicated receiving services free of charge, while 39% paid from their out-of-pocket. The results indicate that at least 56% of respondents lived approximately 1 to 5

km from the health facilities. The service utilisation was heavily influenced by proximity to facilities, integrated health services, affordability, and short waiting duration of less than 30 minutes.

The types of diseases that respondents sought care varied from County to County. These were overall related to morbidity arising from vector borne diseases, respiratory infections and waterborne diseases. Accessibility to quality healthcare was for the most part hampered by lack of drugs, equipment and supplies, service unavailable, staff shortages, inadequate allocation of funds towards health service delivery. Essential amenities such as clean running water and toilets were insufficient in many health facilities.

Based on the 2013/2014 County Appropriation Act, at least half of the Counties included in the assessment had allocated between 15-25% of their approved 2013/2014 County Budgets to health with the lowest being 3% in Meru County. Most of the Counties had embarked on a transformative agenda that would see recruitment of additional staff, upgrading of public health facilities, commissioning of new ones, and acquisition of essential medicines and health commodities. Massive opportunities exist to transform health systems in the Counties from the many opportunities in the devolved structures of governance. Likewise, active engagement among members of the County health leadership was observed in the eight selected Counties, which indicates willingness to reform and transform health care system.

Most counties have embarked on infrastructural development as well purchase and acquisition of equipment as a result of deficit inherited from the national government. Some of the challenges reported include political interference, dissatisfaction of healthcare personnel and lack of clear policy guidance and strategic plans to guide the devolution of health service delivery. The assessment found out that counties continue to receive support from development partners and bilateral agencies.

In conclusion, the realization of gains from devolution are seemingly massive, but may not be immediate, knowing that the health care delivery at the start of devolution was at different stages and that the preparedness in planning and execution may take some time to reorganise under the devolved framework and to harmonise in order to maximise on effective service delivery and ensure that health reform agenda is achieved.

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## 1.0 INTRODUCTION

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## 1.1 Background

Health is a fundamental human right and it is enshrined in the Constitution of Kenya (CoK) 2010. This means that the people of Kenya can enjoy this right as stipulated in the various articles of the Constitution especially Article 43 and the Bills of Rights. It is important to note that for the first time in the history of Kenya health care delivery the Constitution recognises that not only is a health a fundamental human rights issue, but also an individual basic right. In essence, the right to health has been elevated to a level where it can be enjoyed by all collectively and individually. In the event that the right to health is not attained and guaranteed as envisaged, then its enjoyment can be enforced in a court of law similar to civil, social, cultural and political and as other universal human rights.

At the time of independence in 1963, Kenya's government proposed providing free healthcare to all Kenyans in the belief that a healthy population could lead the new country toward greater economic development. By 1965 the government had formalized this "free health for all" concept and abolished user fees for people seeking care in public health facilities, which at the time were managed at the local level. In 1970 the Ministry of Health nationalized the health system and assumed responsibility for operating all public health facilities. However, economic stagnation after 1973 and a dearth of funds available for operating clinics at the community level led the Ministry of Health to reinstate user fees in 1989. A reform process in 1992 led to the creation of District Health Management Boards to facilitate cost-sharing and ensure the availability of funds for health services in peripheral areas. Persistent financial difficulties led the government to undertake a more intensive restructuring of the health system by the mid-1990s.

Since achieving independence in 1963, Kenya has worked to improve the health of its nearly 40 million people, more than half of whom live in rural areas. By the late 1980s Kenya had more than quadrupled the number of health facilities serving its growing population; extended life expectancy from 40 years to 62 years; and improved child survival rates. The economic downturn in the 1980s and the intensification of the HIV/AIDS pandemic in the 1990s exacerbated a number of health challenges for Kenya, where at least 45.9% of the population currently lives in poverty. These include the challenges of extending health services to impoverished and geographically dispersed populations; providing adequate financing to maintain and develop health infrastructure. Since the 1990s some of Kenya's early achievements in health had begun to reverse and have continued.

The historical evolution of health care delivery in Kenya indicates that health was decentralized as early as the 1970s and later officially decentralized through the policy of District Focus for Rural Development Strategy of 1984. The health care delivery was one of the most successful models that worked in this Strategy together with Agricultural extension services. In 1994 the government published the Kenya Health Policy Framework Paper, whose intention was to increase access and provide "quality health care that is acceptable, affordable, and accessible to all" in Kenya by 2010. With decentralization as the guiding strategy for delivering and managing the country's health care needs, the policy framework has been implemented through two five-year plans. The first National Health Sector Strategic Plan covered the period from 1999-2004, and the second covers the period from 2005-2010. Under the framework the country's health system is organized in a hierarchical pyramid. Dispensaries and Health Centres comprise the largest at lowest level of the pyramid. District and provincial hospitals are fewer and higher progressively towards the apex on the pyramid. (The district hospitals are now

termed sub-county and county hospitals and provincial termed level V hospitals.) The highest level is the Kenyatta National Hospital in the capital city, Nairobi which sits at the top as the highest level of the referral system. Before March, 2013, the Ministry of Health was responsible for setting policies, developing standards and allocating resources and managing health care services; however, in accordance with the decentralization scheme, the district was the operational level at which most management took place. Therefore the decentralization of health care is not new and devolution can greatly assist the national level to work smart to build on certain successes and avoid failures of the past. The aspect that should be the driving force is the health allocation and expenditure which has been dismal for several years and stifled meaningful health planning and delivery. Moreover, the previous decentralization models held the financial spending power at the central level. The planning and implementation was done at decentralized units, but failures occurred as a result of inadequate financial, human and material resources not being decentralized or inadequate allocation to meet the demands of the service provision. This situation must be avoided and corrected as devolution takes root.

For too long the care of patients in health care institutions in Kenya has been made to conform to the needs of the weak health system irrespective of whether it meets the needs of the users. The creation of the county health system may offer opportunity for those who are innovative to chart a new discourse in health care delivery that would provide better and affordable care to county residents. It is an opportunity that may allow innovation and real-time data to redesign the devolved health care delivery that puts the needs of the patient “front and centre”. The County specific blueprints for health care is seen as part of a new drive and reform agenda towards improving healthcare standards for all people in Kenya and improving the efficiency of the healthcare service delivery. The Constitution provides critical and important essential steps in the reorganization and re-introduction of ‘health for all’ as it were for Kenyans. The quest for this realization and providing better health care for all Kenyans should be squarely placed at the door step of the Counties’ health departments with emphasis on equitable and accessible health care delivery and together with its financing. The service provision should thrive on its efficiency, quality assurance and affordability to all irrespective of social class, geographical locality and economic status.

The Constitution outlines specific services to be provided by the National and County Governments. The county-level responsibilities are aimed at ensuring equity, promoting accountability and citizen participation while guaranteeing accessible health service delivery. The Fourth Schedule outlines the County health responsibilities as follows:

- i. County health facilities and pharmacies;
- ii. Ambulance services;
- iii. Promotion of primary health care (PHC);
- iv. Licensing and control of undertakings that sell food to the public;
- v. Veterinary services (excluding regulation of the profession); and
- vi. Cemeteries, funeral parlours and crematoria.

The recognition of the right to health as a moral, legal, and constitutional right, however, raises many complex issues including those of coverage, accessibility, cost, accountability, and quality of care. Fulfilment of this right requires an alignment of policy considerations, resource allocation and service delivery to all citizens. The Kenya Gazette Supplement No. 116, Legal Notice No. 137 of August 9, 2013 formally transferred health service provision to County Governments. The Notice provided specifics of the services for each of the six areas enumerated above including refuse removal, refuse dumps and solid

waste disposal. Further, the Government transferred the payroll for health personnel to the County Governments from January 2014. Whereas these functions have been transferred, the instruments and guiding principles that anchors successful transition seem to have been ignored and therefore the likelihood that health sector both at national and county level will experience challenges which could have been avoided during transition phase. There is also the likelihood that the inefficiencies inherent in the previous health system may be inherited and continued thereby still denying Kenyans quality and affordable health care.

Given that the implementation of the Constitution was expected to be progressive and incremental, it is implicit that Counties would depend on the existing facilities as they build additional or new structures to deliver health. The current capacities of the Counties are, therefore, critical to their ability to meet their obligations to the citizens. It is however notable that the right to health is taking place against a backdrop of a myriad of challenges to the health sector including healthcare workforce industrial actions.

Kenya faces a significant shortage of physicians, estimated only 6,000 in the entire country, but according to the World Health Organization estimates in 2006 the figure was 4,500. This number is not adequate for the current population of Kenya. The doctor population ratio of Kenya was just one doctor per 10,000 residents then and now estimated at 1:17,000 a ratio that is below average for the Africa region. More than 50% of Kenyan physicians practice in Nairobi serving estimated 4 million people, which only represents a small fraction of the country's population. It is estimated that only 1,000 physicians work in the public sector, which serves the majority of Kenyans. A corps of 37,000 nurse's supplements physician care, as do traditional midwives, pharmacists, and community health workers. The migration of trained health workers from the public sector to higher paying positions in the private sector, or away from Kenya altogether, has made retention of qualified health personnel a persistent challenge. Kenya has one of the highest net emigration rates for doctors in the world, with 51% leaving the country to work elsewhere according to a study done in the year 2000. This situation could be worse currently due to the persistent shortages of commodities and lack of equipment and tools of trade in most public health facilities.

Make no mistake - the crisis in health system is very real and the medical practitioners' views should not be ignored. When will medical practitioners be able to negotiate working conditions that could boost morale so that patients get the benefit of a well motivated health workforce? The human resource for health should be the preoccupation of both national and county governments as one area requiring inter-governmental cooperation not only in deployment, but also in training and skills development. The original clarion call by health care workers as advocates for quality health care and its beneficial aspects to patients which was the core of their original demand during the strike is still pertinent and valid. The truth is that the public health care delivery working environment is not conducive and enabling. Estimating by some statistics of health workforce especially doctors - 50% work in urban settings. Sooner, the practitioners will have to make a choice. Knowing that there is a shortage of trained and skilled health professionals and increase in private health care industry, the public service may be the loser in the short and medium term. Therefore how to provide quality, equitable, accessible and affordable health care and conform to constitutional requirements needs a strategic paradigm shift. The county health planning including laying important foundational basis is critical for the success ahead. A good health system is as good as its human resource capacity and delivery systems. The status quo remains,

the care delivery is the same and seems that there are no reforms in the health care at present. The worry is that the health care inefficiencies, high costs and poor quality of care will be transferred to many counties. The County health management is preoccupied with having control of health providers, but not concerned about inheriting a demoralized workforce and the teething problems it brings.

Kenya has not attained the Abuja Commitment of 15% GDP allocations to health care. Kenya's total expenditure on health as a percentage of GDP was 4.6% in 2006, according to the 2009 World Health Statistics Report. In 2006 Kenya spent 29 USD per capita on health services. This was below the 34 USD which WHO recommends for African countries to spend on providing a minimum health package for their citizens. According to the WHO, the Government of Kenya covers about 38.7% of the overall expenditures on health, while private expenditures account for 61.3% of overall spending. In 2006, 80% of private expenditures were out of pocket payments for health services. This transfers a burden for financing health care to individuals or households. Taking into consideration the percentage living below the poverty line, it is incomprehensible to figure out how they access health care. The bulk of this burden seemingly has been transferred to the state by the Constitution and both national and county governments must be clear on the expectations of Kenyans and plan accordingly. Therefore while the national government is still holding the financial power, the county can also allocate adequate resources to health sector to demonstrate progressive and incremental realization of quality health care. The national government can also give conditional allocation to aspect of health care that counties must address using its financial spending power. Sadly, the financial resources devoted to health sector has remained low overtime and allocation to health sector is declining instead of increasing as indicated by 2012/13 and 2013/14 budget appropriation. How are Counties positioning themselves to maintain and improve quality health care to their residents?

Some of the challenges emanate from lack of understanding, internalization and interpretation of the constitution provisions. The constitution clearly defines the mandate and role of the health services in devolved units within county governments in Article 6 (Devolution and Access to Services), 4th Schedule, Chapter 11 (Devolved Government) and Article 10 (National Values and Principles of Governance). However, many actors and the leaders in the County health sectors are yet to fully understand these sections of the Constitution and how to implement them.

## **1.2 The Health Sector in Kenya**

The Kenya Government, through various policy guidelines and strategies, including the Health Sector Strategic Plans, has committed to the delivery of affordable, accessible, equitable and appropriate health services that can contribute to improved national health outcomes. However, health indicators in Kenya remain poor and are contributing significantly to the non-realisation of the Millennium Development Goals (MDGs) health targets. For instance, maternal mortality remains high (488/100,000 live births) and can partly be attributed to limited investment in the health sector (GoK, 2012, Kenya MDG Report, 2013).

The GoK has identified the following key challenges to meeting its health goals: i) inadequate and poor state of infrastructure; ii) inadequate human resources for health; iii) frequent medical and supply shortages; and iv) lack of underlying research capacities. Although in the recent past there has been an increase in resource allocation to the entire

health sector, the sector generally remains underfunded with poor capacities to address the health needs of Kenyans (GoK 2012).

Within the health sector, several issues have emerged with regard to its structure and functioning. For example, counties in the northern part of the country have inherited weak health systems within the context of skewed health service personnel in favour of Nairobi and other major towns. Consequently, the ability of the Counties to deliver health under a devolved governance system needs to be understood and addressed to ensure that the recent transfer of health service delivery functions to Counties is informed by appropriate considerations based on disease indices and the capacities therein.

### **1.3 Objectives of the assessment**

The main objective of the assessment was to analyse the capacity of Counties to provide quality healthcare in line with the constitutional provisions with the aim of examining the opportunities, best practices, success stories and challenges of healthcare delivery within the devolved structure. Specifically the assessment sought to:

- i. Examine the population distribution and common ailments in the eight Counties;
- ii. Identify the strengths and challenges of health service delivery in the selected Counties;
- iii. Analyse the perception and expectation of users of health care delivery services
- iv. Document and analyse the preparedness or readiness of the leadership with regards to access to health care as a constitutional right in Kenya
- v. Document the capacity of the Counties to deliver health services;
- vi. Document best-practices and success stories in health service delivery in the eight Counties; and
- vii. Hold consultative meetings with CECs for health, national parliament and other stakeholders to discuss and disseminate the results of the assessment.

### **1.4 Expected outcomes**

The assessment results provide information on the Counties' capacity and capabilities to deliver health while documenting the challenges and opportunities in health service delivery. The documentation of the best practices would facilitate drawing of lessons that can be scaled-up within and beyond the respective Counties and feed directly into the important discourse of devolution of services to the local levels. The lessons learned and information generated will be used to support health system strengthening and creating the enabling environments counties require to entrench the devolved healthcare service delivery in conformity to the stipulated provision of the Kenyan Constitution 2010.

## 2.0 METHODS

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This section elaborates on the methods used for the collection, processing and analysis of the data for this assessment. It also provides information on the approaches employed by the research team to ensure the generation of quality data.

### 2.1: The Aim of the study

The purpose of this study project was to assess and demonstrate and show case how the devolved units and selected county governments are managing health care functions which are already devolved. This was done through a methodological and scientific documentation of information, facts and figures including perceptions of the public who are the consumers, health professionals, managers and policy makers of the devolved health care system. This was necessary to assess the formative stages, tenets and guiding pillars for sound health planning and health service delivery in the devolved system of governance. Consequently, this study seeks to demonstrate best practices, lessons learnt, readiness and uptake that could further provide important information for guiding decision-making in health services planning and efficient implementation. More specifically, experiences, perceptions, and assessments of the actors involved in the health services are identified, allowing the study to generate substantive relevant information about the key aspects, practices and perceptions attributed to the devolved health care delivery from the perspective of these agents.

### 2.2 The Study Design:

This was a qualitative and quantitative study design with mixed research methods and sampling techniques. The selection of the counties to participate was done through simple random sampling. The Q- sample was taken from the Q-sorts who are individuals that participated in the exit interviews and in-depth information from interviews with key informants.

#### 2.2.1 Methodology:

The motivation for developing this methodology derives its strength from the fact that, it was felt that this was the most appropriate existing quantitative method in the social sciences that most fitted the standpoint of the individual perception. Q-methodology has been described as a methodology that “combines the strengths of both qualitative and quantitative research traditions”. Thus, Q-methodology is a method that provides researchers with a systematic and rigorously quantitative means for examining human subjectivity. Subjectivity, for this purpose, is defined simply as a person’s point of view on any matter of social and /or personal importance. The corollary to this concept of subjectivity, making it amenable for analysis, is that subjective points of view are communicable and are always advanced from a position of self-reference. Subjective communication thus lends itself to objective analysis in the Q- method. As such, subjectivity is always anchored in self-reference, i.e. the person’s internal frames of reference as such, Q studies from conception to completion adhere to the methodological axiom that subjectivity is always self-referent.

The study therefore used the following techniques and tools:

- Desk review of documents including policy, programmatic and other relevant records and literature.

- Interviews with key informants using structured questionnaires categorized as facility checklist and county health capacity checklist. The county health capacity checklist was self-administered.
- The exit interview was done using a structured questionnaire which was administered by trained research assistants. It also gathered data on their demographic, socioeconomic profile and facility health care service related information.

### **2.2.2 Sampling and Sample size**

The assessment was conducted in eight (8) Counties in the country. The selection of the Counties was undertaken through a three-step process that ensured a variety of Counties were included in the sample and that the process was random. The steps were as follows:

- i. Using the current national immunization coverage data, the 47 Counties were grouped into three groups (clusters): high, medium and low performers;<sup>2</sup>
- ii. Two to four Counties were randomly selected in the three clusters using a simple random process (the number of Counties per cluster depended on the number of Counties within that cluster). Through this approach the eight Counties were selected for the study.
- iii. A mixture of stratified random sampling and purposive sampling was applied in all the eight (8) selected counties. A list of all the facilities and their Levels in the sub-Counties was provided to the research team by the County Health officials. Any highest Level facility in the County designated as Level IV was purposively selected, same as the County Referral Hospital (Level V). The rest were randomly selected based on a balance of at least one facility per Level (dispensary/Level II; Health Center/Level III in each sub-County).
- iv. Data collection was undertaken in selected public health facilities in selected Counties. From the selection process, the following Counties were selected: Baringo; Kakamega; Mandera; Meru; Nyamira; Trans Nzoia; Uasin Gishu; and West Pokot - whose health facilities were then sampled to generate data.

### **2.2.3 Sampling technique**

At the County level, the survey used a three-stage stratified cluster sampling design whereby the first stage involved listing all the public health facilities in the County. The second stage identified all the level 5 public facilities, if available, for inclusion in the sample. The third stage involved the mapping of all the constituencies, after which at least one (1) health centre or sub-County (Level 3 or 4) facility and two dispensaries (Level 2) were randomly selected in each constituency.

#### **2.2.3.1 Sample size**

The minimum sample size per County for exit interview was 100 and each facility had one checklist and each County had one health capacity checklist. The exit interview sample size was determined based on Bernard sample size determination.

#### **2.2.3.2 Inclusion Criteria**

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<sup>2</sup>Note that immunization was selected for use because it is a national programme that is implemented in all counties.

The focus of the health readiness assessment was on public health facilities. However, in areas where faith-based and non-for-profit institutions provide health services to the general population they too were included. Private hospitals and pharmacies or chemists did not form part of the sample.

Exclusion: Where level 5 data is shared by more than 1 County

## 2.3 Data Collection

This study used a variety of tools for the collection of data. Specifically, four tools which had already been pretested were used to help capture data from the respondents to include; (i) Health facility exit interviews which were administered to clients exiting the health facilities with the aim of assessing their views towards health services and the challenges they face while seeking care; (ii) Key informant In-depth interviews were administered to health managers and opinion leaders in the County; (iii) Health facility checklist was administered at each health facility visited to assess human resource, equipments in order to ascertain their availability and functionality and (iv) County Capacity Checklist was used to document experiences and practices as case-studies, successes and innovations that have occurred in health service delivery since devolution.

### (i) Desk review:

Additional critical documents were reviewed and analysed. Legal, Policy and programmatic guidelines and documents formed the bulk of the desk review. The Devolved Government Act, 2012 that is related to devolution and transfer of functions to Counties as well as other pertinent legislations were reviewed. Other key documents reviewed included:

- a. The Economic Survey 2013;
- b. Kenya Demographic and Health Survey (KDHS 2008-9);
- c. Kenya Service Provision Assessment Reports and the Guidelines to Devolution;
- d. Constitution of Kenya 2010;
- e. Reports of District Health Management Information system (DHMIS);
- f. National Census report (2009); and
- g. Kenya National Budget 2012-2013.
- h. Kenya MDG Report, 2013

### (ii) Health facility checklist:

Information relating to essential and enabling factors for service provision was collected through interviews with the health facility staff, including observations and review of facility reports, source documents and registries. The information gathered targeted areas such as health systems support; personnel; equipment; supplies and some aspects of health service delivery. The County capacity checklist containing In-depth Informants Interviews (IDI) was completed by the CEC for Health, the Director of Health services or a designate. In total 108 checklists were completed.

### (iii) Exit Interviews:

These were conducted at the public health facilities and other non-for-profit health facilities, as appropriate. The aim was to assess the views of community members towards access to health services and the challenges they face in the Counties. In total 846 exit interviews were conducted in all the Counties.

**(iv) Key informant interviews (KIIs):**

These were conducted with different groups of people with the aim of obtaining their views and documenting their perceptions towards the capacity of the Counties to provide quality healthcare in a devolved framework. A total of 134 KIIs were conducted in the Counties involving health managers, healthcare providers, CHWs, CHEWs, community opinion leaders, etc.

**(v) Community group discussions:**

The study team conducted group interviews with members of the community with the aim of capturing their perceptions about the readiness of the counties to provide healthcare services to their citizens. The study team took advantage of public meetings (*barazas*) and other public forums they came across in the course of the data collection exercise to hold these discussions. In total, five group discussions were conducted; three in West Pokot and two in Baringo.

## **2.4: Data processing and analysis**

**2.4.1 Quantitative data:** The exit interviews and health checklists were double-checked by the field supervisors before being entered into a computer by use of EPI-data. Trained data entry personnel were recruited for data entry. Data files were continuously checked and cleaned by a data manager before analysis. The data analysis generated frequencies and cross-tabulations to identify associations amongst the assessment variables.

**2.4.2 Qualitative data:** All qualitative data were transcribed and later typed. The data have been analysed manually based on the assessment themes.

## **2.5: Ethical considerations**

The measures outlined below were taken by the research team to ensure the integrity of the data collection process:

- i. Ethical clearance was sought and awarded by the National Council for Science and Technology;
- ii. All team members were carefully trained and briefed to ensure respect, protection and promotion of the rights of the study participants;
- iii. Informed consent was sought from all study participants and anonymity was assured with respect to reproduced interview data;
- iv. An information sheet and consent form were developed for all the respondents ensuring clarity of the terms and conditions being applied in the assessment; and
- v. The consent form included the following information:
  - a. The purpose of the assessment and the names of the assessment team members;
  - b. The expected time it would take to conduct the interview;
  - c. Issues addressed and the right not to respond to any of the questions;
  - d. The right to stop the interview at will; and
  - e. The contacts of the AIHD Executive Director in case they needed any clarification on the assessment.

## **2.6: The Research Team**

A team of twenty (20) researchers comprising of four (4) team leaders and sixteen (16) research assistants conducted the assessment. Each team was allocated two Counties:

Team 1 covered Mandera and Meru Counties, Team 2 covered Nyamira and Kakamega Counties, Team 3 covered Baringo and West Pokot, while Team 4 covered Trans-Nzoia and Uasin-Gishu Counties.

The research teams were trained over a period of three days in Nairobi to familiarize them with the study objectives and expected outcomes. The training period was also used to test the research assistants' understanding of the study tools and the informed consent process. Part of the training included role-plays on the IDIs. In addition, the data collection teams were taken through understanding community entry and mobilization processes, respecting established structures and general security measures.

## 2.7: Challenges and Study limitations:

The research teams encountered various challenges during data collection that were mitigated depending on the context.

- i. ***Shortage of staff in health facilities:*** Most of the health facilities visited had inadequate staff and those found were overwhelmed with attending to clients making it difficult to conduct interviews. In some cases the facility in-charge who was to provide the required information also doubled as clinical officers or nurses therefore engaging them in the assessment meant holding patients in the queues. Under such circumstances, the research team would split into two so that one team would wait for the service providers to be free while conducting the exit interviews while another team would proceed to another facility.
- ii. ***Timing challenges:*** The patient flow in health facilities varied depending on service provision schedules. Mondays, Thursdays and Fridays were some of the busiest days in some of the facilities while most of the facilities visited on Tuesdays and Wednesdays had less or no clients at all. The teams had to adjust their daily quota of interviews by conducting more interviews with service providers on the less busy days.
- iii. ***Weekends:*** Most of the facilities visited during the weekends were either closed or had one or two personnel to attend to clients. The assessment team, in such instances, had to make a judgement as to whether to interview the available service providers, the clients only or agree with the service providers on a suitable time when they could be available for the KIIs and the facility checklist. In some cases, some KIIs with the service providers were carried out outside the facilities after working hours at their convenience.
- iv. ***Difficult Terrain:*** The assessment team encountered harsh and challenging terrains especially in West Pokot and Mandera, where it was difficult to access the facilities within the required timeframe. As a result, the research team extended the period of data collection in the respective Counties. The use of four-wheel vehicles also enabled the teams to transverse through the rough terrain.
- v. ***Distance between facilities:*** In some Counties, such as West Pokot, Baringo and Mandera the facilities were sparsely distributed in remote areas presenting difficulties in access. The research team overcame this challenge by sequencing the visits in such a manner that all the constituencies were included in the

assessment. In some cases, the County Governments facilitated the research teams by providing additional vehicles to address the access issues.

- vi. In some of the facilities visited, the assessment team had to contend with long distances and uneven terrain in order to access the sampled facilities. The teams also noted instances where due to long distances, clients from neighbouring Counties or sub-Counties found it convenient to seek services away from their Counties of residence, for example in Meru, Uasin Gishu and Kakamega Counties.

### **3.0 RESULTS**

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This section presents the key findings of the assessment in six broad sub-sections: i) socio-demographic characteristics of the respondents; ii) health facilities and their capacities; iii) perceptions towards health service delivery; iv) County health financing; v) positive changes and best practices in health service delivery; and vi) challenges in health service delivery. Special mention should be given to County Specific reports which exhibit

county disparities and slight variation in the all results findings. The attributes ascribes to county specific findings further indicates that the future planning in each county must take cognisance of the county unique findings in their specific reports. The analysis has delved into both qualitative and quantitative information and triangulated information to bring out logical interpretation and result findings. Where possible some the qualitative findings are presented in the form of quotes to give clarity to the result findings through case study documentation.

The findings are further weighted and interpretation provided in such a manner that recognises the duration between the launch of devolution and the period when information was collected. It is therefore important to note that the actual implementation period by County governments was actually from August, 2013 to the time of data collection in March, 2014. Therefore real capacity in some instances may not be demonstrable, but use of proxy indicators and actual practical cases are useful in determining capabilities.

Out of the 846 exit interviews conducted, 157 were from Level 2 facilities, 312 respondents represented Level 3 facilities, 339 respondents were from Level 4 facilities while 38 respondents were from Level 5 facilities.

### 3.1 Socio-demographic characteristics of the respondents

Table 1 presents a summary of the characteristics of the respondents by sex, education, religion and marital status across the eight Counties. It shows that the majority of respondents were females. This is not unexpected result as public health services are mostly used by more women than men usually.

The respondents' level of education was spread across all the categories, majority being of primary education at 43%. Combined primary and secondary education accounted for 75% while those respondents who never attended school or had completed nursery/pre-unit combined accounted for 17%. Among those interviewed, it is worth noting that this proportion signifies a big number not attending primary education, It can be generally deduced that a majority of respondents had significantly some literacy levels. However, there was marked disparity in the level of education across the specific county findings. A breakdown of educational profile of respondents by County revealed mixed results: 54.4% of respondents in Mandera had never attended school compared with 14% of the combined pool. 30% in Uasin Gishu had attained University education compared with 2%, while 40% in West Pokot had only completed nursery education (see Figure 1). This result just shows the educational level of the respondents found on the day of the interview and unless supported by other

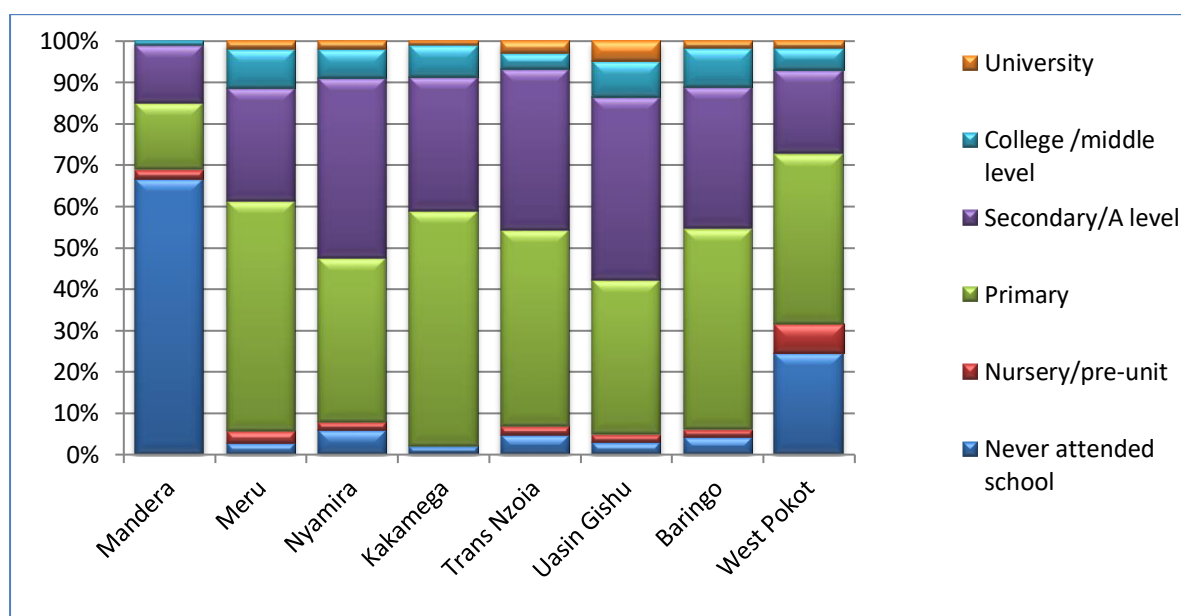
**Table 1: Summary of Socio-demographic characteristics**

Characteristics	Per cent (%) (N=846)
<b>Sex of respondent</b>	
Male	29.0
Female	71.0
<b>Education</b>	
Never attended School	14.0
Nursery/Pre-unit	3.0
Primary	43.0
Secondary .A level	32.0
College/Middle Level	7.0
University	2.0
<b>Religion</b>	
Christian	86.0
Muslim	12.0
Others	2.0
<b>Marital status</b>	
Never married	14.0
Married living together	80.0
Divorced/Separated	3.0
Widowed	3.0

documented information showing similar trends, this finding should not be interpreted otherwise, nor be used to compare educational attainment of counties against each other.

It is a well documented fact that educational level determines health seeking practices, behaviour and health outcomes. In this study a higher proportion of respondents had no education in Mandera (67%) and West Pokot (25%). The significant finding is that in almost all counties the majority of the respondents had primary to secondary education at approximately 70% and above. This finding seems to indicate that very few respondents with educational level above secondary schooling sought services in public health facilities. This fact needs further interrogation and should it be reconfirmed then its implication to health planning and healthcare delivery needs critical policy consideration.

Figure 1: % of highest level of education attained by County

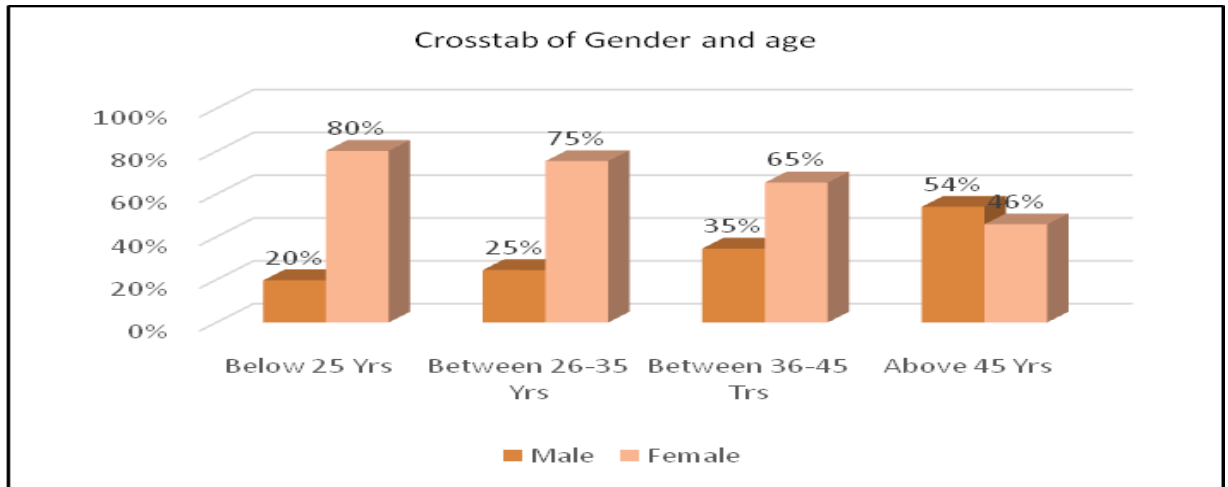


The largest proportion of the interviewees was of Christian faith (86.0%) while 80% of all respondents were married/living together with their partners.

Figure 2 indicates that most of the respondents who visited the health facilities were mainly females aged 25 years and below. The proportion of female respondents declined with age until age bracket 36-45 years while the proportion of males interviewed rose steadily with increasing age reversing the trend overtaking that of female respondents at age bracket above 45 years with the proportion of 54% males and 46% females.

The results also suggest that services were mostly used by females who are young and in their reproductive age group. At above 45 years both men and women tend to utilise the services in a more comparable proportions. This is a significant observation for purposes of health policy formulation, planning, budgeting and resource allocation.

**Figure 2: % distribution of the respondents by age and gender**



### 3.2 Health facilities' capacity to deliver healthcare services

In order to document the main health perceptions and facilitating a determination of the readiness and capabilities existing in the devolved health units that seek to address the health problems among the citizenry, the common health problems that led the respondents to seek healthcare services were identified. This assisted to provide important attributes and access to healthcare delivery in the selected Counties. The ability of the health facilities to deliver adequate health care services was assessed in terms of available human resource for health, level of service provision (availability of functional health facilities, commodities, basic amenities and equipment); affordability (cost); physical accessibility indicated by distance and mode of transport); and user experiences (waiting time, payment sources, and perceptions on service delivery – satisfaction, most improved areas of services, and areas in need of improvement). The common health problems that made respondents seek care were also identified and perceptions on health service delivery determined. The level of political goodwill and priority to improve health as a Constitutional mandate was gauged through proxy indicators from qualitative information. One such important indicator was funding or budgetary allocation for the health sector by Counties that was used to determine and assess the Counties' commitments to health.

The human resources for health to population indices and professional skills could have been some good indicators to determine and assess the readiness and capability. The qualitative information seems to indicate that some counties had made improvements in acquiring additional staff. This finding was only applicable directly to the action taking by counties where evidence existed that staff had been recruited or incentives provided to attract and retain staff had been developed and operational. The ratio of health care staff cadre per 100,000 population is in almost all cases was unfavourable and this is a critical national issue which at present counties may not have much latitude to influence as personnel issues are still being dealt with at the national level and most staff are only seconded to county governments.

### 3.2.1 Services sought in facilities

The common health problems that made respondents to seek care were identified and perceptions on health service delivery sought. Overall, common ailments were cited and remain the most prevalent health problems for which services were sought at 63%, followed by reproductive health services at 17% while immunisation was 8% and chronic diseases combined with laboratory services accounted for 10% of services sought (see Figure 2). Data from facility checklists showed slight variations between counties in order of ranking, but disease categories where most respondents reported to have sought health care remained mainly as common ailments across all the eight counties (respiratory tract infections, malaria, other vector-borne infections and waterborne diseases). The chronic diseases and NCDs seem to be on the upward trend from analysis of County specific reports. Some counties are more affected and this phenomenon needs policy consideration and urgent attention in planning of health system and care delivery.

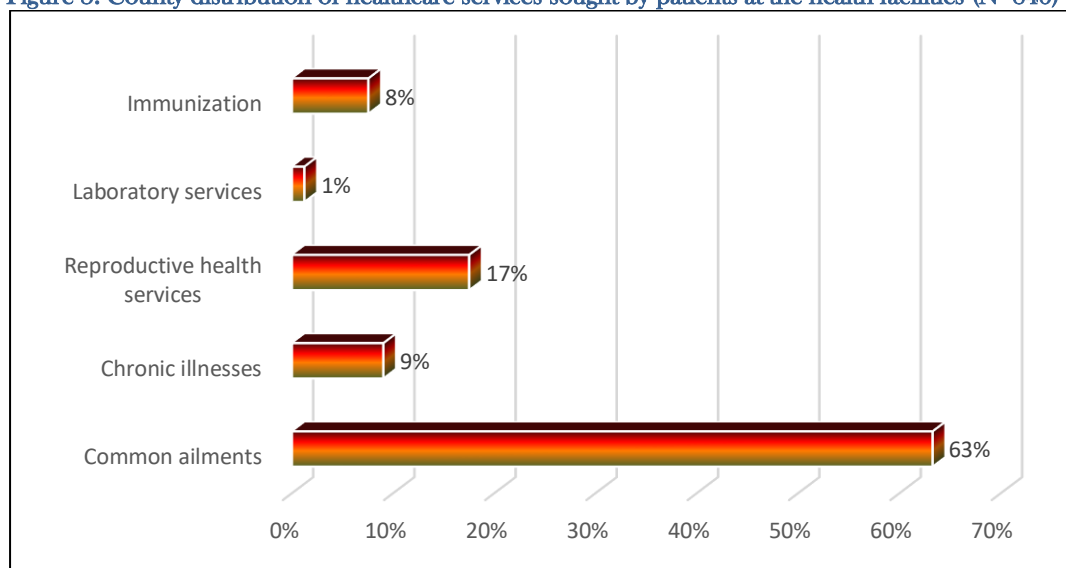
**Table 2: Healthcare services sought by patients at the health facilities (n=697)**

	Age range					Total
	Below 25 Years	Between 26-35 Years	Between 36-45 Years	Between 46-55 Years	Above 55 Years	
COMMON AILMENTS	168 36.5%	155 33.7%	79 17.2%	33 7.2%	25 5.4%	460
CHRONIC AILMENTS	11 16.4%	15 22.4%	15 22.4%	12 17.9%	14 20.9%	67
REPRODUCTIVE HEALTH	71 55.5%	45 35.2%	11 8.6%	0 .0%	1 .8%	128
LABORATORY	4 44.4%	1 11.1%	3 33.3%	1 11.1%	0 .0%	9
IMMUNIZATION	31 55.4%	21 37.5%	2 3.6%	0 .0%	2 3.6%	56
<b>TOTAL</b>	<b>274</b>	<b>226</b>	<b>109</b>	<b>46</b>	<b>42</b>	<b>697</b>

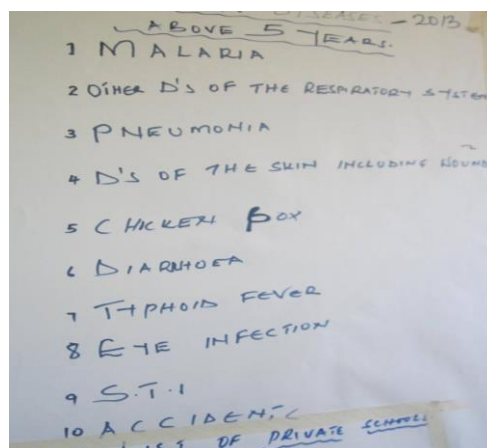
Though the overall picture indicates common ailments as majorly the reason for seeking health care services and are mostly preventable, it could be safer to deduce that the preventable ailments are currently a key contributor to the disease burden of most counties in this assessment. Those who indicated that they sought reproductive health services, for instance, were more in West Pokot and Baringo compared to Uasin Gishu and Mandera.

Counties were at different levels of development, some having more resources than others at the beginning of devolution. Many factors contribute to health seeking and health consumption patterns including socioeconomic status, demographic, infrastructure as well as individual attributes. Therefore it would not be appropriate to do comparison between and across Counties without controlling these factors. Figure 3 describes the different types of care services the respondents reported to have received in the selected 8 Counties.

**Figure 3: County distribution of healthcare services sought by patients at the health facilities (N=846)**



The results corroborate the information from the health records and various registries of some of health facilities where these were presented and reviewed as shown in the photo on the right). The proportion of chronic illnesses (9%) is seemingly high. A review of county specific reports indicates that some counties have an increasing trend in chronic non-communicable diseases. Findings from qualitative information extracted from in-depth interviews further confirm that there is a steady rise of chronic non-communicable diseases (NCDs).



**Photo 1: Top 10 diseases listed in a facility**

From the demographic profiles of the respondents and the types of health service sought, it is clear that in planning for County health services greater emphasis should be placed on prevention or preventive approaches and community based health services. The strategies suggested are practical, easy to initiate ensures greater coverage and ensures improved accessibility. A part from assisting the counties to adhere to constitutional provision for basic health care which must be provided progressively and incrementally, the health care delivery system will also be made accessible, efficient, sustainable and cost-effective. This thinking is currently lacking from most County agenda for health and policy analysis obtained from IDIs. Most counties are thinking about infrastructural improvement, purchase of health commodities and health facilities reorganisation without first thinking of a paradigm shift in strategy and health innovation based on evidence and county's specific epidemiological profile.

### **3.2.2 Access to healthcare services and factors influencing choice of facilities**

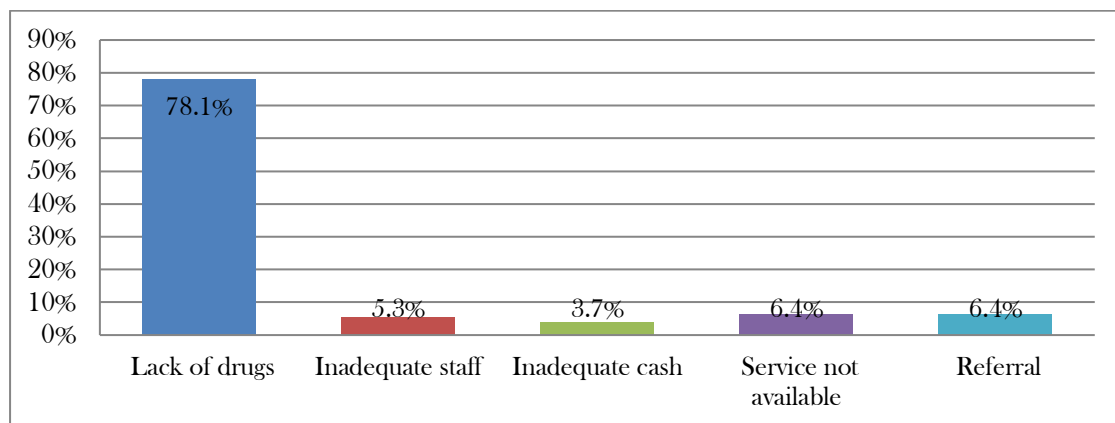
#### **3.2.2.1 Service utilization**

When asked if the respondents got all the health care services they had sought, the majority (76%) of the clients who were interviewed indicated that they had received all the services while (24%) reported having not received all the services they had sought.

Those who reported not receiving all the services they wanted, the common reason cited for this response was lack of drugs (78%) this was especially prominent in certain counties such as Mandera, Meru and Uasin Gishu as shown in Figure 4 below. In other counties the reasons varied; in Nyamira and Trans Nzoia for instance service unavailability was cited. In Kakamega the issue was inadequate funds while in Baringo it was referrals and in West Pokot was inadequate.

*“The health service providers at the facility are doing their best in providing quality services however lack of enough equipment frustrates the effort. Not all services are available at the facility so we give referrals,”* Doctor in Charge, Giaki.

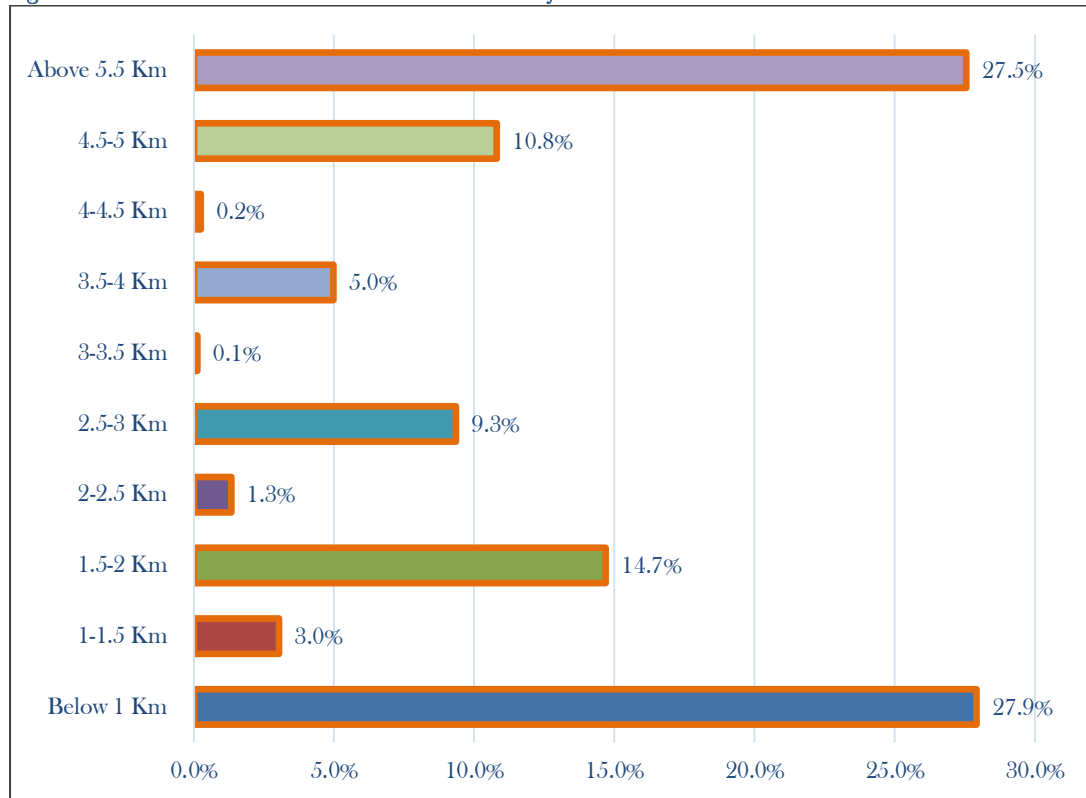
**Figure 4: Distribution of reasons for not getting services by County (N=846)**



### ***3.2.2.2 Distance covered to reach health facility (Health Facility Proximity)***

The respondents were asked about the distance they covered to reach the health facility. This was to determine the physical access and proximity of the health facility. A health facility should be available within a 5 kms radius as the stipulated norm nationally. Results showed that 28% of respondents covered distances below 1.0 km, while another 28% covered more than 5.5 kms with 15% covering between 1.5-2.0 kms and 11% covered between 4.5-5 kms as shown in Figure 5.

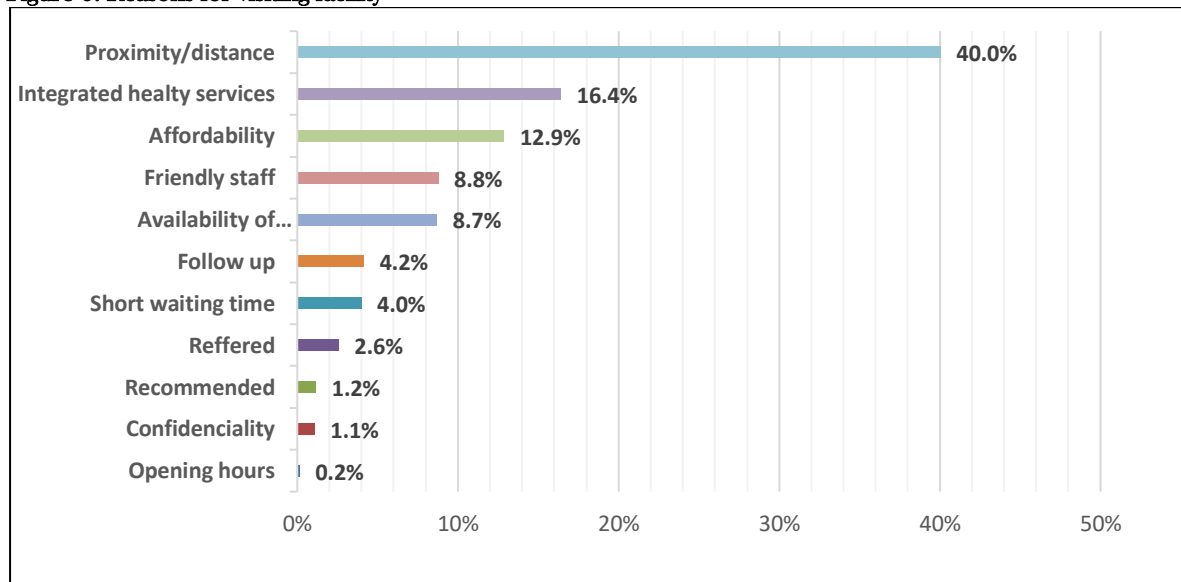
**Figure 5: Distance travelled to access a health facility**



**3.2.2.3 Reasons for choosing health facility:**

The respondents were further asked the reason for choosing a facility. This is to demonstrate what influences a client's choice to a health facility. The response was that many chose the facilities mainly due to; its proximity/distance was 40%, service availability (the possibility of receiving all the services) was 16%, affordability was 13%, friendly staff was 9% and availability of health commodities (drugs and other supplies) was 9% as illustrated in Figure 6. It was established that services at the Level II facilities were offered free of charge.

**Figure 6: Reasons for visiting facility**

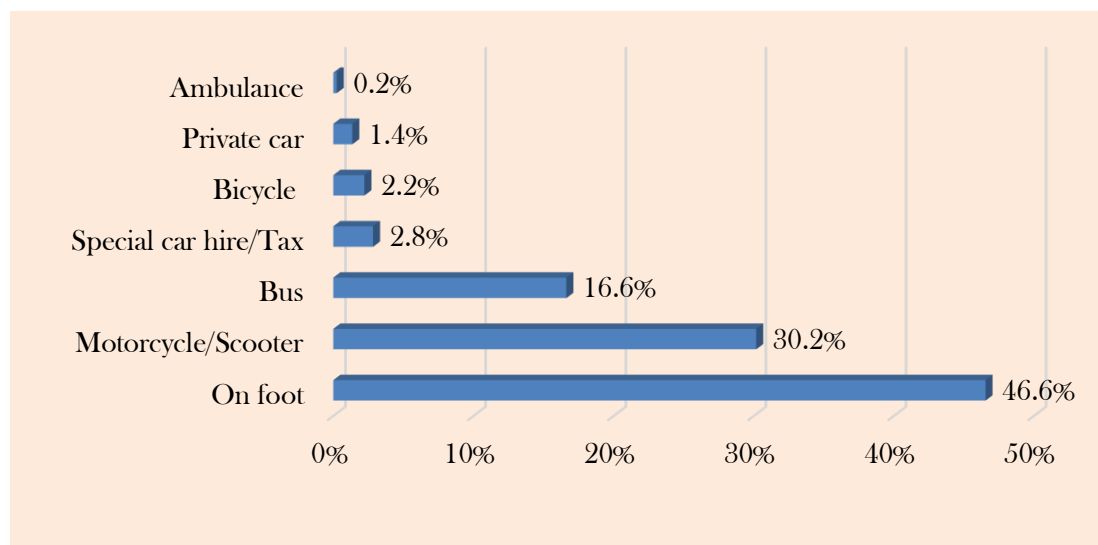


Health seeking behaviour and factors influencing choice of facilities was assessed against facility proximity, mode of transport to facility and cost of services. These results indicate that people are most likely to visit a health facility that is nearer to them, with a likelihood of comprehensive services being offered and when cost is affordable.

### 3.2.2.4 Mode of transport

In addition to finding out the reasons why the respondents chose particular health facilities, the assessment also sought to know the means of transportation respondents used to get to the health facility. When asked how they arrived at the facility, 47% reported that they walked, 30% used motorcycle (*boda boda*), 17% used buses while a few respondents used a special car hire or a taxi (Figure 7).

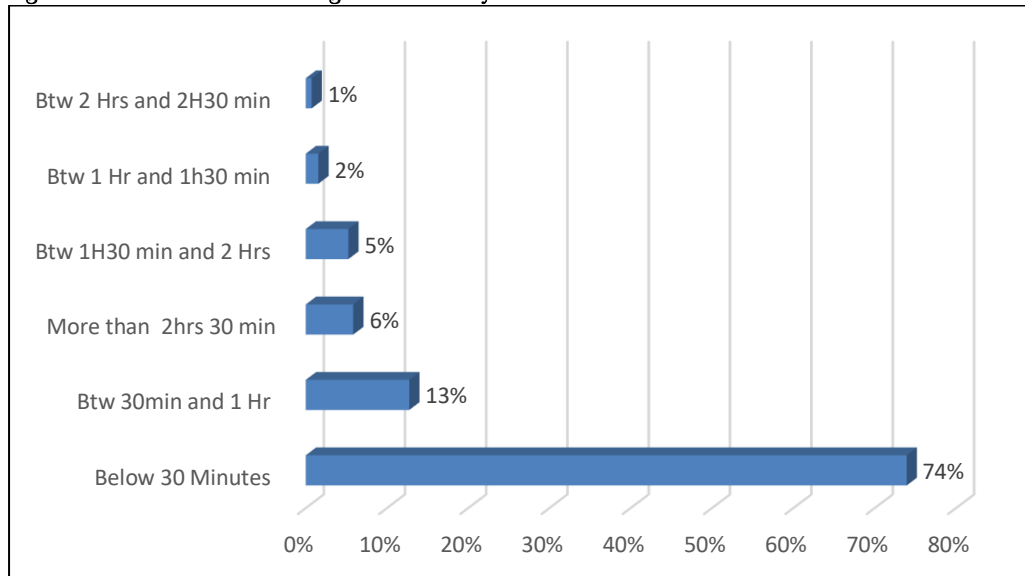
Figure 7: Mode of transport to facility



### 3.2.2.5 Waiting time

Figure 8 shows that close to three quarters of the respondents (74%) experienced short waiting times of less than 30 minutes at the health facilities before receiving the services sought. Another 13% waited between 30 minutes to 1 hour while 6% waited for more than 2 hours. Long waiting hours can be a factor influencing choice of facility and people's health seeking practices.

**Figure 8: Distribution of waiting time at facility**

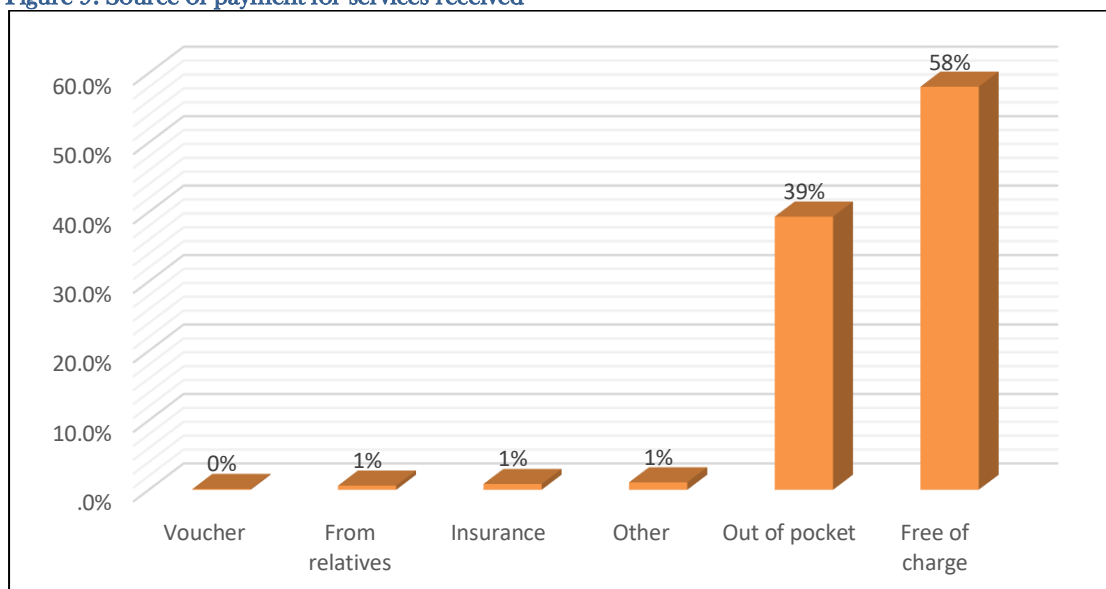


It is very surprising that short waiting time were experienced as compared to the previous experiences where those who sought services in public health facilities complained of long waiting time and queues. The most probable thing is that with county's close supportive supervision either health workers are readily offering services or have a new attitude change or fearful of consequences should one be found not performing duties or absent at place of work. The awareness and the realisation of power of the citizenry could also be another possible factor.

### ***3.2.2.6 Mode of payments for health services and health insurance***

According to the data collected from the exit interviews, a high proportion of respondents (58%) received health services free of charge, while almost two-fifths (39%) paid for services through out-of-pocket payments. Only 1% of the respondents reported having paid through their health insurance cover as shown in Figure 9.

**Figure 9: Source of payment for services received**



*The average cost of service was Ksh. 380 it was surprising to find that in one instance a person paid 28,000 for a one-off service*

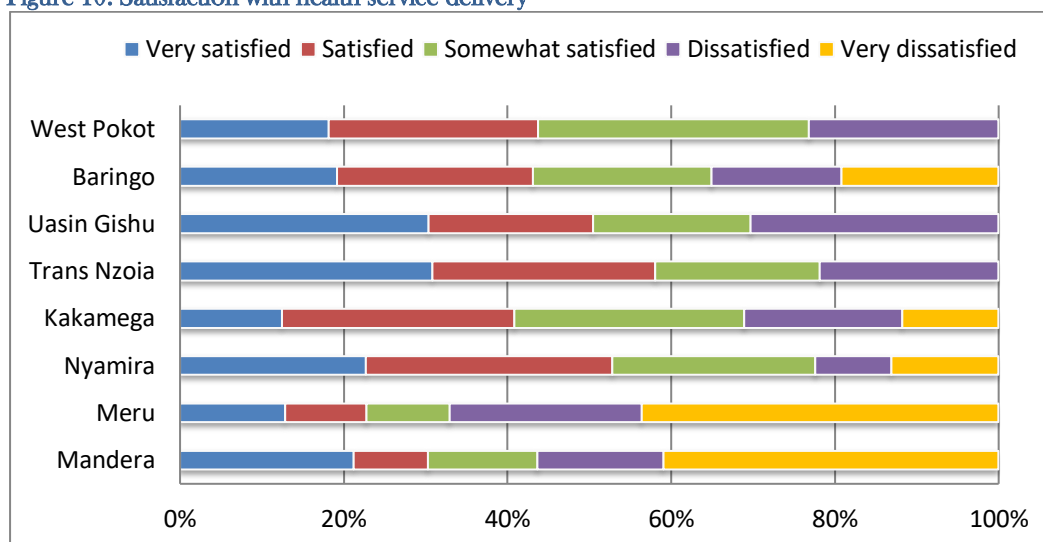
### 3.3 Perceptions towards health service delivery

The study sought to assess the user's perceptions about health service delivery in selected counties using both the qualitative and quantitative information collected from the respondents and key informants. These included questions on satisfaction with health service delivery and their views towards the most improved areas in health service provision.

#### 3.3.1 Satisfaction with health service delivery

The assessment sought to document the views of the exit interviewees' regarding the quality of services they had just received. About one-third (29%) of the respondents reported being very satisfied with the services they had received while 46% reported to being satisfied, 15% were somewhat satisfied with 8% reporting to being very dissatisfied. Across the Counties, the highest satisfaction levels were recorded in Trans Nzoia and Uasin Gishu Counties, probably attributable to a general perception of improved services especially in terms of improvement in drug supplies (Figure 10).

Figure 10: Satisfaction with health service delivery



From the exit interview findings, it was noted that the highest levels of dissatisfaction were reported in Meru and Mandera Counties. This finding correlates and attributed to the aspect of the response received on inadequate supply of drugs and staffing. The qualitative information from key informant as extracted from IDI seen to support the same result for Meru. A health provider in Meru observed that:

The health service providers at the facility are doing their best in providing quality services. However, lack of enough equipment frustrates their efforts. Not all services are available at the facility and so we give referrals. (KII, Health Officer, Meru).

In Mandera efforts had been made to improve staffing and have them retained through incentives. The gap in terms of perception created before and the short period since the intervention was done may not lead to change in perception of the users regarding staffing.

Accessibility, affordability, availability of drugs and staff, good customer care, integrated services, quality and timely service were attributes associated with those who indicated

being either satisfied or very satisfied with the services while the inverse was true. Those who were somewhat satisfied fell on either side of the spectrum with majority being on the dissatisfied or very dissatisfied plane (Table 3).

**Table 3: Table showing comparison of level of satisfaction with main reason for the same**

Rating of negative statements						
	<i>How would you rate on a scale of 1-5 your satisfaction with the services you received</i>					Total
	Very satisfied	Satisfied	Somewhat satisfied	Dissatisfied	Very dissatisfied	
<b>Other specify</b>	4.6%	.8%	1.6%	4.5%	6.3%	2.4%
<b>Long hours</b>			15.1%	9.0%	6.3%	3.1%
<b>Poor quality services</b>			4.8%	14.9%	12.5%	2.1%
<b>Lack of insurance</b>			6.3%	7.5%		1.5%
<b>Poor customer care</b>			4.0%	3.0%		.8%
<b>Inadequate staff</b>		.3%	9.5%	3.0%	6.3%	1.9%
<b>Lack of drugs/supplies</b>		1.3%	37.3%	43.3%	37.5%	10.3%
<b>Expensive services</b>			2.4%	7.5%	12.5%	1.2%
<b>Inaccessible services</b>			3.2%	7.5%		1.1%
Rating of positive statements						
<b>Timely service</b>	8.7%	12.3%	2.4%			8.6%
<b>Quality services</b>	13.7%	10.2%	3.2%			9.2%
<b>Opening hours</b>	.4%	.8%				.5%
<b>Integrated health services</b>	6.2%	9.5%	1.6%			6.4%
<b>Good customer care/friendly staff</b>	9.1%	7.9%	1.6%			6.5%
<b>Confidentiality/privacy</b>		.5%				.2%
<b>Availability of staff</b>	10.0%	7.9%	1.6%		6.3%	6.9%
<b>Availability of drugs/supplies</b>	26.1%	24.0%	1.6%		12.5%	19.1%
<b>Affordable services</b>	7.9%	7.4%	3.2%			6.2%
<b>Accessible services</b>	13.3%	17.1%	.8%			11.9%
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

From qualitative data it was obvious that a number of facilities within Counties mainly from level 3 and higher had initiated infrastructural improvements and improved supply of drugs:

*“Infrastructure development...they have started renovating our theatre. They have supplied drugs...like us we got up to 75% of what we ordered and we are expecting the other 25% very soon. This has improved a lot on outpatient services,”*MO in Charge, Githongo.

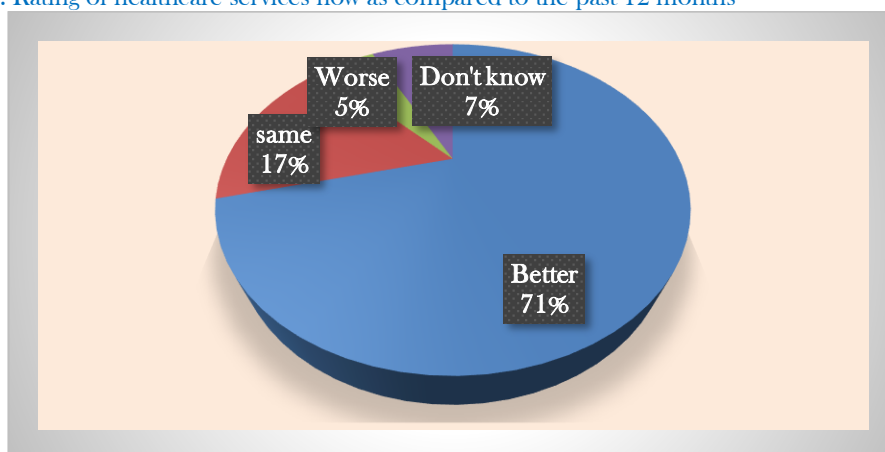
### 3.3.2 Perception of health care services improvement within the past 12 months

A further follow up question asked respondents to indicate changes they perceived to have taken place since the services were devolved. Those who thought that health services had improved were 71% while 16% reported no change by indicating that services had remained the same; 4% reported that the services had deteriorated and 7.5% stated they did not know if there was any improvement. When the assessment team probed further, the 7.5% who stated ‘don’t know’ reported that they were visiting the health facility for the first time or had not accessed the facility in the 12 months prior to the assessment.

### 3.3.3 Most improved areas of service provision

The respondents (71%) who had indicated service improvement were further asked to indicate specific areas where improvements had occurred. They indicated most improved areas were staff (22%) and pharmacy services (16%) while those who thought services had worsened cited emergency and ward admissions as shown in Figure 11 below.

Figure 11: Rating of healthcare services now as compared to the past 12 months



The areas that have improved most include staffing and pharmacy (improved drug stocking levels) as mentioned by 22.1% and 15.8% of the respondents respectively. For the 14% of the respondents who reported ‘other’ (See Table 4), some of the reasons stated were improved hygiene standards, free services and short waiting times. These findings can be attributed to the efforts of the County Governments to improve enabling environment and supportive supervision in order to improve access to health care services following devolution.

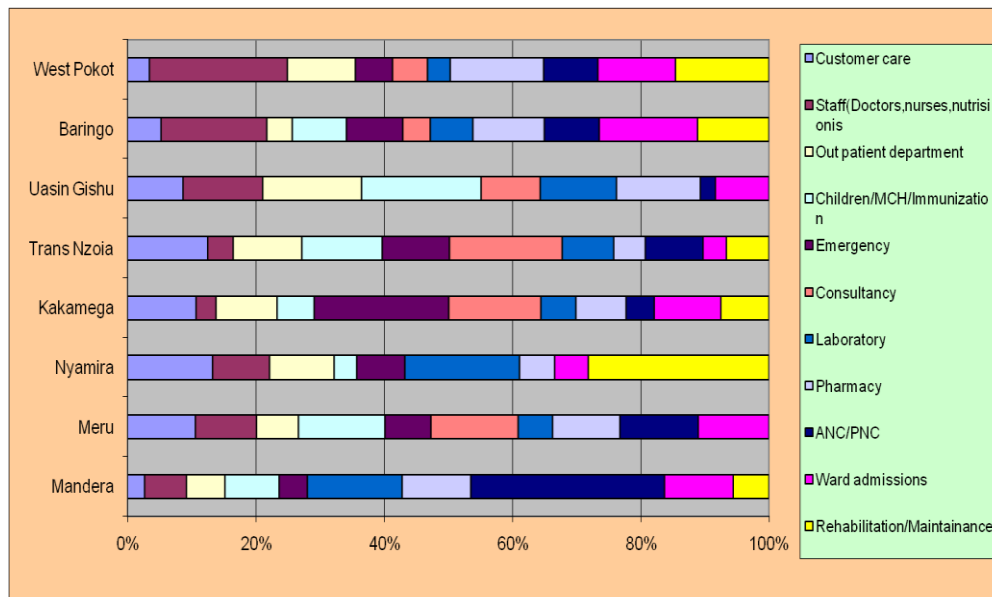
Table 4: Areas that have improved over past 12 months

Area of improvement	No.	%
Staff	169	22.1%
Pharmacy	121	15.8%
Others (specified)	113	14.8%
Customer care	66	8.63%
Outpatient department	63	8.20%
Consultation	51	6.70%
Childcare/MCH/Immunization	46	6.00%
Laboratory	46	6.00%
ANC/PNC	45	5.90%
Ward/Admissions	23	3.00%
Rehabilitation/Maintenance	17	2.20%
Emergency	5	0.70%

### 3.3.4 Areas that need improvement

When respondents were asked to indicate whether there were areas that needed improvement, the findings are as shown in Figure 12. The areas that needed the most improvement' the responses were varied based on the local experiences at county level facility. The need for more staff was high in Baringo and West Pokot while for Mandera, the most felt need was for antenatal and postnatal care (ANC/PNC). It is notable that the views varied by County hence the need to ensure that County health teams understand the particular needs of their constituents and take them into consideration during planning.

**Figure 12: % distribution of views on areas that need improvement**



### 3.3.5 County healthcare personnel

The very essence of a functional health care delivery system is based on appropriate human resource for health. The skill mix and numbers determine the service utilisation, efficiency and quality of care that is provided. The study used various methods to find out the status of these factors.

One of the objectives was to assess the capacity and capability of selected counties to deliver affordable and quality health care services. The personnel population ratio is among key critical factors in the determination of capacity and capability of a health system service delivery. The study tried to demonstrate the capacity through various information gathered from the county capacity checklist questionnaire which collected information about staffing and critical cadre involved in health service delivery. Table 5 shows the ratio of core clinical staff to the population served.

Findings from the assessment indicate that most Counties continue to experience serious shortages of staff given their large catchment populations and the disease burden. Even though most of the Counties such as Mandera, Kakamega and Uasin Gishu had increased their healthcare personnel, the numbers remain inadequate due to the number of people to be served and diversity of service needs and complexities. The most common view held by healthcare personnel was that the introduction of free health services, including free maternity in Level 3 and 4 facilities, had increased the demand for healthcare services yet the number of personnel remained limited. While there were

instances of lack of data, the inadequacy of health personnel was noted to include medical officers, clinical officers, nurses, public health officers and laboratory technicians, as shown in Table 5.

**Table 5: Ratio of core clinical staff to population**

Health Personnel	Baringo	Meru	Mandera	Nyamira	Trans-Nzoia	Uasin-Gishu	Kakamega	West-Pokot
County Population	555,561	1,488,984	1,025,756	656,777	898,854	981,654	1,823,108	562,845
Doctors	24	48	11	17	30	35	44	10
Population per 1 doctor	23,148	31,021	93,251	38,634	29,962	28,047	41,434	56,285
Nurses	464	815	170	332	441	480	977	-
Population per 1 nurse	1,197	1,827	6,034	1,978	2,038	2,045	1,866	-
Clinical officers	95	76	46	59	64	64	137	68
Population per 1 clinical officer	5,848	19,592	22,299	11,132	14,045	15,338	13,307	8,277
Pharmacist	8	12	5	6	11	15	22	2
Population per 1 pharmacist	69,445	124,082	205,151	109,463	81,714	65,444	82,869	281,423
Pharmaceutical technologists	11	14	15	6	10	10	18	12
Population per 1 pharmaceutical technologist	50,506	106,356	68,384	109,463	89,885	98,165	101,284	46,904

The World Health Organization (WHO) threshold is to have at least 2.3 health workers per 1,000 people. The inadequacy of health workforce to meet the needs of the population was cited across the Counties by the interviewed health care staff. They were quick to note that even though the Counties had employed additional staff, the numbers were still insufficient.

One County official noted with concern:

The key challenge we face in terms of staffing is the lack of enough staff and expertise especially specialized doctors to treat our patients. The turnover of staff is high here but we have developed a retainer programme that we hope will address this problem (KII, health official, Mandera County).

Another key respondent noted:

The facility does not have capacity to deliver quality services to the residents of Kineni. The number of patients handled by the facility is a lot compared to the number of staff available. We [the facility] only have two nurses ... and we have been forced to hire assistants to help reduce the workload. (KII, Health personnel, Nyamira County)

Thus, according to the WHO guidelines and indicators for HRH most of the Counties which participated in the assessment are still below the requirements given by the WHO category of “Human Resources for Health (HRH) crisis”.<sup>3</sup>

### 3.4 County healthcare financing

The assessment also sought to explore the level of funding allocated to the health sector by the County Governments, and whether it was sufficient to meet the health needs of the specific County. Table 6 gives a summary of the overall County allocation from the national government *vis a vis* their allocation to the health sector. The highest allocation

<sup>3</sup> WHO (2006) World Health Report.

to the health sector was by Kakamega County at 25% while Meru County had the lowest at 3% of the County budget.

**Table 6: Health budget allocations in the Counties**

County	National Government allocation	County allocation to Health sector	% allocated to health
Kakamega	13.255 billion	3.333 billion	25.0
West Pokot	3.037 billion	686 million	23.0
Trans Nzoia	3.923 billion	1.004billion	19.0
Nyamira	3,317 billion	499 million	15.0
Mandera	6.987 billion	840 million	8.0
Uasin Gishu	4.067 billion	1.2 billion	6.0
Baringo	3.630 billion	195 million	5.0
Meru	5.508 billion	1.83 billion	3.0

Source: CAA 2013/14

There was a feeling within the Counties that even though the funding levels for health had improved and that this was a break from the past. However, the respondents still felt that the funding was still inadequate to meet the health needs of the residents. A KII respondent noted:

The proportion of funding was an improvement from previous budgets at the national level. However, the funding is still not enough to meet the needs because paying for utilities is a problem especially when all health services are free. (KII, Health Officer, Nyamira County)

The same sentiments were echoed by another healthcare provider thus:

It is a fact that the health sector has been receiving the lowest allocation in the National budget. The introduction of free healthcare at Level 2 and 3 facilities, as well as free maternity services means that we are expected to deliver quality services to the public and yet we have limited finances...do you think this is possible? (KII, Health Officer, West Pokot County)

Even though most of the interviewed health workers noted that the health budget allocations were reasonable, they opined that funding still remains inadequate due to the increased demand for health services at the County level. They also observed that due to poor health indicators in some of their Counties; more funds need to be allocated to the health sector for the counties to be able to provide the required services to the people.

### **3.5. Positive changes in health service delivery**

The assessment sought to document some of the reported positive changes that have occurred in the eight counties since the devolution of health services by asking specific questions on the availability of essential medicines and medical/health related commodities, recruitment and staffing and health planning and management.

#### ***3.5.1: Availability of drugs and commodities:***

The pull system in the Counties, whereby the health facilities request directly for drugs according to their needs was reported to have slightly enhanced the availability of essential medicines and health commodities. A health worker stated thus:

Drug stock-outs happened a lot in the past especially drugs to fight common diseases such as Malaria and Diarrhoea. Since devolution of healthcare services, we have been requesting for the drugs that we need and the County Government is doing a good job in supplying drugs at the right time and in the right quantities. (KII, Healthcare Officer).

Although some Counties were still experiencing drug stock-outs at the time of the assessment, the pull system of procurement in the Counties was seen as providing the health teams a choice to demand for the medicines needed for the ailments prevalent in the counties and to prioritise purchases with Kenya Medical Supplies Agency (KEMSA). Moreover, counties can now plan and procure for health commodities on their own ensuring that value for money is observed. However, there seem not to be available a standard of approved equipment or list to guide the liberalised acquisition.

### ***3.5.2: Recruitment of additional healthcare workers:***

Most of the Counties involved in the study did not have adequate numbers of healthcare workers and were therefore forced to do with staff available to them. Moreover, some of the counties the situation was so dire that additional new staff had to be hired. A good example was Mandera County that had increased the health workforce by more than 200%, a clear indication that devolution had brought about positive changes. It is notable that community members in one site in Mandera had seen the first nurse in a nearby health facility since independence.

### ***3.5.3: Supportive Supervision and Monitoring:***

It was evident from the qualitative inquiries that effective supportive supervision and monitoring would contribute significantly to improved performance and accountability.

A healthcare worker observed that:

Devolution has strengthened monitoring and evaluation which in turn has improved the quality of services that the hospital offers. Regular monitoring by the County Health Management Team (CHMT) has curtailed cases of staff absenteeism thus ensuring hospital staff are always available. (KII, Health Records and Information officer)

### ***3.5. 4: Access to funds:***

Although there are still health budget allocation wrangles at the national level, access to the available funds at County levels has improved considerably. Funds are prioritized and directed towards specific areas of need as opposed to the ‘casting a net in the sea’ type of approach. Funding to facilities coupled with prompt disbursement was reported to have contributed to the increased efficiency and capacity of the facilities to deliver healthcare.

A key informant remarked:

Devolution has increased autonomy in the mobilization of financial resources from local sources and the possibility of deciding on how to use them for the implementation of health services. (KII, County Official, Kapenguria)

### ***3.5.5: Reduced bureaucracy:***

In some Counties, devolution of services was seen to have reduced the often lengthy bureaucratic procedures for decision-making and implementation. Most interviewed healthcare providers noted that since devolution, there have been changes because they *do not need to go to Nairobi for every decision to be made*; rather they seek clarity immediately from the County health officials. A key informant stated that:

Health services have become more responsive. The County Government is working to ensure that health services are tailored to meet different needs of the community and that the limited public resources available are more effectively and efficiently utilized. (KII, Health worker, Kacheliba)

There was however a feeling by some health providers that the current County leadership does not follow due processes. The fact that the health facilities are being refurbished within a short period of time was seen as taking shortcuts in the procurement processes (e.g. in some cases new facilities were constructed and commissioned within a period of six months, which was not the practice in the centralized regime). Some of the County Health Secretaries and Chief Officers were perceived naïve to government processes termed bureaucratic since they had worked in the NGO or private sectors prior to joining public service.

### ***3.5.6: Improved communication and feedback channels:***

Most healthcare workers reported improved communication channels and feedback mechanisms. A key informant posited that:

The Government is now closer to the people and we are able to address problems easily and get solutions quickly. Previously, problems had to be escalated to the National Government, prolonging the feedback process. (KII, Opinion Leader, Sigor)

### ***3.5.7: Expansion and upgrading of health facilities:***

Most Counties had embarked on upgrading health facilities to meet the demands of the people. For example, in Mandera and Baringo Counties health facilities were being upgraded and expanded especially in the rural and remote areas. In Baringo County for instance, the County planned to refurbish all Level 4 health facilities as evident from the construction of the mortuary at Kabarnet Level 4 hospital and a modern theatre complete with a surgical ward at Chemoligot sub-County hospital.

### ***3.5.8: Acquisition of new equipment:***

In Baringo, the County Government had acquired eight new ambulances (6 in good working and 2 in fairly good working condition) to deal with referral and emergency cases.

A key informant remarked:

Before the County Government came into place, we had only one ambulance that was used by all health facilities in the County but now we have more, and as we progress the County plans to procure more ambulances to efficiently cater for all the sub-Counties. (KII, Medical Superintendent, Baringo)

Other Counties, such as Trans Nzoia, had budgeted for the procurement of ambulances for all the sub-Counties. Kakamega County, on the other hand, had outsourced ambulance services from the Kenya Red Cross, which was reported to have improved efficiency in response to emergencies.

### 3.5.9: Best practices and success stories

Below are three examples of the success stories that were captured by the assessment team in the various counties.

- i. *West Pokot County: Construction of an ultra-modern abattoir as a source of revenue for the County:* The livestock sub-sector has huge potential for generating household income and revenue for West Pokot County. In 2012, the National Government embarked on the construction of a multi-million abattoir in Chepararia town at the cost approximately Kshs. 124 million. It would benefit livestock farmers in the region, saving them the risks and costs of transporting their animals to Nairobi for slaughter. Previously, livestock farmers in the region used traditional slaughter houses and as a result they were unable to successfully market their products in main urban areas and the export market where demand for quality is high. The completion of the abattoir was taken over by the County Government and it is set for completion by the end of 2014. It comprises a waiting bay, an emergency room for slaughtering weak animals, a weigh bridge, inspection rooms, three cold rooms and septic tanks for waste management. Further, the County Government, through the Department of Agriculture and Livestock Services, plans to improve the farmers' capacity to adopt modern animal farming methods to help increase productivity and boost incomes. In addition to the creation of employment opportunities for the youth, the proceeds from the abattoir would supplement the revenue sources for the County.



*Side view of the ultra-modern abattoir*

- ii. *Baringo County: Mortuary at Eldama Ravine sub-County Hospital:* The Baringo County has a dire need for public mortuary services. The only functioning mortuary in Kabarnet Level 4 Hospital has served the entire county for over 30 years. All other Level 4 hospitals in the County either use improvised morgues or depend on Kabarnet Level 4 Hospital. In some instances, where distances to access the morgue is too far and costly, community members bury the dead immediately after death or completely abandon the bodies. Eldama Ravine Level 4 Hospital located within Eldama Ravine town has embarked on the construction of a fully equipped mortuary with funding from the County Government to help decongest the one at Kabarnet. The mortuary is part of the County Government's efforts to improve service delivery in the health sector. On completion, the new facility will accommodate about 30 bodies. Previously, the hospital used a makeshift wooden structure as a morgue, which could only accommodate 5 bodies at any given time. The initiative to construct the new mortuary would address a great need of the residents of Baringo.



The mortuary at Eldama Ravine Sub-County Hospital under construction

- iii. *Mandera County: Recruitment of new healthcare workers and payment of a retainer allowance:* For a long time, Mandera County did not have enough healthcare workers in the facilities, a situation that was compounded by high turnover. In addition, very few health facilities were functional and it took community members a lot of time to access health facilities due to the vastness of the area. But with devolution changes were being observed and experienced. The County had employed additional healthcare providers and re-opened health facilities that had been closed before the county government took over devolved health sector functions. A County health official noted that: *we only found 154 staff in the entire County and we have hired 285 additional staff since we took over. They are located in different facilities and cover all cadres of staff. All facilities are now staffed. We now need to invest in continuing professional development to refresh staff skills through short courses since there are some skill gaps, e.g. in anaesthesia. We have to train those willing to go for those types of trainings.* In addition to recruiting more staff, the County health officials have offered a one-off allowance of 10,000 Kenya shillings for any new staff in order to help them settle in a bid to curb the high turnover.

### 3.6 Challenges in health service delivery

Even though there have been improvements in the delivery of healthcare services in the Counties, gaps still exist and some problematic areas persist. This section addresses such gaps.

#### 3.6.1 *Drugs supply and distribution:*

Most facilities in the Counties continue to experience drug shortages and irregular supply of drugs. The interviewed healthcare providers noted the causes of the drug shortages to be inadequate funding, supply chain management from KEMSA and the availability of counterfeit drugs from scrupulous dealers. The study team however noted that the shortage of drugs was mostly reported at Levels 2 and 3 in the Counties.

### ***3.6.2: Mechanisms to address health emergencies:***

One of the key health responsibilities of the Counties as outlined in the Fourth Schedule of the Constitution is the provision of ambulances and access to emergency care. However, even with devolution 12 months down the line, the study team found no clear mechanisms on how some Counties are dealing with emergencies or plans on addressing such emergencies when they occur. One of the KII respondents observed:

The emergency preparedness is poor because there is no resource person at the referral hospital to call or contact for immediate response [in such situations]. (KII, Health Centre provider)

Another respondent observed that:

Emergency preparedness is poor. For example, we only have one ambulance in the whole County. How do you expect the health facilities to be responsive? (KII, Health Provider)

### ***3.6.3: Sustainability of donor funded projects:***

There has been enormous support and contribution by NGOs and bilateral partners in Kenya. NGOs and partners contribute in various capacities to compliment health initiatives provided by the governments of the various counties. Some of the major partners include and not limited to Academic Model for the Prevention and Treatment of HIV (AMPATH), African Development Bank (AfDB), and APHIAplus. For example, in West Pokot County the healthcare workers acknowledged the enormous contribution of NGOs towards healthcare development but a few were concerned about the sustainability of these initiatives at the end of external funding. This is a valid concern that needs to be reviewed through the intergovernmental arrangements to ensure that existing agreements are renegotiated to suit each county requirement and needs.

### ***3.6.4: Political influence and inconsistent functionality of existing committees:***

A number of health workers reported political interference in various areas including job placements and transfers, selection of facility management committees, and procurement processes which affected service delivery. A key informant observed:

I am convinced that political interference will affect placement of health personnel especially in this community. A few MCAs overstep their mandates or do not understand their mandates and think they have the ability to hire and terminate the employment of health personnel. (KII, Healthcare Provider)

Another key informant remarked that:

We are worried about political interference. With County Governments being in charge of healthcare services, our jobs are not guaranteed. There is an MCA in this area that caused the transfer of a nurse simply because she [nurse] was not a member of the local community. (KII, healthcare provider)

### ***3.6.5: Cross-County overflow of patients:***

One of the key challenges facing the Counties is how to deal with patients seeking services from another county. In certain circumstances, a different county health facility cross the boundary provides better services or is better equipped to handle some health related care. The issue that was encountered was whether there are official formalised modalities existing between counties to facilitate users to access such care. The County gaining additional patients was perceived to incur additional cost and also gaining income from patients from a different county. There was uncertainty in dealing with this matter; it would be desirable to have a system that allows for adjustment for these movements of patients. An issue of concern with having to cater for many cross-county health facilities was reported by those hosting Level 5 hospitals. In our view this was already anticipated and Level 5 hospitals are considered for additional financial allocation from the national government. It was confirmed that although the national government was reported to be allocating extra financial resources for Level 5 facilities, the CECs and COs noted that the funds were insufficient. A key informant decried thus:

In this County, we have better healthcare facilities than our neighbouring Pokot and Turkana counties. Sometimes we are forced to deal with an overflow of patients from these counties. This is despite the fact our budgetary allocation does not take this into account. (IDI, Healthcare Provider, Baringo)

### ***3.6.6: Inter-community conflicts:***

Some communities in the Counties are in conflict with each other. For example, it emerged that the relationship between Pokot and Tugen is hostile, thus interfering with sharing of limited resources between the two neighbouring Counties as stated by a community opinion leader:

The relationship with our neighbouring community is not very good as a result of cattle rustling...this means that we are not able to share resources as neighbours due to this animosity. For example, we have a market at the border, which we are unable to share amicably. (KII, opinion leader)

Cordial relationship between neighbouring Counties is an important aspect that ensures sharing of resources and co-existence of communities.

### ***3.6.7: Transparency and accountability:***

It was evident from the qualitative inquiries that poorly developed communication channels and lack of public participation in most counties have resulted in how counties are perceived in the area of accountability and governance. Lack of clear information in processes and management (such as who reports to who) may interfere with transparency and accountability of how service delivery mechanisms at Counties are handled and managed. This in turn has a direct impact on how resources are used. A study participant had the following to say:

The County Government should invent ways of ensuring transparency and accountability as well as prudent use of public funds. Suggestion boxes although helpful, are not effective...how can you send a thief to catch a thief? (KII, Local Administration Leader)

A County official also added that:

County procurement departments are semi-autonomous in nature while most of the health functions remain centralized hence the challenge of procuring services/equipment and allocation of tenders. Moreover, the personnel employed under the Economic Stimulus Package (ESP) are not sure whether they will be absorbed by the County Government. (KII, County official)

### ***3.6.8: Negative attitude of healthcare personnel towards devolution of health services:***

Most healthcare workers were not in favour of devolution of healthcare services citing salary irregularities, delays in payment, withdrawal of allowances, lack of proper structures and systems (especially for training) and lack of County capacity to deliver as the main reasons. A key informant remarked that:

Devolution of healthcare was done in an abrupt manner resulting in confusion on human resource management, payrolls have been affected and some of our colleagues have not received their January/February [2014] salaries, and withdrawal of extraneous allowances. My view is devolve other health services but not personnel. (IDI, health worker)

### ***3.6.9: Remuneration models:***

The actual reality is that there was no staff movement and therefore there was no issue that could have caused crisis if the transition was well managed. The lack of proper handling of health personnel who are still national asset seconded to counties should have had clear inter-governmental agreement to avoid confusion being created. The absorption of healthcare workers seconded from the National Government to the County Governments took time to materialize. A lot of paperwork was involved as Counties sought to get the process right from the onset. However, during the assessment, the teams were informed that some of health workers, mostly non-medical staff and working at the lower level health facilities were overlooked in this 'streamlining' process. A key informant noted thus:

The money we use to pay these people is often released every quarter (after 3 months) and this payment schedule is not appropriate according to me. Because the personnel we have help us to run this facility and they have families to take care of. They cannot therefore wait for 3 months for their salaries. There should be a way of disbursing some money to the facility after every month to cover for the costs of salaries and wages. (KII, Health Facility Committee Member)

In a nutshell, both the health workers and County officials saw the management of health workforce as the key challenge to the devolved service provision. The use of local incentives was seen as one way of mitigating these challenges but representatives of CSOs and FBOs involved in the assessment raised the question of sustainability. The study participants recognized the need for policy guidance to inform Counties on ways of managing the workforce.

## 4.0 DISCUSSION

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Since independence in 1963, Kenya's healthcare system had remained largely centralised with decisions taken at MoH headquarters and conveyed top-down through the provincial medical officers to the district levels. Centralised functions at the headquarters included policy formulation, coordination of activities of all health stakeholders (government, development partners, NGOs and the private sector), policy reforms on various issues including charging of user fees, and undertaking supportive supervision and M&E. Although through the District Focus for Rural Development Strategy in 1984, a number of health sector related services were actually decentralised. The aspect of policy formulation, standards, guidelines, SOPs and health financing were majorly retained and controlled at the central level. Therefore devolution of health services is not completely new and not greatly been affected, but was therefore seen as a game changer in the way health service delivery was to be reorganised, made more accountable, equitable and responsive including provision of adequate financing based on rational allocation based on specific real needs within each county. The expectation of Kenyans towards devolution and its governance is that health services are to more accessible, affordable and available closer to the people who need it. This assessment was therefore aimed at ascertaining the readiness of the Counties to deliver on health as stipulated in the Constitution. The assessment aimed at examining the readiness of the County Governments in terms of health facilities and human resource availability relative to the needs of the people. The assessment also aimed at assessing the changes that have occurred since the devolution of health services took place.

The results of this assessment seem to indicate that various positive changes are taking place within different counties. Some areas have also not gone well. In terms of health planning and strategic visioning, most counties have really not paid adequate attention. The health sector reform agenda is still done sporadically and disjointed. No clear coherent thinking to come out with a master blue print to ensure efficient delivery which is sustainable. Against this backdrop, the discussion is structured in four sub-sections: i) readiness of counties to deliver health; ii) perceptions towards health service delivery; iii) positive changes and best practices in health service delivery; and iv) gaps in health service delivery at the County level.

### 4.1 Readiness of Counties to deliver health

The result indicates that the morbidity patterns of most counties are majorly preventable communicable diseases. These are either due to environmental factors, poor hygiene, water and sanitation related and vector borne in nature. Similar results were reported in the KDHS 2008/9 (KNBS and ICF Macro, 2010). This calls for an increase in the investment of Counties in preventive care. The financial allocation to health sector was encouraging in most counties some exceeding the Abuja 15%, however, due to increased demand for care and burden of disease including need for massive infrastructural development and reforms required, the amounts may not be adequate to sustain both current recurrent and development expenditures. Most Counties are not giving adequate attention to the Community Health Strategy in their policy pronouncements. There has not been a major paradigm shift on how to revolutionise health reform agenda that would reengineer healthcare delivery within a county context. The priority and focus is still on curative and facility based health services. It is notable that even at the National Government level the distribution of health resources was mainly skewed towards curative services, which accounted for 75% of health resources (Economic Survey, 2013).

In order to provide efficient and responsive health care that will address the burden of disease by ensuring a balance between demand and supply, innovating approaches in health care delivery must be sought. The Counties need to rationalise human resource for health with appropriate skill sets to manage and treat predominant health conditions in the counties. The management includes health planning, research, epidemic and disease surveillance and control including publishing behavioural and statistical epidemiological report for the county. Funding or health financing options must be based on evidence and quantification and projections made based on disease epidemiologic profiles and progression. This is more urgent and pressing needs in Counties that have been marginalized in the past (including Mandera, West Pokot and Baringo) to be considered for equalisation funding specifically to health service delivery to assist in accelerating improvement in health outcomes. It is notable that for some of the Counties to reach an acceptable doctor/population ratio, a lot more investment needs to be made in the health sector. Retaining health providers in remote areas continues to be a big challenge for County Governments. The incentive measures that some counties have put in place raise the questions of affordability in the longer-term and sustainability. Overall, the issue of human resource for health is a pressing concern both for national and county governments.

The surprising result was that most respondents could access health facilities that are within less than one kilometre radius. Further interrogation is needed as the situation before devolution was that people sought care from health facilities that were far away from them. The results further show that majority of patients reported to have received the services they sought for at the health facilities. This is a pointer that either health services are readily available or that the necessary health staff are also available to the patients. The reason for not getting all the services that patients required was predominantly due to lack of drugs. It was noted that most counties had problems with logistics and supply management. There is need to strengthen and improve procurement and supply management in health care delivery. Strengthening quantification and forecasting including tracking of commodities in the supply chain and logistic system would greatly reduce the perennial problem of stock-outs or run-outs. Most of these problems were mostly reported in Level 2 and 3. Concerns regarding procurement of drugs have dominated media reports in the last 12 months and there are current efforts by the National Government to reform KEMSA and to provide a revised pharmaceutical policy through *Sessional Paper No.4 on the Kenya National Pharmaceutical Policy*. While some County Governments are seeking clearance to be able to purchase drugs from other sources, the key concern with diversifying sources of essential medicines and health commodities is in relation to ensuring they are of good quality. The counties are at liberty to purchase from any source, but the national government through the ministry of Health should move with speed to provide standards and specifications of equipments that can be used in health facilities.

Proximity of health facilities was a key determinant of the health seeking behaviour of the respondents. The results show that two-fifths of the interviewees reported that distance determined where they sought their health services. The short distances to facilities made geographical access better with most people (46%) walking to health facilities. It is therefore imperative that the Counties come up with innovative ways of ensuring that people in the remote areas are within reach and can easily access health facilities. Integrated health services and affordability were strong predictors in influencing the choice of a facility. Given that less than 1% of the citizens had access to health insurance,

it is important that County governments develop mechanisms and strategies of introducing viable health insurance scheme to the people. Introduction of community health insurance schemes and/or linking people to the National Health Insurance Fund (NHIF) are areas that should be further explored.

The geographical placement of health facilities and distribution networks by types and levels is critical in ensuring that those who are in need of care receive appropriate and quality care in a timely manner. In this regard, available health facilities should be well equipped to address the scope of work specified for the facility type and avoid the challenges of referrals that are not indicated, but provide appropriate care and only deal with cases that actually require referrals to higher level of care. In particular referrals to level 5 and 6 facilities should be a last resort by the County health care team.

In terms of human resource availability, the apparent increase may not be due to numbers, but due to reduced absentees that were many as a result of lack of close supervision and oversight. Improved supportive supervision has resulted in less staff absenteeism leading to apparent improved services according to the respondents. Counties need to recruit more specialised personnel to cater for the various specialised healthcare needs of the people within its jurisdiction, but this needs to be rationalised and well targeted. Given that hiring of healthcare workers is now under the County governments, counties need to conduct audits of the available health personnel *vis a vis* the demand of the services and the disease burden and hire personnel with appropriate skills mix. This requires a HRH policy and a plan for each county. During the transitional period this should also be done nationally in order to provide information for decision making and to plan for human resource deployment at the end of the secondment period. The staff audit and skills assessment should have already been done even before functions were devolved, but it is an exercise that is needed to be done urgently.

#### **4.2 Perceptions towards health service delivery**

Levels of satisfaction with the healthcare services were reported in all the counties involved in the assessment. The main reason for satisfaction was the availability of staff in the health facilities. This level of satisfaction could be reflective of the initial investments that the County Governments have made through hiring new health personnel and expanding access to healthcare in areas that had not had such services. Most of the healthcare workers interviewed for the study had been employed less than one year prior to the assessment, when the devolved structures came into place. What has emerged from study is that with the devolution of health services to the Counties, the local people are beginning to appreciate the benefits of devolution. The feelings of satisfaction were more apparent in marginalized communities where people historically spent long hours in accessing health services.

It should, however, be noted that the highest level of dissatisfaction was with the lack of drugs in the health facilities (10.3%). This is indicative of the facts that even though the County Governments have improved on the delivery of healthcare, some health facilities are yet to benefit from the supply of the drugs and other commodities. This level of dissatisfaction reflects the high expectations the community members have of the new County Governments. Most people expected the County Government to solve the challenges that had negatively affected health service delivery over the years within a very short period. In essence, individual County governments need to develop mechanisms

of procuring drugs be it from KEMSA or other agencies to ensure that drug stock-outs are minimized.

### **4.3 Positive changes and best practices in health service delivery**

Devolution of health services has brought about positive changes in the Counties that were involved in the assessment. The positive changes observed ranged from availability of essential medicines and health commodities, recruitment of additional healthcare workers, enhanced mechanisms of supportive supervision and monitoring thus boosting transparency and accountability, availability of funds at the County level, expansion of health facilities and acquisition of new equipment. Literature on devolution asserts that service delivery improves when the services are moved closer to the people (Nelson, 2007). The findings from this assessment confirm this assertion whereby people in the Counties, 12 months after the transfer of service delivery, report that positive changes are happening in their areas. This was captured by a County Executive in Mandera: *“Mandera County attained independence with devolved governance.”*

### **4.4 Gaps in health service delivery at the county level**

The assessment illustrates that although there have been achievements in the health sector; counties are still faced with many challenges, most of which they have inherited from the national government. These challenges range from shortage of staff, accessibility of health services, inadequate supply of essential medicines and health commodities and poor working conditions for the health workers. In addition, the reluctance of the health workforce to be devolved continues to be a key challenge to County Governments across the country. Despite these challenges, the County Governments expressed their commitment to fully deliver on their health mandates.

It should be noted that decentralization does not eliminate the politics of health management. In fact, it has been shown to shift politics from the national to the local level or from the MoH to the County health departments. Local politicians and bureaucrats, like their national counterparts, face similar obstacles and may have only weak incentives to improve the functioning of the system (Nelson, 2007). The assessment highlighted the issue of political interference in the delivery of healthcare especially in the context of human resource management. Furthermore, respondents were not clear about the different functions of the County Governments more so the roles and responsibilities of the various leadership levels, which they felt, could result in mismanagement of the resources. Lack of clarity on roles had resulted in apathy among some of the healthcare workers. Despite the fact that most Counties are still facing teething problems, the positive changes observed by the research team indicate that devolution is working although there is an urgent need for Counties to be facilitated and supported by all health stakeholders to ensure that they deliver on the health mandates.

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## **5.0 CONCLUSIONS AND RECOMMENDATIONS**

## 5.1 Conclusions

The Constitution of Kenya has devolved health services function to the county governments and only leaving limited aspects such as policy, standards, regulatory, international health and national referral facilities as functions of the national government. This implies that Counties bear the overall responsibilities for planning, financing, coordinating delivery and monitoring the fulfilment of the right to *'the highest attainable standard of health'* (Constitution of Kenya, 2010).

It is evident from the assessment that the realization of devolution of health services may not be immediate, especially because of the varied levels of preparedness within the Counties. Some of the Counties that started at a relative disadvantage will need more time to strengthen their capacities and abilities to effectively and efficiently use devolved resources, for both curative and preventive healthcare. Disadvantaged Counties would therefore require particular assistance to catch-up up with the rest of the Counties, especially those in better resourced areas such as Nairobi and its environs. In the long run, success of devolution will depend on the availability of resources (both financial and human) for Counties to carry out their assigned functions, and their empowerment to use resources effectively.

The major challenges facing devolution of healthcare services include, but are not limited to, serious shortage of resources, inadequate infrastructure and lack of essential medical supplies and commodities. Although better distribution and deployment of health personnel may somewhat alleviate the acute shortages in some Counties, more still needs to be done. Many Counties will especially require strengthening in health planning, implementation and monitoring. The study participants reported low motivation of health workers especially in remote areas who are challenged by the poor working conditions as well as work overload. In addition, there is low morale among CHWs (most of them were reportedly inactive due to lack of proper supervision, support and motivation).

Despite the challenges facing devolved health service delivery, it is evident from the assessment that most of the Counties are striving to fulfil their mandates. This is especially demonstrated by the individual County governments' concerted efforts to put the appropriate infrastructure and structures in place. For instance, the construction of mortuaries, purchase of new ambulances and recruitment of health workers, and increasing allocation of County budgets to the health sector are key measures to ensuring quality health service delivery.

## 5.2 Recommendations

Based on the assessment findings, the following recommendations have been made on access to healthcare health workforce, essential medicines and health commodities, and management of health service delivery.

### *(a) Access to healthcare services*

- i. County Governments should allocate a high proportion of the funds to the health sector while paying attention to disease prevention and health promotion since most of the diseases are preventable.

- ii. Counties should explore the use of community-based insurance schemes or link their constituents to NHIF to ensure that community members have access to health services.
- iii. Counties should invest in the use of outreach services to access remote areas that are yet to be served with health facilities.
- iv. Both national and county governments should ensure that there is adequate funding for Level 5 hospitals because they serve people beyond the specific Counties where they are located. The fact that in the 2014/15 budget the funds for Level 5 hospitals were not earmarked portends a key challenge to the ability of Counties to fully support the operations of such facilities that offer critical services to a majority of Kenyans. This is important since they serve people from multiple counties and offer a higher range of healthcare services that may not be available in all counties.

***(b) Health workforce***

- i. There is an urgent need for Counties to recruit more health workers to ensure delivery of quality healthcare. The terms and conditions of the workers can be negotiated by individual Counties collectively, but should be left as a focus of all the Counties individually depending on their challenges in attracting and retaining human resource for health.
- ii. There is a need for the County governments to organize regular stakeholders' forums to ensure different stakeholders including County management, healthcare workers CHMTs and community members clearly understand the County's health strategic objectives and programmes under the devolved system.
- iii. Community Health Strategy needs to be strengthened through proper management and motivation of the CHWs and CHEWs as well as effective supervision and M&E. Effective support to CHWs and CHEWs would facilitate the Counties' investments in preventive and promotive healthcare.

***(c) Essential medicines and health commodities***

- i. Structures should be put in place in and among Counties to ensure the acquisition of quality essential medicines and health commodities. This could entail several Counties collaborating in the review and ordering of such commodities jointly to maximise on quantity of scales through intergovernmental agreements.
- ii. County Governments should be involved in the review of the *Sessional Paper No.4 on the Kenya National Pharmaceutical Policy* to ensure that the provisions are responsive to County needs.

***(d) Management of health service delivery***

- i. County governments should conduct audits of the available health personnel *vis* a *vis* the demand for services and the disease burden and recruit personnel with appropriate skills mix.
- ii. The County Governments should develop clear structures for personnel management especially in regards to appointments, transfers, promotions and

career progression. The lack of clarity in the management of the health personnel is causing discontent among the workers and their leadership. However, the provisions are clear and both management and personnel should take interest and familiarised themselves with what is provided in the instrument of devolution.

- iii. The County Assemblies should come up with acts/laws to safeguard health services for the vulnerable and marginalized in the community for example people living with disabilities, vulnerable children, women, youth, among others.
- iv. The capacity of CHMTs should be enhanced so that they can engage in all aspects of service delivery including the involvement of the public.
- v. As the Counties build their ‘in-house’ capacity, they need to strengthen inter-County relations and mechanisms especially with neighbouring Counties or those within the same region to enhance delivery of healthcare. Counties that have Levels 5 and 6 health facilities should engage in such collaborative measures.

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## ANNEX 1: SUMMARY INDICATOR TABLE

Table 7: Key County indicators

ITEMS	BARINGO	KAKAMEGA	MANDERA	MERU	NYAMIRA	TRANS-NZOIA	UASIN-GISHU	WEST-POKOT	SOURCE AND YEAR
<b>POPULATION<sup>1</sup></b>									
Total	60,991	1,823,108	1,025,756	1,488,984	656,777	898,854	981,654	562,845	KNBS (2009)
Population Density PPL/SQ.KM	50	515	39	195.5	665	328	267	56	KNBS (2009)
Male	296,998	852,411	593,891	713,711	305,476	433,312	477,819	271,187	KNBS (2009)
Female	2,944,230	914,851	495,718	729,662	331,183	438,008	473,765	274,417	KNBS (2009)
Under 5	95,779	309,271	144,860	206,402	110,779	141,154	154,157	88,388	KNBS (2009)
Under 1	20,737	65,632	21,396	40,414	23,556	29,625	32,354	18,551	KNBS (2009)
<b>NUTRITION<sup>1</sup></b>									
Underweight(%)	22.7	10.2	24.6	24	12	15	15	23	MOH (2012)
Stunted Height (%)	25.9	23.4	25.4	28	20	29	29	26	MOH (2012)
<b>CHILD HEALTH<sup>1</sup></b>									
Full Immunization Coverage(%)	56.9	73.9	7.6	73	85	43	72	51	MOH (2012)
<b>MATERNAL HEALTH<sup>1</sup></b>									
Births Delivered at Health Facility(%)	30.7	34.6	35.1	42	56	22	32	18	MOH (2012)
Contraceptive Prevalence(%)	21.6	39.2	4.5	50.5	58.3	27.4	32.2	9.5	MOH (2012)
<b>HIV/AIDS<sup>1</sup></b>									
No of People on ARVS	2423	18597	109	10319	8321	6248	16579	979	MOH (2012)
Mother to Child Transmission (%)	7.6	7.3	0	10	9.6	6.5	5.9	8	MOH (2012)
No of People Tested for HIV	2423	18597	109	10319	8321	6248	16579	979	MOH (2012)
<b>MALARIA<sup>1</sup></b>									
Malaria test Positive rate(%)	26.2	40.3	11.2	43.7	3.1	30.1	25.8	29.2	MOH (2012)

Malaria cases (per 100,000 people)	28051	37295	2495	32549	17722	18053	23028	24880	MOH (2012)
Malaria admission	1476	1228	999	161	372	208	99	2464	MOH (2012)
<b>TUBERCULOSIS (TB)<sup>1</sup></b>									
TB prevalence (per 100,000 people)	108	185	126	158	139	155	190	191	MOH(2012)
TB incidence (per 100,000 people)	42	53	52	80	45	50	67	85	MOH (2012)
<b>HEALTH FACILITIES<sup>2</sup></b>									
Public	174	132	57	95	74	53	111	67	CHC (2014)
Level 2	149	84	33	59	34	38	93	57	CHC (2014)
Level 3	20	36	18	22	32	11	18	6	CHC (2014)
Level 4	5	11	6	13	8	4	-	4	CHC (2014)
Level 5	-	1	-	1	-	-	-	-	CHC(2014)
FBOs	15	2	1	43	16	9	-	22	CHC(2014)
NGO'S	5	-	-	5	-	2	-	2	CHC (2014)
Private	12	92	-	2	33	30	58	15	CHC (2014)
<b>HEALTH PERSONNEL<sup>1</sup></b>									
Nurses (per 100,000 people)	68	47	9	57	41	42	35	42	MOH (2012)
Doctors to Population Ratio	5	5	1	8	1	5	8	2	MOH (2012)
Clinical officers (per 100,000 people)	15	7	3	7	5	6	6	8	MOH(2012)
<b>HEALTH FINANCING<sup>3</sup></b>									
Proportion allocation in Kshs	195m	3.3b	540m	177m	499m	742m	260m	686m	CAA(2013)
Percentage Allocation (%)	5	25	8	3	15	19	6	23	CAA(2013)
NHIF coverage (% of County Population)	13.3	23.4	7.6	25.3	27.7	15.3	27.4	8	MOH 2012

Referencing source:

1. KNBS (2009): Kenya National Bureau of statistics, 2009 Census; [1](#)(consulted on date\_11\_07\_2014 at 11.23am).
2. MOH (2012): Kenya health at Glance; [1](#) (consulted on date\_11\_07\_2014 at 11.23am).
3. CHC (2014): County Health Readiness Checklist.
4. CAA (2013) County Appropriation Act ,[3](#) and [3](#) (consulted on date 03.07.2014 at 4.00 pm).