Influences on Compliance Behaviour towards ISO 9001:2015 QMS Implementation by Workers at Kenyatta National Hospital, Kenya

By

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DECLARATION

Declaration by Candidate

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DEDICATION

This work is dedicated to my late parents Mr Joseph Anyong'a, Mrs Cecilia Ondeche and Mrs Margaret Mandera (Mama Mkubwa). You planted the seed but didn't live long enough to see the fruits. It is also dedicated to my wife Josephine Khamete and my children Lena, Shamira and Zawadi. May this work inspire you to achieve greater things.

'*When you walk through a storm; hold your head up high;*
And don't be afraid of the dark;
At the end of a storm; there is a golden sky;
And the sweet silver song of a lark!
Walk on through the wind; walk on through the rain;
All your dreams be tossed and blown;
Walk on! Walk on! With hope in your heart;
And you'll never walk alone..
Gerry Mersden

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ABSTRACT

The Introduction of ISO certification at KNH and in the public sector in general was aimed at improving service delivery to the citizenry. However, anecdotal evidence suggests that this has not been achieved. One of the reasons for this failure is the inability of the workers to fully comply with the requirements of the ISO Quality Management System (QMS) requirements. The study sought to examine the factors that influence compliance behaviour towards ISO 9001:2015 Quality Management System at Kenyatta National Hospital. Guided by the Theory of Planned Behaviour, the study sought to assess 1) compliance behavior towards ISO 9001:2015 QMS at KNH; 2) the effects of workers' attitudes on compliance towards ISO 9001:2015 QMS procedures at KNH; 3) the influence of organization norms on compliance with ISO 9001:2015 QMS procedures at KNH; and; 4) the extent workers' behaviour control affects compliance with ISO 9001:2015 QMS procedures at KNH. The study employed a cross sectional survey design. Primary data was quantitative and was collected from 291 staff of KNH selected through a multistage sampling procedure, by use of a questionnaire. Augmentative qualitative data was collected from purposively selected key informants and Focused Group Discussions. Statistical data was analysed and presented using tables and figures. Tests conducted included cross tabulations, correlation analysis, factor analysis as well as multiple regression analysis. Qualitative data was analysed thematically and presented using narratives and direct quotes. Findings revealed strong intentions to compliance with ISO 9001:2015 QMS procedures by workers at KNH with a mean score of 82%. However, this fell short of the required threshold of 100% compliance. Awareness levels were also high but also fell short of the required threshold. Tests for the hypotheses revealed that attitudes, norms and behaviour control are positively correlated with compliance with ISO 9001:2015 QMS procedures with Pearson's r values of 0.522, 0.477 and 0.305 respectively. (p=0.00). Prediction tests on the other hand revealed that behaviour control had the least predictor value of compliance followed by attitude while norms had the highest predictor value. However, attitudes, norms and behaviour control only accounted for 37.8% of the effect on compliance with ISO procedures. The study concluded that positive workers' attitudes have a positive effect on compliance with ISO 9001:2015 QMS at KNH; positive organization norms have a positive influence on Compliance with ISO 9001:2015 QMS at Kenyatta National Hospital and strong behaviour control affects compliance with ISO 9001:2015 QMS positively. The study recommends that to enhance compliance with reforms, there is need to improve on the attitudes and normative beliefs of staff. This can be achieved by improvements on policy development and communication, providing incentives linked with reforms, providing equipment and infrastructure, and enhancing employee involvement in order to improve adoption of reforms.

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ABBREVIATIONS AND ACRONYMS

AAct	Attitude Towards Behaviour
ANOVA	Analysis of Variance
BI	Behavioural Intention
CEO	Chief Executive Officer
CIDA	Canadian International Development Agency
CORD	Coalition for Reforms and Democracy
CQI	Continuous Quality Improvements
CSDH	Commission on Social Determinants of Health
CSRP	Civil Service Reform Programme
EBM	Evidence Based Medicine
ERC	Ethics Review Committee
ERS	Economic Recovery Strategy for Wealth Creation
GDP	Gross Domestic Product
GoK	Government of Kenya
HR	Human Resource
HSSP	Health Sector Strategic Plan
ICT	Information and Communication Technology
IMF	International Monetary Fund
ISO	International Organization for Standardization
JCI	Joint Commission International
JCIASH	Joint Commission International Accreditation Standards for Hospitals
KACC	Kenya Anti-Corruption Commission
KEBS	Kenya Bureau of Standards

KEPH	Kenya Essential Package for Health
KNH	Kenyatta National Hospital
KQMH	Kenya Quality Model for Health
MDAs	Ministries, Departments and Agencies
MoH	Ministry of Health
OPM	Office of the Prime Minister
PBC	Perceived Behaviour Control
PSTD	Public Sector Transformation Department
PSTF	Public Sector Transformation Framework
PSTS	Public Sector Transformation Strategy
QMS	Quality Management System
RBM	Results Based Management
RoK	Republic of Kenya
SDGs	Sustainable Development Goals
SN	Subjective Norms
SPSS	Statistical Package for Social Sciences
SWAp	Sector Wide Approach
TACT	Target, Action, Context, Time
TJC	The Joint Commission
TPB	Theory of Planned Behaviour
TQM	Total Quality Management
UHC	Universal Health Care
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

The Introduction of ISO certification in the public service was aimed at improving service delivery and ensuring the products and services offered by the public sector are globally competitive. This is envisaged in the national development blueprint Kenya's Vision 2030. Services at the apex of health provision in Kenya remain below public expectations despite Kenyatta National Hospital being ISO 9001:2015 Certified. ISO certification is largely a top-down approach initiated by top management and implemented by the workers. This is also typical of the many reforms being undertaken within the public sector. The need to examine workers' behaviour towards these reforms (ISO certification included) is a concern for both academicians and policymakers.

Kenya as a country has been in pursuit of quality service delivery to ensure that the government meets its development objectives. This has been the main driver of public sector reforms. Service delivery is perceived as a set of activities performed by an organization that aims at creating value, which includes specific services, economic activities, performance to customers as well as other organizational activities. This is part of the value creation process such as leadership and management styles, the structure of operations, the organization cultures, and customer relationship initiatives among others (Edvardsson, 2005). The significance of the service delivery involves the central thrust to the achievement o excellent service for the Government and the public as customers (Stoker, 2012). It is also essential for economic reasons because of the importance placed on the national competitiveness of the civil service.

The term public sector refers to all the services offered by the government. It covers a much wider concept than civil service does. This is because it includes the ministries and the departments of the central government, the judiciary and the legislature, parastatals, local governments, security forces, and professional regulatory bodies (Economic Commission for Africa, 2010). According to Batley *et al.,* (2012), public service is provided by the government to people living within its jurisdiction, either directly through the public sector or by financing the provision of services. The term public service is associated with a social consensus usually expressed through democratic elections that certain services should be available to all, regardless of income.

Public servants therefore must continue with the improvement programs to meet the challenges facing the country as well as achieve rapid economic and social development, a direct result of effective and efficient service delivery (Barrientos and Hulme, 2009). Effectiveness in customer service typically refers to doing the right things and measures constructs like customer satisfaction on dimensions such as service quality, speed, timing, and human interaction. Service delivery is effective whenever its outcomes and accomplishments are of value to its customers (Koech, 2016).

Public Sector Reforms refers to the “processes and practices which are concerned with improving the capacity of institutions to make policy and deliver services in an efficient, effective, and accountable manner” (Economic Commission for Africa, 2010: 5). Reform measures include financial and fiscal reform, civil service reform, legal and judicial reform, decentralization, enhancing accountability and transparency and improving corporate regulatory frameworks among others (African Development Bank, 2005). The focus of this study is on service delivery reforms in the public service.

Public sector reforms in Kenya have had a long history since independence. The history of public sector reforms in Kenya dates back to 1965 with the overarching objective of better public service delivery to reduce poverty, improve livelihoods and sustain good governance. This was outlined in the Sessional Paper No. 10 of 1965 (Kilelo *et al.*, 2015). The Paper was meant to guide economic growth – that was built around equity informed by African Socialism. The thinking around Sessional Paper No. 10 in terms of equity and development suffered bad leadership and poor governance in implementation right from when the paper was mooted. Governance institutions and state-owned enterprises suffered neglect, leading to poor service delivery and stunted development outcomes. It is largely argued that the Paper was drafted by the political elite and largely had no input from the implementers.

The Public Sector Transformation Strategy (PSTS) was the first real attempt at bringing down the reform agenda to public servants by involving individual Ministries Departments and Agencies (MDAs). Specifically, the strategy provided that every MDA in the public sector is to be goal-driven, and have systems, tools, organizational culture, and management practices in place to deliver demonstrable benefit to the citizens of Kenya now and in the future (OPM/PSTD 2010 in Hope 2012). Indeed, this was a clear attempt at targeting the behaviour of public servants. The intention was to achieve citizen satisfaction and public confidence in the sector, build interagency coordination and collaboration in service delivery, and, enable government institutions to conduct their business in a goal-driven manner. The latter means to plan, allocate resources, deliver, monitor, and report on the contributions they make to the lives of Kenyans. Implementation of the PSTS was vested with public sector institutions (Hope, 2012). This period was also characterized by the introduction of performance contracting that was to be cascaded downwards to individual employees in the public

service. Performance Contracting became the cornerstone of the PSTS and continues to drive service delivery and accountability in the public service to date.

The attainment of full benefits of performance contracting is, however, hampered by various challenges. For instance, resources that are very essential in coordinating and implementing performance contracts within government ministries, departments, and agencies (MDAs) are inadequate. Among these resources are sufficient finances to aid in activities facilitation at every phase of the performance contract process. This hinders efforts such as training of officers in the public service on matters to do with performance contracts. As such, it is clear that the uptake of training appointments on performance contracts is very slow, a fact which is greatly limiting its overall success. Further, some sectors of the public sector are yet to embrace performance contracting (Ong'era, 2019).

Public sector reforms have two official aims. The first is to adjust the functions and roles of the state in society to fit current government visions - issues of "what to do". The second aim is to improve the efficiency, effectiveness, legitimacy, and accountability of the state in carrying out those functions – issues of "how to do" it.

Recent reforms (Economic Recovery Strategy (ERS), Public Sector Transformation Strategy (PSTS), Public Sector Transformation Framework (PSTF) seek to improve government performance by building managerial capacities, developing positive organizational cultures, and providing incentives for performance both at an individual, organizational and country level. In this phase, some donors are allocating aid based on the country's performance. This shift from first to second generation reforms also implies that different questions were asked. Questions of the structural adjustment period about why African civil servants and organizations behave badly are now replaced by explorations about what will make them perform better.

The worker's voice to the reform agenda is yet to be seen. The involvement of the workers in the reform agenda should not be cosmetic but rather based on real consultations with feedback. This is because the workers are the implementers of the reforms and are the ones that meet the citizens seeking public services. For service delivery and improved public sector performance, the importance of worker involvement is paramount.

King and Grace (2005), observed that the concept of service delivery can be defined as a structured and synthesized approach to achieving a sustainable culture within an organization. Service delivery cannot be performed in an *ad hoc* manner but is a structured process of managing the people, business processes, and technology to align business strategies to the environment and enhance competitiveness in the market. Involvement of workers, therefore, is important since it first and foremost brings out greater employee commitment to service and the employer. Secondly, more and better ideas are generated whenever employees are involved. Thirdly, implementation and adoption of change are much easier since some of the proposed changes are from the employees themselves. The focus has now shifted to what will make the public servants perform better.

The Kenyan Health System has been facing many challenges that include declining trends of health indicators, health systems failure, dissatisfied customers/clients, and health providers resulting in high attrition rates. There also exist wide disparities in the quality of services delivered not only between public and private institutions of similar categorization but also across regions and towns and between institutions of disparate ownership and or sponsorship. Investments, particularly in infrastructure and human resources, have not been appropriately coordinated, with the result that these inputs are not rationalized or equitably distributed across the country.

The Constitution of Kenya, 2010, in its chapter on Bills of Rights is clear on the need to address the citizens' expectations of the right to the highest attainable standards of health including reproductive health and emergency treatment. The social pillar for the Vision 2030 indicates the need to improve the overall livelihoods of Kenyans, through the provision of efficient and high-quality health care systems with the best standards (Government of Kenya, 2011). To date, the challenges facing the public health sector remain unresolved and quality service delivery remains a mirage for many Kenyans.

Health care systems in developing countries remain weak as evidenced by lack of coordination, fragmentation of services, scarcity of resources, including drugs and supplies, inadequate and decaying infrastructure, inequity in resource distribution, and access to care and very deplorable quality of care (Welcome, 2011). Significant problems of public health systems in many countries are poor quality services, unequal distribution of resources, unequal procurement systems, and lack of supervision coupled with a high disease burden (Marmot & CSDH, 2007).

Kenya is not an exception when it comes to the difficulties of implementing policies in the health care sector (Glenngård & Maina, 2007). According to Nyaga (2016), the sector has embraced the adoption of modern technology resulting in improvement in service delivery. The author further argues that service provision or delivery is a function of efficient procurement and supply channels, investment in infrastructure as well as competent human resources drafted into the system. The increase in resources should lead to improved service delivery and enhanced access to services. Thus, according to World Health Organization (2008), ensuring the availability of health services that meet a minimum quality standard and securing access to them are key functions of a health system.

In the first three decades after independence, the people of the Government of Kenya enjoyed an impressive improvement in all health indicators. For instance, from 1960 to 1990 life expectancy rose from 43 to 62 years, infant mortality dropped during this period from 122 to 63 and under-five mortality declined from 204 to 93 per 1000 live births. However, most indicators showed deterioration during the 1990s, so that by the year 2000 the life expectancy was back to 49 years, infant mortality was some 83, and under-five-mortality some 134 per 1000 live births. The main reasons for this deterioration are the AIDS epidemic, the manifestation of resistant malaria, the epidemiological transition with an increasing burden of chronic-degenerative diseases. Strong inequity between the poor and the rich and rapid population growth are underlying factors driving negative health trends. Whereas Kenyan health budgets had risen in absolute terms, the health care services for most rural and urban poor have deteriorated (Flessa, *et al,* 2011).

The process of adapting the health care system reform is seen in perspectives of the Vision 2030, stating affordability, equity, quality and capacity as the main objectives of the entire social sector. Implementing the new constitution which was promulgated in August 2010, equally impacts the system design of the Kenyan Health Sector, especially in terms of decentralization and realizing the 'Right to Health' (ibid).

Access to quality and affordable healthcare remains one of the biggest global challenges today (Bangdiwala, *et al*, 2010). The provision of quality healthcare as a public service has been highlighted as one of the most effective ways of achieving Sustainable Development Goal number 3 on health. Service delivery within the health sector remains a challenge. Institutions in the health sector have been faced with challenges of neglect; poor planning and apathy by the medical staff in general (Tilson & Berkowitz, 2016).

The goal of Kenya's Vision 2030 for the Health Sector is to provide equitable and affordable health care at the highest affordable standards to its citizens (Atieno, *et al,* 2014). Good health is a prerequisite for enhanced economic growth, poverty reduction and a precursor to the realization of the Vision's Social Goals. In 2018, the Government of Kenya launched the Third Medium Term Plan, which prioritizes the implementation of the Big Four Agenda for the period 2018-2022. One of the key targets of this plan is the achievement of 100% Universal Health Coverage (UHC) by 2022. The key targets under this pillar include i) expansion of social health protection schemes to cover harmonized benefit packages to targeted populations and ensure that 51.6 million Kenyans have access to the National Health Insurance Fund (NHIF) by 2022. ii) Implementation of Linda Mama Project to cover 1.36 million mothers and babies; iii) Establishment of 10 new referral hospitals and 4 Cancer Centres; and; iv) Expansion of Managed Equipment Services to 120 hospitals by 2022 (GoK, 2018). The achievement of UHC is not only dependent on financial resources but also a factor of quality service delivered by public hospitals. Over the years, there has been a corresponding increase in budget allocations for the health sector. Despite this emphasis, the health sector has continued to be pegged by numerous challenges in service delivery.

Cognizant of the importance of making Kenyan products and services competitive, the Government of the Republic of Kenya issued a directive in 2010, that all public sector agencies should begin the process of ISO 9001:2008 certification and ensure that they are fully certified by 2012 (Amwayi, 2012). To ensure its implementation and monitoring, ISO certification was included as a performance contract requirement.

According to ISO (2015), to attain ISO Certification, organizations must submit documents that report their internal processes, procedures and standards. These

documents (or the Quality Management System), determine that an organization can provide quality products and services consistently. The International Standard, which is known as the ISO 9001:2015 gives a list of requirements for a system that an organization can provide quality products and services. Through the implementation of the standard, ISO 9001:2015 aims to improve customer experience and satisfaction. It also aims to improve the internal systems of an organization so that it can produce quality services and products while promoting a culture that is aimed toward growth and continuous improvement.

The ISO 9001 comprises 10 mandatory clauses that include scope, normative references, terms and definitions, the context of the organization, leadership, planning, support, operation, performance evaluation and improvement. Requirements 1-6 mainly cover the planning aspects, 7 and 8 cover implementations, 9 cover measurement while requirement 10 covers continual improvement. The mandatory requirements need to be complied with while non-mandatory requirements may be submitted for documentation purposes.

Formal ISO certification to International Standard ISO 9001:2015 follows after successful Quality Management System (QMS) implementation, operation and certification body assessment. While many international standards specify requirements, ISO 9001:2015 remains the most widely adopted QMS standard in the world. There are over 350 individual ISO 9001 requirements that organizations should adopt and integrate into their business processes when implementing an effective QMS. However, businesses must also consider and adopt any relevant contractual or customer requirements and relevant statutory and regulatory requirements that affect the functionality of products and services. Conformity assessment to ISO certification is carried out by an independent certification body that must be accredited to ISO 17025.

The requirements for attaining ISO certification are driven by the need for competitiveness.

A Quality Management System is a set of policies, processes and procedures required for planning and execution in the core business area of the organization. These are areas that can impact the organization’s ability to meet customer requirements. The QMS is described in various documents within the organization.

As stated in the ISO requirements, top management is responsible for the QMS while employees are responsible for delivering quality in their aspects of work. Depending on the organization's culture, top management usually delegates, by appointing quality professionals to upper-level management teams. A quality manager is often responsible for analyzing QMS data and performance evaluation by monitoring and measuring the achievement of the quality objectives, quality policies, undertaking internal audits and for improving the quality of products and services.

The introduction of ISO certification cut across the entire public sector and was aimed at improving service delivery (Njenga, 2013). Again, the process remained driven from the top but due to the requirements of the Standard, all employees were required to be involved in the process. Under this performance target, public sector organizations were supposed to achieve quality certification within three years and subsequently maintain certification status by complying with the Quality Management System (QMS).

Public sector organizations that have retained certification have since graduated from the 2001 Standard to the 2008 standard and now to the 2015 standard. The focus of this study is on the implementation and compliance with ISO 9001:2015 QMS certification at Kenyatta National Hospital as part of the reform agenda.

According to Ndirangu (2011), ISO Certification is a quality system that would meet the requirements of a recognized standard. Despite the apparent expense and bother, many organizations globally have quality systems that adhere to the requirement of the ISO and have received third-party accreditation. The ISO certification ensures that a certified company maintains a quality management system that will enable it to meet its published quality standards relating to the processes and activities for delivering goods and services by providing guidelines for the development, implementation, and management of a quality management system. Organizations must document practices that affect the quality of their products and deliver the procedures consistently to gain and maintain ISO certification. In short, ISO certification could be viewed as a system for managing internal business processes from the beginning to the end of a value chain.

Ndirangu (2011) further notes that several Government Departments and State Corporations have undertaken ISO certification to enhance their quality reputation or to fulfill expectations from the customers. The underlying motive for certification has an orientation in the sense that firms implement ISO standards out of external pressure, mainly clients' demands.

The adoption of quality management systems is expected to improve organizational efficiency in competitiveness and improved business performance. Regular third-party audits by certification bodies and internal audits establish both the effectiveness, whether the QMS has been developed to meet the needs of organizations and the certification standards; and the efficiency, whether the company is implementing its system optimally. Successful implementation of the QMS leads to improved customer focus and employee involvement and ultimately improved service delivery to the

citizens. Where the QMS has not implemented successfully incidences of customer dissatisfaction and poor service delivery are abound.

The Kenyatta National Hospital (KNH) is one of the oldest public institutions in Kenya. The Hospital was built to fulfill the role of being a National Teaching and Referral Hospital, as well as to provide a medical research environment. Established in 1901, as the Native Civil Hospital, with a bed capacity of 40, KNH became a State Corporation in 1987 with a Board of Management and is at the apex of the referral system in the Health Sector in Kenya.

As one of the oldest public institutions in Kenya, the Hospital has undergone various transformations as part of the wider public sector reforms. It, therefore, provides a model case for understanding reforms in the public sector and the place of the workers in these reforms.

Since 2007, KNH has been implementing several reforms aimed at improving service delivery. These include changes in the organization structure; review of the pay structure; adoption of quality management systems; performance contracting; development of service charter; automation of services and development of strategic plans.

Quality management initiatives have been undertaken at the Kenyatta National Hospital. Lean Six Sigma is a method of management employed to minimize operational waste to improve treatment outcomes while driving down costs of care and can be used in combination with Kenya Quality Management of Health (KQMH), 5S Kaizen that KNH is already implementing. (GoK 2011a). Six Sigma is a quality improvement system that strives to produce perfection in products and services. It uses facts, information and data to make decisions and manage business performance,

identifies root causes of problems and determines permanent solutions (Ehrlich, 2002). Both Joint Commission International Accreditation Standards for Hospitals (JCIASH) and Lean Six Sigma are geared toward a journey of culture change and continuous quality improvement. Full implementation of the KQMH results in ISO Certification for the Health facility (GoK, 2011a).

Standardization, accreditation, and assessment of health care organizations are inevitable to improve quality (Oliveira & Matsuda, 2016). On the other hand, a surge of external quality assessments has affected the health care delivery system over the last two decades throughout the world. Governments, service consumers, professional medical associations, managers of insurance companies, and other beneficiaries attempt to enhance the quality of health service delivery through the accreditation of activities. Both Joint Commission for Accreditation of Health Organizations (JCAHO) and Joint Commission International (JCI) standards provide a certain framework and a systematic approach for the efficient performance of the health care organizations, which can be the primary model for assessing these organizations.

In 2018 KNH attained ISO 9001:2015 certification. This represented an upgrade from the ISO 9001: 2008 certification. The certification was approved and issued by the Kenya Bureau of Standards after confirming that the Hospital had met all the requirements required in the revised Standard. However, it is important to note that the hospital has been implementing ISO 9001 standards since 2006 and has progressively moved from the 2001 Standard, the 2008 standard and subsequently to the 2015 standards.

1.2 Statement of the Problem

One of the key reforms that have targeted all public sector organizations in improving service delivery is the implementation of ISO 9001 Quality Management Systems and

subsequent certification. Implementation of ISO certification requires that employees comply with the requirements of the QMS. The success of such implementation is influenced by attitudes, perceptions and behaviors exhibited by the employees involved in the business processes. There is also a need for employee involvement in ensuring that they support the entire process. The lack of employee involvement leads to resistance to change and a lack of internalization of the requirements of the QMS. As a result, public sector organizations, such as Kenyatta National Hospital (KNH), are caught up with the dilemma of compliance versus commitment with anecdotal evidence suggesting that implementation is driven mostly by compliance with performance contract requirements as opposed to a commitment to improving the service quality. In as much as the organizations are certified, the quality of services provided remains below public expectations.

Adoption and successful implementation of the Quality Management Systems and reforms in general by the workers are dependent on many factors linked to their involvement. Firstly, the workers must have adequate knowledge of the expectations of the organization and their expectations. Secondly, they must have a positive attitude towards the outcomes of the initiatives. Perceived positive outcomes lead to favourable positive attitudes towards the proposed changes. Thirdly, the organizational norms around the changes must be favourable to allow for the changes to be internalized. Finally, the workers must demonstrate capability and ability to implement the changes.

Perhaps the events of February and March 2018, have led to lot more questions asked about the QMS implementation at KNH. On February 19th, 2018, Kenyans woke up to the news that a baby had been stolen at KNH while the father and mother sought treatment at the facility. The police were called and the culprits were identified and arrested (Daily Nation, 2018a). In another dramatic turn of events, doctors at KNH were

accused of conducting brain surgery on the wrong patient. (The Daily Nation, 2018b) Investigations into the latter incident have established the culpability of the nurse in charge. However, the underlying problem was compliance with the laid down procedures. This is a major concern in the implementation of the quality management systems in place. The two incidents and others not mentioned in this report are an indication of the workers of KNH failing to comply with the basic requirements of the quality management systems. This is although the hospital was in the process of upgrading to the 2015 Standard of ISO 9001. Certification and regular internal audits focus more on conformity (adjustment of behaviour), largely driven by management as opposed to compliance (Change in behaviour) that is based on workers' interaction with the standard. Literature has suggested that top management is responsible for the development of the quality management systems while the employees are responsible for the deliverance of quality to customers. Additionally, the absence of studies on employee everyday interactions with the standard makes it difficult to interpret the events and provide empirical data that will support decision-making.

There is not much literature on the implementation of ISO 9001 QMS and its effects on employee behaviour. The diversity of perceptions in the organization, the influence of the standard's relevance, personnel mobilization, and other themes remain underexplored in the literature. There is also a significant shortage of studies analysing the adoption of ISO 9001 QMS from the workers' standpoint. There is, therefore, a need to refocus attention on the employee and his everyday dealings with the standard, exploring how personnel interprets ISO 9001 QMS which in turn affects compliance. The study, therefore, sought to answer the following two questions:

1. What are the factors that influence compliance behaviour towards ISO 9001:2015 QMS implementation by workers at Kenyatta National Hospital?

2. To what extent do attitudes, norms and behaviour control influence compliance with ISO 9001:2015 QMS at Kenyatta National Hospital?

1.3 Objectives of the Study

1.3.1 Main Objective

The main objective of the study was to investigate the factors that influence compliance behaviour towards ISO 9001:2015 QMS by workers at Kenyatta National Hospital.

1.3.2 Specific Objectives

1. To establish compliance behaviour towards ISO 9001:2015 QMS implementation by workers at Kenyatta National Hospital.
2. To determine the effects of workers' attitudes on compliance with ISO 9001:2015 QMS at Kenyatta National Hospital.
3. To examine the influence of norms on compliance with ISO 9001:2015 QMS at Kenyatta National Hospital.
4. To analyse the extent workers' behavioural control affects compliance with ISO 9001:2015 QMS at Kenyatta National Hospital.

1.4 Justification of the Study

Organizational behaviour studies help scholars and practitioners gain insights into how workers behave and perform in the workplace. It is important to help build an understanding of aspects in the workplace that can improve motivation, increase performance and support organizations to relate better with their workers. Sociological concepts, theories and models support organizational behaviour through their contribution to the study of interpersonal dynamics like leadership, group dynamics, organizational culture, communication and conflict among others. By looking at attitudes, norms and behaviour control and applying a sociological theory, the study

makes a significant contribution to the existing body of knowledge in both Sociology and Organizational Behaviour.

This study provides useful additions to the existing literature on the adoption of ISO 9001 QMS from a worker's standpoint. In particular, it provides insights into the attitudes and norms that result in the introduction of the standard to public sector organizations. By using ISO 9001 QMS as a case study for reforms, the study will also provide a broader understanding of factors that influence the adoption of reforms in the public sector.

Additionally, the findings of this study may be adopted by the management of KNH and used to improve the adoption of organizational reforms and hence improve service delivery. By understanding how workers perceive the current reforms and what influences their behaviour, the management would be in a better position to improve on the architecture and implementation approach of any new reforms. Besides, information from the study will help the management better understand the behaviour of the workers and as such develop appropriate techniques for initiating reforms.

In summary, the management of KNH may use the findings of this study to chart a new strategic direction in improving service delivery.

1.5 Delimitation of the Study

Kenyatta National Hospital as a public institution has been implementing various reforms since 1987 when it was gazetted as a State Corporation. Like all public sector reforms, the aims have been to improve service delivery within the hospital. To provide an in-depth understanding of how workers interpret reforms, the study focussed on the adoption of ISO 9001 QMS certification, one of the reforms, as a case study. Interpretation of reforms was looked at by assessing the behaviour of workers. The

study was conducted amongst all employees of Kenyatta National Hospital, which is the largest referral hospital in Kenya. Finally, the findings of this study can be applied to understand the influences of compliance behaviour towards ISO 9001: 2015 QMS at Kenyatta National Hospital and to a large extent reforms within the wider public sector.

1.6 Organization of the Thesis

This thesis is organized into six chapters. Chapter one is the introduction that contains the background, the problem statement, the objectives of the study, the justification of the study and the scope of the study. Chapter two contains a review of related literature that also includes the theoretical framework. Chapter three contains the research methodology that includes the research design, sampling, data collection procedures and data analysis procedures. Chapter four contains discussions on the compliance with ISO 9001:2015 QMS by workers at Kenyatta National Hospital. Chapter five discusses the influence of attitudes, norms and behaviour control on workers' compliance with ISO 9001:2015 QMS at Kenyatta National Hospital. Finally, chapter six discusses the conclusions and recommendations of the study based on the findings.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents an analysis of relevant literature in the areas of public sector reforms, ISO 9001:2015 compliance, workers' attitudes, organizational norms and workers' behaviour control. The chapter also discusses in detail the theoretical framework as well as the study hypothesis.

2.2 Public Sector Reforms and Service Delivery

Public sector reforms in Kenya date back to the post-independence period with the enactment of the Sessional Paper No. 10 of 1965. Since then to date, the process has taken five distinct phases. Hope, (2012) and Oyugi, (2006) have identified some of the phases. The periods include Civil Service Reform Programme (CSRP) I (1993 - 1998); CSRP II (1999 – 2002); Economic Recovery Strategy for Wealth Creation (2003 – 2007); Public Sector Transformation Strategy (Grand Coalition) (2008 – 2012); Post 2010 Constitution of Kenya (Devolution) (2013 – Present).

CSRP I (1993 – 1998) was mainly aimed at reorganizing the civil service, improving staffing levels including the numbers; reviewing pay and benefits package; personnel management and training; financial and performance management to enhance transparency and accountability. The key achievements under CSRP I included downsizing of the civil service through the voluntary early retirement scheme and abolition of 26,000 posts; development of integrated payroll and personnel database system; decompression of salary scales; training policy; and unique identification numbers for civil servants to eliminate ghost workers (Hope, 2012; Kilelo, 2015). However, despite these achievements, CSRP I did not contribute significantly to the

improvement of the wider public sector performance with the quality of public service deteriorating further (Oyugi, 2006; Hope 2012).

Towards the end of 1999, the CSRP II (1999 – 2002) was initiated to improve the performance of the civil service in service delivery. It is largely built on the successes of CSRP I. The priority areas under CSRP II included rationalization of ministerial functions and structures; staff rationalization; management of wage bills; pay and benefits reforms; performance improvement initiatives; training and capacity building. Development of a medium-term expenditure framework; strengthening of government financial and accounting functions; and legal and judicial reforms were also undertaken during this period (World Bank, 2001; Oyugi 2006; Hope 2012). However, like CSRP I, CSRP II was deemed to have failed since it did not address declining public confidence in public sector management standards. Service delivery was at its lowest. Two main reasons were advanced for this failure. Hope, (2012) identified a lack of government commitment and lack of ownership. He avers that local ownership with control is a key principle for achieving results in reform programmes noting that it must be a local endogenous process that will better reflect local priorities and interests and avoid being donor-driven and/or imposed.

In 2002, Kenya went into a General Election, which culminated in the defeat of the ruling party KANU. The opposition under the National Rainbow Coalition (NARC) took over power and formed the new Government. The opposition was elected on a platform of reforms and commitment to do things differently. True to its word, the third phase of reforms kicked off in 2003. This was anchored in The Economic Recovery Strategy for Wealth Creation (ERS 2003 – 2007). The ERS 2003 – 2007 was aimed at strengthening the institutions of governance. This was based on the premise that good governance underpins sustainable development. At this time, the public sector was

characterized by wastefulness and inefficiency (Hope, 2012). For the first time, the reform agenda was shifting from the mainstream civil service to covering all institutions within the public sector (Hope, 2012).

The priority areas under ERS (2003 – 2007) included accelerating the ongoing ministerial rationalization; developing, introducing and institutionalizing performance-based management practices; undertaking job evaluation for determination of grading and terms of service; undertaking service delivery surveys and use of service charters; developing clear recruitment and training policy and putting all permanent secretaries and CEOs of state corporations on performance contracts (Government of Kenya, 2003; Hope, 2012). This phase was driven by Results-Based Management (RBM) as a framework for changing the culture and modus operandi of the public sector. RBM focused on achieving outcomes, implementing performance measurement, learning, adapting to change as well as reporting performance. The Rapid Results Initiative under the RBM was introduced to cultivate a strong focus on results and was used to attempt to fast-track improvements in service delivery and working conditions by several public sector institutions. This period was characterized by a lot of success as observed by Hope (2012). Quoting the Office of the Prime Minister, he observes that there was a success in delivering tangible results to citizens and this helped consolidate support for reforms. Economic growth was witnessed in all key sectors with the annual GDP growth rate hitting a record 7% in 2007. Key frameworks put in place during this period included strategic planning, performance contracting, annual work plans and service delivery charters.

However, the pace of these reforms was interrupted by the 2007 General Elections and the post-election violence that followed the elections. The negotiations that followed led to the formation of the Grand Coalition Government between the Mwai Kibaki Led

Party of National Unity and Raila Odinga's Orange Democratic Movement with the former retaining his position as the President and the latter becoming the Prime Minister under the National Accord and Reconciliation Act, 2008. Through Agenda Four, the stage was set for the fourth phase of the public sector reforms and transformation covering the period 2008 – 2012 (CIDA, 2009).

In 2008, the Government released a national vision and strategy. The vision known as Vision 2030 is the Government's development blueprint covering the period 2008 – 2030. An efficient, motivated and well-trained public service is one of the major foundations of the Vision with public service reforms further enhancing, among other things, performance contracting, building capacity in governance and inculcating public service values and ethics for national transformation. Additionally, this period of reforms is marked by two key developments in 2010.

These are the launch of the Public Sector Transformation Strategy: From Reform to Transformation (2010 – 2014), in January 2010 and the promulgation of the Constitution of Kenya in August 2010 (Hope, 2012).

The Public Sector Transformation Strategy (PSTS) was the first real attempt at bringing down the reform agenda to public servants by involving individual Ministries Departments and Agencies (MDAs). Specifically, the strategy provides that every MDA in the public sector is to be goal-driven, and have systems, tools, organisational culture and management practices in place to deliver demonstrable benefit to the citizens of Kenya now and in the future (OPM/PSTD, 2010 in Hope 2012). Indeed, this was a clear attempt at targeting the behaviour of public servants.

The PSTS was comprised of three components that included service and openness, coordination and cooperation and effectiveness and accountability. The first component

was intended to transform the delivery of public sector services and engagement with citizens to ensure services are available, accessible, and affordable and information about them is available and accessible. The intention was to achieve citizen satisfaction and public confidence in the sector. The second component sought to strengthen capacity across the whole government to coordinate and cooperate on policy development and program delivery. The focus was on building interagency coordination and collaboration in service delivery. The third component focused on enabling government institutions to conduct their ongoing program business in a goal-driven manner, which means to plan, allocate resources, deliver, monitor and report on the contributions they make to the lives of Kenyans. This means developing government institutions and ensuring that each of them is effectively and ethically able to fulfill its mandate. Additionally, several cross-cutting issues with potentially significant impacts on outcomes were identified. These included gender mainstreaming, youth mainstreaming, the challenge of HIV/AIDS, environmental management, drug and alcohol abuse and public sector governance. Implementation of the PSTS was vested with public sector institutions (Hope, 2012). The PSTS was implemented in 2014 and continues to inform various public sector reform initiatives.

The Constitution of Kenya 2010 was promulgated in August of 2010. The Constitution contains various principles and elements that have direct impacts on public sector performance, reforms and transformation. Specifically, Chapter 4 on the Bill of Rights and Chapter 6 on Leadership and Integrity provides standards of governance for the Country (Government of Kenya, 2010). In essence, the Constitution of Kenya, 2010, provided a supreme, lawful and legally binding basis for Kenyan public servants and their institutions to modify their behaviour in delivering public services and interacting with their fellow Kenyans in that pursuit. Both the Constitution of Kenya 2010 and the

PSTS are anchored in the view that efficiently and effectively delivering public service is not a privilege in a democratic environment but rather a legitimate expectation of Kenyans (Hope, 2012).

The period under the Grand Coalition Government was characterized by significant achievements in areas of education, agriculture, infrastructure, ICT, judicial reforms, taxation, women and youth affairs and energy and electricity. In his assessment of the performance of the grand coalition government, Schroiber, (2016) observes that the success of the reforms during this period exceeded all other periods in Kenyan reform history. He however observes that there were areas in which little success was recorded citing economic growth and poverty reduction. The promulgation of the Constitution of Kenya in 2010 was also a significant achievement as it set forth a new system of governance in Kenya in Devolution. He also notes that the key reforms in the judiciary returned public confidence in the institution. However, there was evidence of little change in accountability during this period owing to the grand corruption cases that were reported between 2009 and 2013.

The 2013 General elections marked two important milestones for Kenya. First, the country conducted elections under a new constitution that provided two levels of government that is the National Government and the County Government. Secondly, a new political party, the Jubilee Coalition won the elections and formed the Government. Interestingly, the opposition CORD won most of the County seats and had a significant number in parliament. In the first period of its administration, there was more focus on transitioning to a devolved system and more emphasis was put on passing legislation and setting up structures as provided for by the constitution. There was also dealing with a disgruntled opposition that was keen on frustrating the government agenda. The reform agenda at this stage took the backstage.

The lack of focus on accountability and service delivery led to a deterioration of service delivery. In fact, in an interview with the Africa Report in December 2013, the former Prime Minister, observed that:

> '...the rising cost of living though inflation has been contained… the regularity with which the police officers are caught committing crimes suggests they are systematically abusing their offices…. There is widespread industrial unrest… we are also seeing the emergence of a rogue parliament… a number of these proposed laws can cancel the democratic gains that have been made over the past two decades.'(www.theafricareport.com/East-Horn-Africa accessed on May 20th 2018).

The government revisited the transformation agenda in 2016. The strategy aimed at including county governments in the reform agenda since the provision of most services had been devolved to the counties. The key challenges faced at that time included: insufficient service delivery; centralized control and top-down management; inadequate accountability and transparency; weak management information; low productivity; poorly paid and demotivated staff; conflicting labour relations; and; professional ethos and work ethic (Government of Kenya, 2017). Other Challenges and constraints which had to be addressed included: brain-drain; citizen impatience at the pace of constitutional change; the vision of change; lack of clearly defined roles and responsibilities; weak co-ordination; persistence of a rule-bound culture in the Public Service; and inadequate skills and capacity (Government of Kenya, 2017). The government then launched the Public Service Transformation Framework (PSTF 2017 – 2022) (Government of Kenya, 2017). The PSTF (2017 – 2022), marked the fifth phase of the reform and transformation agenda being implemented in Kenya.

This Framework ushered in a new phase of reforms guided by the Constitution and the Kenya Vision 2030. It takes into account the aspirations of global and regional frameworks including Sustainable Development Goals (SDGs) and the African Union

Agenda 2063. For the Public Service to carry out its vital role in development, the performance, attitude and management approaches of public servants must be transformed. It is the transformation that will ensure the delivery of quality services to Kenyans. This, however, requires a shift of focus from process to result. The new path being charted is about integrating service delivery, ensuring that there is a clear line of sight from the Constitution, Vision 2030 and the Medium-Term Plans. It also includes a clear correlation with Sector Plans, Ministerial Strategic Plans, County Integrated Development Plans, Annual Work Plans, Performance Contract Targets and Staff Performance Appraisals (Government of Kenya, 2017).

The Public Service Transformation Framework agenda is set to focus on four key principles; transparency, collaboration, innovation and results-oriented. The Framework is premised on five key pillars, namely: (i) Human capital management, (ii) Transformative and value-driven leadership, (iii) Fit-for purpose public institutions, (iv) Effective and efficient service delivery, (v) Productivity, innovation and global competitiveness. The Framework, therefore, presents a “Do-It-Yourself’’ approach in Government entities across the Public Service are expected to adopt. The Framework also highlights how to build: high-performing institutions; transformative leaders; productive human capital; citizen-centred service delivery; internal effectiveness as well as accountability; and adopt lean management practices and techniques which focus on the effective use of resources to increase productivity and capacity. Fundamentally, it provides a blueprint for performance improvement programmes in the Public Service.

Lufunyo (2013) analysed the impact of public sector reforms on service delivery in Tanzania. The main question was to what extent the public sector reforms have contributed to or inhibited service delivery. The questions were identification of

reforms that have been affected, an assessment of its impact on service delivery and finally identification of challenges that affect the implementation of reforms. A review of documentary information relevant to the subject matter was made. Data were qualitatively analysed. Also, a descriptive approach was used for primary data. The study concluded that public sector reforms in local authorities for improved service delivery in Tanzania, in general, have had many positive results despite a few challenges. Findings justify that, currently, the contribution of public sector reforms in local authorities has a significant impact. Findings were in agreement with the literature that reforms are necessary for improved service delivery.

What then affects the successful implementation of reforms and specifically from a worker's standpoint? Wild *et al.,* (2012) focused on the common constraints and, incentive problems in service delivery. Their study aimed to identify common constraints and incentive problems that impair performance in social service delivery, provide a more systemic review of the evidence available on these constraints and present some implications of this for choices about service delivery mechanisms, financing, and aid modalities. The study identified five main categories of governance constraint: political market imperfections; policy incoherence; lack of performance monitoring; collective action challenges; and issues of moral hazard. Across the three-sector areas reviewed (education, health, water and sanitation), and across multiple countries, these categories describe general characteristics within the wider political system that can act as constraints to service delivery and which shape actors' decision logics and incentive structures.

D'Ortenzio (2012) in understanding change and change management processes in the Australian Public Services made several observations. He demonstrated the need for public sector employees to have a 'voice' in change and change management processes

and practices that affect them both in a personal and professional capacity. According to Batley *et al.,* (2010) the challenges to service delivery include Political- market imperfections concerning the relationships between politicians and citizens. These include a lack of credibility in the promises politicians make to citizens. Policy incoherence is another challenge both within and across sectors in policy design, structure and roles causing some parts of the entity policy design to become implementable. This can be horizontal, with overlapping mandates and confused responsibilities among co-providers and other public bodies. Finally, there is another service delivery challenge of ineffective performance oversight, where formal processes for monitoring and supervision are not followed and informal processes are insufficient. This includes cases where monitoring and supervision processes are not clearly defined.

The Health Sector in Kenya has not been free of these challenges either. The Government identified major challenges facing the health sector in Kenya as the poor system of performance management with the existence of unclear performance targets (GoK, 2017). The global health sector is characterized by long waits for medical care in public hospitals, which are sources of dissatisfaction for patients. There are cases of doctors accused of negligence of duty, drunkenness, failing to follow standard procedures during attendance to patients, and denying patients critical information on decisions like sterilization or family planning.

The health and human services sector is characterized by professional staff who hold considerable authority and autonomy, impacting directly on client and budgetary outcomes (Rigoli & Dussault, 2003). Structural change, by itself, will not change the behaviour of front-line practitioners due to barriers such as a low level of ownership for organizational outcomes; an inability to change clinical attitude and behaviour; low

levels of policy awareness and organizational deliverables (Parker *et al.*, 2008). Successful adoption of reforms must therefore address these barriers by targeting a behaviour change. This can be achieved through increasing policy awareness and organizational deliverables.

The setting of performance targets and continuous monitoring of performance also improve the adoption of service delivery. World Health Organization (WHO) describes targets as incentive mechanisms where an objective to be met in the future is established (WHO 2008). Targets associated with a measure represent a goal and standard to be achieved over time. Standards are statements that define the required key functions, activities, processes and structures so that various departments in an organization can provide quality services. Performance Standard or goals are management-approved expressions of the performance thresholds, requirements, or expectations that must be met to be appraised at a particular level of performance (Chegenye, *et al.,* 2013). Standards and goals for a given performance define an acceptable range of performance and falling below that level is said to be unacceptable. Employees need targets so that they can know what is expected of them (Smith, *et al.,* 2012).

Administrative reforms are normally characterized by intrinsic constraints, dilemmas, limitations, trade-offs and paradoxes (Pollitt *et al.,* 2011). The principles of organizational design tend to come in contradictory pairs and administrative reforms often happen in cycles and waves (Talbot & Johnson, 2007). Modernization of the state implies both integration and specialization and to achieve its intended effects a reform needs to balance these partly competing reform measures (Christensen & Lægreid, 2012). Pollitt *et al.,* (2011) argue that there seems to be a stimulus-response pattern between specialization and coordination. New public management reforms increased specialization, autonomy and fragmentation, which then triggered a return to more

integrated organizational structures and the use of instruments to improve coherence and coordination (Christensen & Lægreid, 2012). Thus, public sector organizations are complex multi-functional entities trying to balance partly contradictory goals and considerations. This seems to be a systemic feature of public sector organizations that needs to be taken into consideration when reorganizing the administrative apparatus, rather than regarding it as a disease that must be eliminated (Ostrom, 2008).

Organizations have to learn to live with trade-offs and dilemmas rather than searching for one generic solution (Lipsky, 2010). Trying to find the best way of organizing based on a "one size fits all" approach is normally not a successful reform strategy, partly because administrative reforms are often a political exercise with rather ambiguous roots in organizational or management theory (Andrews, 2013). We cannot expect a single dominant organizational principle but need to understand the competing principles, institutional complexity and the co-existence and mixes of different organizational forms (Olsen, 2007).

The Kenyan Health System has been facing many challenges that include declining trends of health indicators, health systems failure, dissatisfied customers/clients and health providers resulting in high attrition rates. There also exist wide disparities in the quality of services delivered not only between public and private institutions of similar categorization but also across regions and towns and between institutions of disparate ownership and or sponsorship. Investments, particularly in infrastructure and human resources, have not been appropriately coordinated, with the result that these inputs are not rationalized or equitably distributed across the country (Njunwa 2005).

The Constitution of Kenya, 2010, in its chapter on Bills of Rights is clear on the need to address the citizens' expectations of the right to the highest attainable standards of health including reproductive health and emergency treatment. The social pillar for the

Vision 2030 indicates the need to improve the overall livelihoods of Kenyans, through the provision of efficient and high-quality health care systems with the best standards (Government of Kenya, 2011). To date, the challenges facing the public health sector remain unresolved and quality service delivery remains a mirage for many Kenyans.

Health care systems in developing countries remain weak as evidenced by lack of coordination, fragmentation of services, scarcity of resources, including drugs and supplies, inadequate and decaying infrastructure, inequity in resource distribution, and access to care and very deplorable quality of care (Welcome, 2011). According to him, although health has the potential to attract considerable political attention, the amount of attention it receives varies from place to place.

Significant problems of public health systems in many countries are poor quality services, unequal distribution of resources, unequal procurement systems, and lack of supervision coupled with a high disease burden (Marmot & CSDH, 2007). Kenya is not an exception when it comes to the difficulties of implementing policies in the health care sector (Glenngård & Maina, 2007). According to Nyaga (2016), the sector has embraced the adoption of modern technology resulting in improvement in service delivery. The author further argues that service provision or delivery is a function of efficient procurement and supply channels, investment in infrastructure as well as competent human resources drafted into the system. The increase in resources should lead to improved service delivery and enhanced access to services. Thus, according to WHO (2008), ensuring the availability of health services that meet a minimum quality standard and securing access to them are key functions of a health system.

In the period after independence, Kenya enjoyed an impressive improvement in the provision of health care as evidenced by some of the key indicators. For example, between 1963 and 1990, life expectancy rose to 62 years from 43 years, infant mortality

declined to 63 from 122 and under 5 mortality declined from 204 to 93 per 1000 live births. However, between the 1990s and 2000, the indicators showed a declining trend with life expectancy dropping to 49 years, infant mortality increasing to 83 and under 5 mortality rising to 134 per 1000 live births. The main reasons attributed to this decline included the AIDS epidemic, the manifestation of resistant malaria, and the epidemiological transition with an increasing burden of chronic-degenerative diseases (Flessa *et al.,* 2011). Additionally, strong inequity between the poor and the rich and rapid population growth are underlying factors driving negative health trends. Whereas Kenyan health budgets had risen in absolute terms until 2005, the health care services for the majority of rural and urban poor have deteriorated (Flessa *et al.,* 2011).

The Health Care Reforms was the Government’s response to these declining trends. Based on a comprehensive "Health Policy Framework" (1994) two "National Health Sector Strategic Plans" (Health Sector Strategic Plan (HSSP) I: 1999-2004; HSSP II: 2009-2010) were approved, the latter building the cornerstone of the Kenyan health care reform. HSSP II provided the blueprint for innovations like the definition of a "Kenya Essential Package of Health" (KEPH), a "Community Strategy", and a "Joint Framework of Work and Financing" (JPWD) as an expression of the Sector-Wide Approach (SWAp) and a "Hospital Reform" aiming at more autonomy for provincial hospitals (now Level 5 Hospitals). These have been articulated in Kenya’s Vision 2030, where affordability, equity, quality and capacity became the main objectives of the entire social sector. Implementing the new constitution which was promulgated in August 2010 was to equally impact the system design of the Kenyan Health Sector, especially in terms of decentralization and realizing the 'Right to Health'. Access to quality and affordable healthcare remains one of the biggest global challenges today (Bangdiwala *et al.*, 2010).

The provision of quality healthcare as a public service has been highlighted as one of the most effective ways of achieving Sustainable Development Goal number 3 on health. Service delivery within the health sector remains a challenge. Institutions in the health sector have been faced with challenges of neglect; poor planning and apathy by the medical staff in general (Tilson & Berkowitz, 2016).

The current Kenyan Constitution that was promulgated in the year 2010 adopts a devolved system of governance that seeks to enhance efficiency, effectiveness, accountability and transparency amongst others in as far as the public sector is concerned (Kilelo, *et al.,* 2015). This was a radical departure from the highly centralized form of governance that had been in place since independence but resulted in political and economic disempowerment and unequal distribution of resources. The highly centralized government system also led to the weak, unresponsive, inefficient, and inequitable distribution of health services in the country (Ndavi *et al.,* 2009). Provision of health services is one of the functions that was devolved to the Counties. It is expected that a devolved health system will improve efficiency, stimulate innovation, improve access to and equity of services, and promote accountability and transparency in service delivery. Additionally, the goal of Kenya's Vision 2030 for the Health Sector is to provide equitable and affordable health care at the highest affordable standards to its citizens (Atieno *et al., 2014*). Good health is a prerequisite for enhanced economic growth, poverty reduction and a precursor to the realization of the Vision's Social Goals.

In summary, there have been numerous efforts in improving service delivery in public sector organizations in Kenya. Literature available suggests that there have been improvements in the delivery of services to the citizenry. However, the health sector is still facing challenges in meeting citizen expectations. It is also important to note that

evaluations on the impact of reforms have focussed more on the macro-level analysis i.e., at the institutional level. The analysis has also tended to focus more on the implementation of structures and systems. There is very little literature on the Micro level (individual workers) analysis and the interaction of the workers with the reforms. This has denied policymakers insightful information that would support the implementation of reforms. The place and voices of individual workers are hardly documented in the literature. Through this study, the influences on the behaviour of workers towards compliance are well documented and it provides a useful contribution to the much-needed micro-level analysis on the reform agenda as represented by ISO 9001 quality management system certification.

2.3 ISO 9001:2015 QMS, Importance, Compliance and Challenges

ISO dates from 1947, after a meeting at the Institute of Civil Engineers in London at which delegates from 25 countries met to coordinate international standards for industrial manufacturing (ASQ, 2015). ISO is a Greek word meaning "Equal". International Organization for Standardization (ISO) is the world's largest non-profit organization to develop and publish international management system standards on various subjects such as ISO 9001:2015.

Implementation of the ISO 9001 Quality Management system represents the basic precondition of a company's success and entrance into the market. This implementation of QMS is a voluntary process supported by the organization's strategy, motivations, policies and goals (ISO 2015). ISO 9000 certification can result in greater efficiencies, cost reduction, and improved productivity. ISO 9001:2015 promotes the adoption of a process approach when developing, implementing and improving the effectiveness of a quality management system, to enhance customer satisfaction by meeting customer requirements. ISO 9000 is a series, or family, of quality management standards, while

ISO 9001 is a standard within the family. The ISO 9000 family of standards also contains an individual standard named ISO 9000. This standard lays out the fundamentals and vocabulary for quality management systems (QMS).

ISO's fundamental mission is to provide common specifications, terms, standards, and units of measurement to organizations around the world. ISO does not provide certification or conformity assessment. Rather, it facilitates global trade and innovation to allow every organization in every sector from around the world to have a common language and common expectations for everything from technology and manufacturing to food safety, healthcare, and agriculture. ISO standards benefit organizations at the environmental, economic, and societal levels and help developing countries meet the United Nations Sustainable Development Goals through the ISO Action Plan for Developing Countries, a program that provides technical courses to assist developing countries in meeting international standards. ISO has published more than 22,000 standards since its first published standard in 1951.

ISOs overall mission is built on the following core initiatives for its members: Strengthening the links between standardization and public policy by providing thought leadership and promoting awareness of best practices; Identifying and building national standardization strategies by applying best practices; Ensuring the efficient operation of their organizations while managing financial; sustainability and risk; Ensuring participation of, and collaboration with, key stakeholders in all standardization projects; Increasing adherence to Good Standardization Practices (GSP) among standards experts in every national organization and evaluating all processes to determine their alignment with the World Trade Organization (WTO) Technical Barriers to Trade (TBT) Agreement.

These principles are the strategic basis for all decisions relating to Quality Management in the organization and are infused within all aspects of the ISO 9001:2015 language. Every organization will prioritize each principle differently at various stages of its development.

ISO (2015a) defines ISO 9001:2015 as an international standard dedicated to Quality Management Systems (QMS). It outlines a framework for improving quality and a vocabulary of understanding for any organization looking to provide products and services that consistently meet the requirements and expectations of customers and other relevant interested parties in the most efficient manner possible. The QMS is the aggregate of all the processes, resources, assets, and cultural values that support the goal of customer satisfaction and organizational efficiency. First published in 1987, the latest iteration ISO 9001:2015 replaced ISO 9001:2008.

Accordingly, ISO (2015a) provides a detailed description of what the 2015 standard entails. ISO 9001:2015 doesn’t dictate what an organization’s objectives should be or how to achieve them. In other words, it doesn't tell anyone how to run their business. It's a flexible standard that allows each organization to define for itself what its objectives and adherence to the standard ought to be. ISO 9001:2015 defines the guiding principles that can be used to create efficiencies by aligning and streamlining processes throughout the organization, to bring down costs, create new opportunities, meet regulatory requirements, and help organizations expand into new markets in which clients demand ISO 9001 certification (the last of which is increasingly crucial for businesses working in or with the public sector or serving as suppliers in automotive or private OEM (Original Equipment Manufacturer) scenarios).

ISO does not perform certifications to ISO 9001:2015. Instead, organizations engage an independent certification body to audit their QMS implementation against the ISO

requirements. Organizations of any size can certify to this standard, including smaller ones with no dedicated Quality resources.

ISO 9001:2015 contains a subset of tactical elements that complement the strategic principles provided above. These five elements, which represent a significant advance on ISO 9001:2008, are the Plan-Do-Check-Act cycle; Risk-based thinking; Leadership participation; Unified structure, and Clarified documentation requirements. (ISO, 2015b)

These elements are complementary and are highly integrated into the fabric of ISO 9001:2015. As such, discussing them in isolation from one another is somewhat artificial and carries the danger of misrepresenting the organic quality of the standard.

Plan-Do-Check-Act (PDCA) is a process approach that manages processes and systems to create a cycle of continuous improvement. It considers the QMS as an entire system and provides systematic management of the QMS from planning and implementation through to checks and improvement. PDCA helps organizations achieve better customer satisfaction and, consequently, higher levels of customer confidence in an organization's abilities to meet customer requirements.

Clause 4 in ISO 9001:2015 is “Context of the organization,” which deals with understanding the priorities of the organization and its stakeholders, as well as the risks involved with impending change. Context refers to all issues (internal and external, negative and positive) that impact an organization and that are impacted by the opportunities and risks at hand.

Since the understanding of these issues arises from strategic planning at the executive level, “Context of the organization” ensures that leadership becomes aware of the importance of the integrated QMS in the organization’s strategic priorities, which also

complements the priorities of Section 5 on Leadership Responsibilities. Organizations must also consider the scope of the QMS to ensure that its applicability and boundaries serve the requirements of interested parties (both internal and external) and the products and services that form the core of the organization's business. "Context" also covers an audit of existing processes and the requirements for new processes, as well as the resources and inputs needed to support them that the QMS might require.

Risk-based thinking has always been part of ISO 9001, but the 2015 standard has made this approach more explicit. While ISO 9001:2015 sometimes seems to present "risk" as the opposite of "opportunity," it provides a more nuanced concept of risk as it applies to an organization. In this approach, opportunities arise from favourable situations intended to achieve a positive result, such as developing a new product or enhancing an old one to attract new customers or enter a new market. Such opportunities can also carry risks associated with change. For example, enhancing an older product could alienate existing customers or create supply chain problems when sourcing parts to repair older models. ISO 9001:2015, therefore, defines risk not as the probability of loss or damage, but as "the effect of uncertainty." Risk carries a possibility of loss, but also the possibility of opportunity. Not all risks result in loss or opportunities, but an awareness of the circumstances in which each of them can arise results in a more effective QMS that facilitates positive results and mitigates negative ones.

ISO 9001:2015 does not provide prescriptive methods for implementing or documenting risk management in an organization. As with other sections of the standard, it is up to each organization to determine their approach to managing risk and the level of risk with which they are comfortable.

ISO 9001:2015 requires leadership to move from a position of supporting the QMS to participating in its success. Leadership is responsible for ensuring that the QMS remains

focused on customer requirements and for establishing and communicating the overall QMS policy for the organization. Leadership also has the following requirements for demonstrating its commitment to the QMS: Taking accountability for the effectiveness of the QMS; Ensuring that the QMS is aligned to the context and strategy of the organization; Integrating the QMS into the organization's existing processes; Promoting the QMS and risk-based thinking; Acquiring required resources for the QMS; Communicating the importance of adhering to the QMS; Ensuring the success of the QMS; Supporting the staff who maintain the QMS; Promoting the continual improvement of the QMS as well as Supporting leadership in other areas that support the QMS. For the leadership of many organizations, even those certified to ISO 9001:2008 or other standards, these new responsibilities presented fresh challenges.

Previous iterations of ISO 9001 have received criticism for placing an excessive burden on documentation on organizations. To meet this criticism, ISO 9001:2015 does not prescribe specific approaches to the governance of documentation. It is up to each organization to determine its approach to maintenance, retention, and disposition of all documentation.

ISO 9001:2008 adhered to the guidelines for QMS documentation outlined in ISO/TR 10013:2001, which distinguished between records, processes, and Quality manuals in a much more defined way. ISO 9001:2015 has simplified these categories to one overarching category of "documented information." ISO 9001:2015 uses the phrase "maintain documented information" to suggest working documentation that requires updating, such as procedures and work instructions, and uses 'retain documented information to suggest records, which are completed and archived documents that provide evidence of past conformity with requirements.

While ISO 9001:2015 does not explicitly state categories of documentation such as procedures, work instructions, quality manuals, and records, organizations should still look to the definitions and categories provided in ISO/TR 10013 for guidance on the options for documentation should be. It is, however, the responsibility of the organization to determine the best media or type for its documentation. Organizations can also look for guidance on documentation from their technical writers and business analysts. Where the term “information” is not preceded by “documentation,” ISO 9001:2015 does not require that the information be documented (ASQ, 2015).

This less prescriptive approach allows organizations to determine their scope for documentation and to scale the requirements to their resources. It is important to note, however, that the lack of prescriptive direction is not the same as reduced responsibilities for documentation. Section 7.5 lays out the general responsibilities for documentation that ensures the effectiveness of the QMS. Organizations must ensure that all documentation has adequate identifying information, is in a media format that facilitates easy and efficient interaction, and is regularly reviewed and approved by appropriate subject matter experts. Organizations must also ensure that documentation is subject to governance that addresses control, distribution, storage, retention, security, and disposition.

The inclusion of risk-based thinking in ISO 9001:2015 has a direct influence on the complexity of documentation required for each organization. Essentially, the greater the risk of uncertainty, the greater the requirements for documentation that effectively captures the complexity of that risk and the full extent of the actions the organization takes to mitigate it. ISO 9001:2015 is prescriptive regarding the processes that require documentation. This information is located throughout the standard and is not located

in a single section, which makes it difficult for the reader to quantify exactly what they need to do.

According to ISO.org, the ISO 9000:2015 and ISO 9001:2015 standards are based on seven quality management principles that senior management can apply to promote organizational improvement. The first principle is Customer focus which focuses on understanding the needs of existing and future customers; aligning organizational objectives with customer needs and expectations; meeting customer requirements; measuring customer satisfaction; managing customer relationships; aiming to exceed customer expectations and learning more about the customer experience and customer satisfaction. The second principle is Leadership, which focuses on establishing a vision and direction for the organization; setting challenging goals; modelling organizational values; establishing trust; equipping and empowering employees; recognizing employee contributions as well as learning more about leadership.

The third principle, which is also important to this study is the engagement of people. It involves ensuring that people's abilities are used and valued; making people accountable; enabling participation in continual improvement; evaluating individual performance; enabling learning and knowledge sharing; enabling open discussion of problems and constraints; learning more about employee involvement. This is the principle that puts people at the centre of the QMS. The fourth principle is the process approach. This entails Managing activities as processes; measuring the capability of activities; identifying linkages between activities; prioritizing improvement opportunities; deploying resources effectively; learning more about a process view of work and seeing process analysis tools.

The fifth principle focuses on improvement. This includes improving organizational performance and capabilities; aligning improvement activities; empowering people to

make improvements; measuring improvement consistently; celebrating improvements and learning more about approaches to continual improvement. The sixth principle involves evidence-based decision making that includes ensuring accessibility and accuracy of data; using appropriate methods to analyse data; making decisions based on analysis; and; balancing data analysis with practical experience.

The seventh and final principle focuses on relationship management and involves identifying and selecting suppliers to manage costs, optimize resources, and create value. It also involves establishing relationships considering both the short and long term as well as sharing expertise, resources, information, and plans with partners. Relationship management entails collaborating on improvement and development activities and recognizing supplier successes.

The Performance Contract Guidelines introduced by the Government of Kenya in 2003, made it mandatory for all public sector organizations to attain ISO 9001 QMS certification. The main objective was to achieve higher operational efficiency; increase customer confidence; raise staff awareness and involvement; as well as respond to global demands for quality goods and services. As of 2017, over 200 public sector organizations, that included ministries, departments and agencies had obtained ISO certification. A 2020 survey by ISO indicated that 536 organizations in Kenya had obtained 9001:2015 certification. These are in both the private and public sectors. The survey also notes that only 9 organizations in the health sector had attained certification (ISO.org 2021). The focus now shifted to ensuring that these organizations continue to maintain their certification and upgrade to higher standards (Ndirangu *et al.,* 2011, Obura *et al.*, 2018).

The government had identified challenges to service delivery in the public sector. The citizenry's confidence in the government was very low. Performance Contracts

originated from the perception that the performance of the Public Sector has been consistently falling below the expectations of the Public. Performance Contracting is part of broader public sector reforms aimed at improving efficiency and effectiveness in the management of public service. The problems that inhibited the performance of government agencies are largely common and had been identified as excessive controls, the multiplicity of principles, frequent political interference, lethargy poor management and outright mismanagement (GoK, 2005). The rationale for introducing performance contracts and hence QMS (amongst other indicators in the PC)) was to ensure that the public sector is transformed into being more focused and responsive to the needs of those it serves. The result will be a public sector directing its energies towards delivering targeted results for Kenyans and utilizing resources more productively

To effectively address service delivery challenges, public sector organizations need to identify and manage numerous linked processes to function effectively. The output of one process often forms the input of another process. “Process approach” is the “application of a system of processes within an organization, together with the identification and interactions of these processes, and their management to produce the desired outcome (ISO 2019). The concept of quality and the benefits it would confer on the health providers’ work and the outcomes for their patients have not been completely understood by health managers and providers (Mathauer & Imhoff, 2006).

There is general agreement in the literature that ISO has numerous benefits to organizations. Fonseca *et al.,* (2018) observed that reported benefits are risk-based thinking, mapping of the organizational context, and stakeholder identification. Simultaneously those were the issues that required more attention and effort to be mastered and implemented. Additionally, there is evidence that ISO 9001:2015 enhances both internal and external organizational issues and generates benefits for all

the researched dimensions. Moreover, it is possible to conclude that the perceived benefits from ISO 9001:2015 implementation and certification seem to be strongly influenced by two primary dimensions: the (smaller) organization size and the (lesser) international presence.

In a study of the University of Nairobi and ISO benefits, Moturi (2015) observes that Significant achievements have been realized concerning institutionalization of quality into the university processes, work environment, documentation and record management, customer satisfaction, infrastructure and facilities, use of ICT as a prime mover of performance improvement, and ranking of the university. Opportunities for improvement as well as critical success factors are presented.

Additionally, Ochieng (2015) observes that ISO 9001 certification influenced the return on net assets of the organizations thereby influencing their performance. There were significant differences in net asset value among organizations with ISO 9001 certification and those that did not possess the certification. On profit and revenue, there were no significant differences between the ISO 9001 certified and non-certified organizations.

In another study, Fonseca (2019) makes further observations on the perceived benefits of the ISO 9001:2015 standard. The author identifies the adoption of risk-based thinking as the major difficulty to be overcome, but simultaneously as the major benefit to being realized. The alignment with other management systems, the increased top management commitment, the identification of risks and opportunities and the knowledge management were also reported as significant benefits. The initial timing when organizations started working on the transition process and the activities carried out seem to differ between countries, while the adjustments performed to the existing management systems seem to differ by sector and size of the organization. The benefits

attained by the organizations vary according to the perception regarding the information resources made available and organizations should be aware of the advantages of early planning. The organizations that rated the benefits of ISO 9001:2015 adoption higher, considered the information resources as adequate and started working with ISO 9001:2015 at an earlier stage, while those that rated the benefits lower stated that the information resources were made available too late. A study by Brown *et al*., (in Noreha, 2017) found that QMS ISO 9001 had improved quality awareness and product, but not in productivity, costs, wastage rates, staff motivation and staff retention. Quality management is expected to create an environment that will boost up job satisfaction of an employee and perform his best for the organization.

Despite the known benefits, there are also challenges identified in the implementation of the ISO 9001:2015 QMS. Fonseca *et al*., (2018), observe that the primary drivers to successful implementation were linked to external factors. He observes that where external motivations were the primary drivers of ISO 9001:2015 implementation systematically rate higher all the benefits when compared with the rating ascribed by those organizations who claimed internal motivations. On the other hand, Almeida *et al*., (2018) identified factors that affect the successful implementation of the 2015 QMS including top management commitment, team commitment, training, responsibilities and authorities defined, schedule for implementation, quality culture, resource availability, integration between departments, level of bureaucracy, quality staff reliability as well as the level of awareness regarding the ISO 9001 significance. Understanding the critical factors is important to ensure that managers allocate resources appropriately during the implementation and maintenance of ISO 9001:2015.

According to Helgi (2015), organizations seem to look at the implementation of a quality management system as a project and they employ standard project management

tools, albeit to a different extent and in different ways. The commitment and direct participation of management was a key factor for a successful implementation, as well as direct participation of the employees, and good preparation and goal setting. It can be concluded that organizations that planned for their internal cost of implementation, that is the cost of direct participation of the employees, were likely to implement their quality management systems in the time they expected—and their time of implementation was shorter than for organizations that didn't look at this internal cost.

Noreha *et al.,* (2017) citing various studies observed that QMS ISO 9001 is a group of rules and processes which are interconnected that are implemented within departments in an organization, and to ensure those processes can execute harmoniously and achieve good quality and performance levels of goods produced or services provided. ISO 9001 had brought a lot of advantages and benefits to an organization such as improved productivity, consistency in quality, employee involvement, staff morale and job satisfaction. As institutions adopted QMS ISO 9001, it is expected that employees will contribute more and feel satisfied with their jobs and perform their best for the institutions. Employee satisfaction is described as how people perceive the rewards and benefits they had received and it is an attitude of an individual employee. In contrast, in the service sector such as the health sector, the implementation of QMS will influence employees to improve their performance.

Additionally, Aamer *et al.,* (2021) observe that the limited implementation of ISO 9001 certifications could be due to several internal and external factors such as the relatively low awareness level of the certification and guidelines, and the inconsistency of understanding the certification purpose. The benefits focused solely on improving the quality of systems efficiency and increasing quality awareness, and not on internationalization.

What then is compliance with the ISO 9001:2015 QMS and what are the factors that affect compliance? ISO audits are undertaken to establish conformity to the QMS and where there is no conformity, a non-conformity report is issued to the organization with corresponding corrective action reports.

The Open Education Sociology dictionary defines conformity as adherence to accepted behaviours, norms, standards, and values; acting as expected; maintaining the status quo. People conform to group pressure because they are dependent on the group for satisfying two important desires: the desire to have an accurate perception of reality and the desire to be accepted by other people. People want to hold accurate beliefs about the world because such beliefs usually lead to rewarding outcomes. Organizations seek to conform to laws, regulations and standards simply because they want to maintain legitimacy as well as provide goods and services that are acceptable to the general public. ISO 9001:2015 seeks to ensure that organizations conform to the international standards as prescribed in their quality management system. Conformity is therefore a change in behaviour to fit prescribed norms or standards.

On the other hand, compliance refers to when an individual changes his or her behaviour in response to an explicit or implicit request made by another person. Compliance is often referred to as an active form of social influence in that it is usually intentionally initiated by a person. The influence could be explicit such as work instructions or implicit usually based on rewards and punishment. Studies on social psychology focus on people as a whole and how thoughts, feelings and behaviours allow individuals to attain compliance and/or make them vulnerable to complying with the demands of others. Their gaining of or submission to compliance is frequently influenced by construals—i.e. an individual's interpretation of their social environment and interactions. Aronson *et al*., (2010), opines that studies on compliance aim to

examine overt and subtle social influences experienced in various forms by all individuals. Implicit and explicit psychological processes are also studied since they shape interactions. This is because these processes explain how certain individuals can make another comply and why someone else succumbs to compliance.

Within the ISO vocabulary, compliance is viewed as part of conformity. ISO compliance refers to a quality management standard used by organizations to prove that they provide services and/or products that meet certain requirements. These requirements are regulated by the ISO 9000 series which is the only quality standard that businesses can aspire to. Compliance means that the management system fully adheres to the requirements of the standard. Certification means that the management system has actually been certified to be in conformance (compliance) with all the requirements of the standard. (ISO, 2015a). Compliance is commonly referred to as following the instructions – you need to do only what you are told to do. This is the most simplistic definition. However, within the ambit of the quality industry and quality management functions, the definition of compliance gets complex. It has some key traits including legality/standards/requirements specified as the most fundamental one through which the legal implementations are carried out. The second key trait of compliance also gets reflected through the first key trait that legalities/standards applied are the requirements that are specified externally to the person(s) or organization. On the other hand, conformance is referred to as doing something in a recognized way – you need to follow the guidelines for attaining product quality so that it serves the intended purpose. It has wide implications throughout the different facets of life; not being limited to work life. The act of going against the specified guidelines results in a non-conformance. The main objective of keeping the quality systems and their application conforming is to ensure improved products and processes that a company

may have established to deliver consistent results, products, or services. The standards of conformance may change for different locations and situations based on the acceptable things for that particular marketplace. But in any industry, having all the operations in place and implementing the best practices are required to meet conformity (ISO 2015a).

ISO compliance is achieved when an organization meets the requirements outlined in a specific standard developed by the International Organization for Standardization (ISO). ISO has developed thousands of standards which cover all areas of business. They are frameworks used by organizations to embed internationally standardized business practices (ISO 2015a). The benefits of ISO compliance are twofold: driving improvements to internal business operations and enhancing external reputation. ISO compliance means the organization utilizes processes and procedures developed by experts. When up scaling or optimizing operations, ISO compliance helps organizations align with international standards.

Finally, Weaver (2014) identifies several factors that affect compliance within organizations. The first factor was perceived incentives linked with compliance. This included factors such as incentives, sanctions and monitoring problems. He opines that in an organization where there are no systems to reinforce this then compliance levels are bound to be low. Secondly, he identifies willingness to comply. This, he notes that is linked to information and cognition problems and attitude and beliefs. Where there is inadequate information and negative attitudes about organizational initiatives, then there is bound to be lower levels of compliance. Finally, he identifies capacity to comply which he links to lack of awareness and understanding and resource and autonomy problems.

Awareness and employee engagement then become key pillars of success in the implementation of the standard. Mukwakungu *et al.,* (2018) defines employee awareness as a level to which an employee knows certain policies, situation, documents or any other important information. Policy of systematically increasing of employee awareness is an important element of employee engagement strategy. Employee awareness has two important sides. Firstly, it fosters integrity in the staff: sharing and nurturing corporate culture and ethics, improving communications and commitment, code of conduct, among others. Secondly, it ameliorates practical knowledge on the enacted corporate policies and workplace procedures, comprising routine operations, business processes and emergency actions (Mukwakungu *et al.*, 2018).

The authors note that many of companies and organizations have their programs for improvement of employee awareness that includes knowledge on company's strategic goals, policies to reduce energy and time waste (or other saving options), decreasing operational costs and increasing efficiency, improving knowledge and professional attitudes, because the higher employee awareness the better competitiveness of the company. In a big number of companies yet employee awareness initiatives can be characterized as just fragmentary efforts which cannot gain serious results (Mukwakungu *et al.*, 2018).

On the other hand, employee engagement is a complex approach to establishing relationships between the employees and management, aimed to form up a really effective team from a slack workgroup by cultivating positive behaviours and approaches to work. Employee Engagement means certain redistribution of managerial authorities and competencies in favour of employees (Mukwakungu *et al.*, 2018).

Engaging employees into proactive working activities is a way to increase their self-organization and to share with them the responsibility for results of a task or a project they are involved into (to improve their feeling of ownership on results, self-confidence and to stimulate them to strive harder towards success). Employee Engagement struggles for the following results: Employees are granted more autonomy in making decisions; Employees get less of strict directives, but get more possibilities for self-management; Employees are more amenable to themselves, so they have to analyse impact of their decisions; Employees may join a common partnership (may become shareholders of the project); Remunerations of employees are linked to results of their work; Management leads and inspires the employees, but not rule them with rigid directives; and; Employees are trusted and involved into work planning and business decision-making (Mukwakungu *et al.,* 2018; Nolan 2015).

Finally, studies have also shown that other socio-demographic factors may affect adoption of reforms and by extension compliance in organizations. The age of the employee may have an impact on how well the company adopts changes. In their studies, Aba (2019) observe that the age of employees may have positive or negative effects on adoption of changes in the organization. The author notes that older employees bring about experience, critical knowledge, stay longer in the jobs and can train the younger employees. On the flipside, the author notes that younger employees bring about new thinking, are less expensive, learn faster and respond faster to change. These arguments are also supported by Heather (2019).

Number of years in service has also been identified as another factor that affect adoption of change in organizations. Prowse (2019), observed that long serving employees have knowledge of the company culture, products and services, they are also able to transfer

knowledge and skills and give a positive indication about the workplace environment. The downside of older employees include resistance to change, they are slower to take up new initiatives as well as expensive to move them from one post. Level of education has also been identified to affect implementation of change in an organization. Cipoleti (2017), observes that educated staff can handle complex projects, are easier to impact new ideas, are more goal oriented, are amenable to on-going training and are innovative thinkers. Their biggest downside is that they can lead to a fragmented culture and establishment of silos in organizations.

In summary, there is general agreement in literature that the introduction of ISO standards to organizations leads to improved quality, improved staff motivation as well as increased employee involvement and productivity. Literature has also suggested that retention of certification is pegged on compliance with the QMS. Compliance is viewed from a conformance perspective and a documentation perspective. Whereas studies have identified different factors that affect compliance, there is a pointer to either external driven factors such as customer pressure and government regulations or internal driven factors such as the organization's desire to improve and remain competitive. However, the literature is silent on the overt and subtle influences that affect compliance. These include issues such as communication, decision making and staff motivation. There is therefore need to provide additional evidence of compliance levels from a behavioural perspective as well as the key challenges faced by public sector organizations in pursuit of compliance. The behavioural aspects include attitudes, normative influences as well as behaviour control.

2.4 Workers' Attitudes and ISO Compliance

The association between attitudes and behaviours depends on the level of generality of the two. Specific attitudes predict specific behaviours, and broad attitudes predict broad behaviour patterns. A now-classic study of this problem was conducted by Fishbein and Ajzen (1974) to compare the prediction of specific behaviours and multiple behaviours as a function of attitudes towards a specific object. Attitudes towards religiosity were measured with five different types of scales, including simply self-reporting attitudes towards being religious, a measure composed of five semantic differential scales (e.g., good-bad; harmful beneficial), a Guttman scale, a set of Likert scales, and a Thurstone scale.

Attitude is derived from a Latin word "Optus" which means ready and fit for action. The concept "attitude" is one that has been frequently studied in social science. There is no universally accepted convention where definition and measurement are integrated. A psychological definition of attitude identifies a verbal expression as behaviour. Those who use a psychological definition of attitude attempt to reduce prejudice and discrimination by changing attitudes. A sociological definition of attitude looks at verbal expression as an intention to act. Common to sociological definitions is the view that an attitude is a "mental position with regard to a fact or state or a feeling or emotion toward a fact or state" (Merriam Webster's Online Dictionary). Those whose use a sociological definition of attitude attempt to reduce prejudice and discrimination by changing behaviour (Chaiklin, 2011).

Earlier, attitude referred to something that could be directly observed like, the moves of fighters in a boxing ring. However, in the context of psychology attitude can be defined as the feelings and thoughts of an individual regarding an object or event. New researches suggest that attitude cannot be observed directly because it's the cognitive

process that compels individuals to act in a certain way. Attitude precedes behaviour and it guides and influences the actions of an individual. This suggests that, the choice of men social conduct in a given situation depends on formed attitude. Currently, the concept of attitude is considered the most important predictor of behaviour in psychology. Many researchers have developed interest in social cognition because, attitude is an important pervasive factor in human life, without which it's difficult for researchers to analyse individuals' social conduct and relationships with one another. (Kasi, 2019)

Tri-component model or three component model is the best widely recognized framework of attitude structure. The model can be traced back to the work of Carl Hovland and Milton Rosenberg 1960. However, this model categorized the structure of attitude into three components including, cognitive, affective and behavioural. Cognitive component refers to the thought or thinking through which an individual develop belief about an attitude object. Affective component are the negative or positive feelings of an individual about given attitude object. Behavioural component refers to the action of an individual towards attitude object (Kasi, 2019).

Kasi (2019) further notes that, the model suggest that the attitude is permanent rather than temporary, momentary feeling towards an object is not an attitude. Additionally, attitude is limited to socially significant objects or events. Attitude is generalizable and abstract, an individual attitude is not formed for a given object based on a single event in one place at single time though it is formed through individual overall experience with attitude object for instance, if you need a specific book and it's not available in a given library, you will not develop a feeling of dislike towards library based on the occurrence of single event however, if your overall experience was bad due to the

unfriendly staff, unavailability of books and bad study environment, you may develop a feeling of dislike towards a given library.

Ajzen (1989) defined attitude as an individual disposition to respond favourably or unfavourably to an object, person, institution or event or any other discriminable aspect of the individual’s world.

He notes that although formal definitions of attitude vary, most contemporary social psychologists seem to agree that the characteristic attribute of attitude is its evaluative dimension. He further notes that attitude is a latent variable or hypothetical construct. Being inaccessible to direct observation, it must be inferred from measurable responses, which must reflect positive or negative evaluations of the attitude effect.

The different types of responses fall in three categories that include cognition, affect and conation. Under cognition, expressions of beliefs about attitude object (verbal) and perceptual reactions to attitude object (non-verbal) are the responses used to infer attitudes. On the other hand, expressions of feelings towards attitude object (verbal) and psychological reaction to attitude object (non-verbal) are the responses used to infer attitudes. Finally, expressions of behavioural intentions (verbal) and overt behaviours with respect to attitude object (non-verbal) are used to infer attitudes. He concludes by saying that attitudes are merely related to beliefs, they are actually a function of beliefs i.e., beliefs are assumed to have causal effects on attitudes (Ajzen, 1989).

In summary an attitude’s affective component is the emotional or feeling part of the attitude. This component can lead to behavioural outcomes. The affective component is concerned with a person's emotional reactions and includes whether such reaction is positive or negative, good or bad, desirable or undesirable e.t.c. for example, A person who believes hard work earns promotions may feel anger or frustration when he or she

works hard but is not promoted. Cognitive component of attitude refers to the thought, perception or ideas of the person toward the object of the attitude. It is the culmination of knowledge and beliefs affecting a person's attitude towards various concepts. The cognitive component of attitudes refers to the beliefs, thoughts, and attributes that we would associate with an object. It is the opinion or belief segment of an attitude. For example, snakes are poisonous or ISO is good for the organization. It refers to that part of attitude which is related in general knowledge of a person. Finally, Behaviour component of an attitude consists of a person's tendencies to behave in a particular way toward an object. It refers to that part of attitude which reflects the intention of a person in the short-run or long run. Using the above example, the behavioural attitude maybe- 'I cannot wait to kiss the baby', or 'we better keep those smokers out of the library or I do not intend to comply with ISO procedures.

Does Attitude affect the adoption of changes in organizations? In a study of employee attitudes and performance Brayfield (1995) established that Job satisfaction does not imply strong motivation for outstanding performance; and productivity may be only peripherally related to many of the goals toward which the industrial worker is striving. Strong motivation is a function of attitudes due to the perceived outcomes of the employee's behaviour. On the other hand, Thompson (1996) undertook a study on employee attitudes and organization performance. He concluded that Strong relationships were found for customer satisfaction, absenteeism, second level grievances, safety, and profits in the expected directions. In the second phase of his study, a qualitative research project was conducted to determine those aspects of the organizational climate that were associated with the high scoring groups but not with either the average or low scoring groups. Strong evidence was found indicating that the

presence of a caring, involved leader was the critical ingredient in the organization's success.

In a 2018 study, Thompson *et al.,* (2018) established that workers who hold more negative beliefs are less likely to receive help from peers (and supervisors), report more negative job attitudes, and have lower levels of in-role performance, citizenship behaviour, and creativity. Furthermore, employees with more negative beliefs about accepting help from co-workers are seen less favourably by their supervisors. Koo, (1998) in a study of how a company in Hong Kong applied a longitudinal employee attitude survey as a monitoring tool in its journey towards acquiring the ISO certificate. Quality success drivers were found to be the key determinants for the perceived strengths of the company. A study by Magd *et al.,* (2003) on management attitudes towards ISO certification established those Egyptian organisations have a high level of understanding of the purpose of ISO certification. The main motivators behind the implementation of certified quality system in Egypt were to improve the efficiency of the quality system, and to cope with pressures from competitors/foreign partners. The principal perceived benefits of ISO 9001:2000 for Egyptian organisations include improved documentation, improved efficiency of the quality system and more effective supplier selection.

A strong positive attitude is important aspect in adoption of changes in the organization. There are several advantages to this. Joseph, (2019) identifies four key advantages of a strong positive attitude. First, he notes that a strong positive attitude fosters management of change and adaptability. He notes that employees who display a positive attitude toward change may welcome and even embrace it, as they may view it as a chance to enhance their skills. As a result, they may adapt to change more quickly than an employee with a negative attitude, reducing the time it takes to implement

change in a productive manner. The second advantage involves enhancement of team work. To him, employees who embrace diverse workers and are willing to assimilate them into their team can foster a spirit of cooperation, making the team more productive in the process. The third advantage includes innovation. Workplace attitude can affect the presence of innovation and creativity, which can lead to increased productivity. Workers with a positive attitude toward their job and the company are more likely to make helpful suggestions or ideas that help the business grow. On the other hand, workers with a negative attitude may only be concerned with producing enough to get by while having little interest in innovation. Finally, he observes that a strong positive attitude contributes to retention of staff and reduces turnover. Employees who feel good about their jobs and workplace may be less likely to leave for greener pastures, helping companies to minimize the productivity gap associated with turnover. Employees with negative attitudes may eventually seek an improved work situation and decide to leave the company.

In conclusion, there is general agreement in the literature that attitude is the most important predictor of behaviour. Literature has also identified the three components of attitude that include cognitive, affective and behavioural components. The importance of workers' attitude in organization performance has also been elaborated in literature available. However, in the theory of planned behaviour discussed elsewhere in this chapter, other predictors of behaviour are introduced. In the theory, the proponents point out norms and behaviour control as being other important predictors of behaviour. The authors also introduced a bi-component structure of attitude that comprises only of experiential and instrumental aspects. Aside from determining the most important influence on workers' behaviour, there is also need to look at attitude in the context of adoption of organizational reforms, which is inadequately covered in the literature.

2.5 Norms and ISO Compliance

There has been varied definitions of Norms. However, there is general agreement that norms are established rules of conduct determined by culture. Norms define rules standards and ideas that provide social order, guide individuals, determine right and wrong, positive and negative (Perkins, 2003). Organizational Norms is a set of rules for human behaviour in the organization. Organizational norms regard information sharing for example as usual, correct and socially expected work place behaviour. Norms are also elements that affect behaviour in organizational culture, institutionalize and strengthen the social system. They are codes of conduct and criteria adopted by the majority of employees, which are developed in accordance with the cultural values of an organization.

It is also important to distinguish norms from values. Values are standards that people have created to define good, right, beautiful and ugly. In many places, it is seen that value is mixed with culture. While norms are distinct and guiding, values comprise of abstracts and general concepts. Norms are learned in the individual's socialization process, while values are instilled through culture. An organization's value system defines what is good or bad for members of the organization, what can be desired or not, what should or should not be done and forms the basis of behaviour. Norms are therefore formed within the organization depending on basic values. Norms are social rules and standards that guide members of the social system in explaining and interpreting events, phenomena and situations (Borsari *et al*., 2003; Perkins, 2003; Cialdini, 2003).

Norms are either descriptive or injunctive. Injunctive norms reflect people's perceptions of what behaviours are approved or disapproved by others. They assist an individual in determining what is acceptable and unacceptable social behaviour. In other words,

injunctive norms represent what we think other people approve or disapprove of. Descriptive norms involve perceptions of which behaviours are typically performed. They normally refer to the perception of others' behaviour. These norms are based on observations of those around you (Borsari *et al.*, 2003). Descriptive norms represent how people actually behave, regardless of whether the behaviour is approved or disapproved. For example, an injunctive norm that almost all people share is that littering is wrong, however, there are still plenty of cases in which people litter. According to Cialdini *et al.,* (1990), Injunctive norms assist an individual in determining what is acceptable and unacceptable social behaviour. This would be the morals of your interpersonal networks and surrounding community. For example, you leave the concert and walk into a library. You automatically lower your voice to a whisper as you ask the librarian for directions to a particular section. Why? Because that's what you're supposed to do in a library: It's the injunctive norm.

Descriptive norms involve perceptions of which behaviours are typically performed They normally refer to the perception of others' behaviour. You're watching a concert and as the musicians stop playing, everyone else stands up and starts clapping. You most likely will stand up and begin clapping too. Why? Because that's what everyone else is doing: It's the descriptive norm.

Both kinds of norms motivate human action; people tend to do what is socially approved as well as what is popular. When put together, these norms have a counterproductive effect. For example, a campaign that focuses individuals on the frequent occurrences of an offense against the environment has the potential to increase the occurrence of that offense" (Borsari *et al.*, 2003) These two norms are constructed from three sources: observable behaviour, direct/indirect communication and self-knowledge. Observing others behaviour is the easiest form of norm information.

However, it is susceptible to the fundamental attribution error. The fundamental attribution error is the tendency of individuals to view others' behaviour as a trait rather than a factor influenced by situational variables Direct (what words mean) and indirect (what words imply) communication, also has its flaws. Information may be distorted intentionally or unintentionally. Personal attitudes and behaviours also have an influence over the perception of norms. However, it is highly susceptible to "the false consensus effect." The false consensus effect is when a person thinks that others think and act as they do. These different sources of information about norms can sometimes lead to inaccurate perceptions about other's behaviours and attitudes.

Borsari and Carey's metadata analysis of studies showed that people misperceive injunctive norms more than they do descriptive norms, and that injunctive norms are more likely to predict drinking behaviour and negative consequences of drinking. However, the use of both in social norms campaigns has shown that it is unclear which type of norm is more likely to change behaviour (Perkins, 2003).

Why are norms important in organizations? Stamper *et al.,* (2000) notes that norms exist in a community and will govern how members behave, think, make judgements and perceive the world. The shared norms are what defined a culture or subculture. A subculture may be a team who know how to work effectively together, and their norms include a solution to their organisational problems. Norms can be represented in all kinds of signs, whether in documents, oral communication or behaviour, in order to preserve, to spread and to follow them. However, one cannot always put hands conveniently on a norm, as one might grasp a document that carries information through an organisation. The authors further note that a norm is more like a field of force that makes the members of the community tend to behave or think in a certain way. People do not always conform to every organizational norm, but the encompassing, informal

culture will provide the norms that govern how far it is reasonable to depart from the norms specific to the organization and also how other people will react to those departures. Any lack of suitable cultural meta-norms will limit how far it will be possible to organize at all. Behaviour which is not governed by any kind of norms is, by definition, intrinsically chaotic or random. We can of course have norms (tolerance or even admiration of eccentricity, withholding of judgement for a while and so on) that permit or even require random behaviour which is, of course, important in changing organisations especially when the organisations are trying to learn or solve problems such as poor implementation of ISO QMS.

Finally, Stamper *et al.,* (2000) identifies norm governing behaviour. To them, any social group, from an extended family to an organisation, that has the ability to sustain itself despite a turnover of membership, requires three kinds of norm-governed behaviour: autopoiesis, learning and interaction. Autopoiesis is the self-referring behaviour that enables the structure to maintain itself. Without that internal coherence, the structure dissolves back into the broader, encompassing culture and ceases to be capable of interaction with other structures, sustaining an identify and being regarded in anyway as responsible. Interaction depends upon chains of norms where conditions depend on external states of affairs and lead, perhaps through many steps, to consequents which dispose group members to intervene externally, whereas autopoiesis depends on loops of norms concerned with internal states and actions. Group coherence demands channel capacity for autopoiesis, the loss of which accounts for the disappearance of extended family groups in western societies over the last century. But organisations must achieve a balance between autopoiesis and interaction to survive; this is why all major successful companies must interact with the business environment very closely to avoid the danger of self-absorption and to sustain their business positions. Learning, the

behaviour of continual adjustment of its norms, lies between autopoiesis and interaction, enabling the group to observe its environment, reflect upon itself, change its norms so that it can behave externally differently and more appropriately in future. The transformation of many small and medium companies into leaders in their business sections exemplifies that.

Scholars have drawn a strong relationship between Norms and Organization Culture. In fact, in some instances the two are used interchangeably albeit different. Culture and norms have a distinct relationship to organization performance. Cultural dimensions reflect beliefs, values and assumptions that workers carry with them to the workplace. Culture is the composite of individuals, but each individual may have his/her own values that correspond or conflict with those of the general society. The degree of congruence affects how well a given individual will function in that society (Mulins, 2010).

López-Fresno (2010) notes that different organizations have different work cultures set in places, which they implement. Organizational culture has brought about a radical change in the functioning of different organizations. It is the study of organizational management and studies, which includes the description of attitude, psychology, and belief, and experience, personal and cultural values of an organization. Like varied personalities, there are different types of organizational cultures that function, by following a method of working that is best suited to their core business.

Recognition of the specific cultural characteristics of different country environments may help frame a reform program that meshes better with health worker values and, hence, is likely to have a more positive effect upon worker motivation (Franco, *et al.,* 2002). On the other hand, health sector reform frequently aims at changing some of the “developing country environment” characteristics. This may in the long run bring

about improved performance but it should be recognized that such reforms are attempting to change work behaviours that may be deeply embedded in the cultural fabric (Mathauer *et al.*, 2006).

Often a key thrust of reform programs is to create a stronger link between performance and reward. However, this may conflict with values present in many developing country societies which emphasize the importance of seniority, age, and experience (Franco e*t al.*, 2002). For example, implementation of merit-based promotion systems may lead to uneasiness among workers if younger people are promoted to higher positions than more senior employees. If the cultural values are very strong this may paralyze the organization, as employees feel reluctant to take orders from younger bosses and instead seek informal advice from more senior, but lower level, staff (Branham, 2012). On the other hand, cultural values in some developing countries emphasize collective rather than individual action. In such a cultural context, reforms engendering a performance orientation among a group or team of workers may be found very acceptable (Franco *et al.*, 2002).

Some reforms have tried to reinforce worker links to their communities by making service providers more accountable to community members (Willis-Shattuck, 2008). This has been attempted through the establishment of district health boards, hospital boards, empowerment of village health committees, etc. These new (or reinvigorated) organizational structures create an alternative and potentially effective feedback loop. Part of the success of a highly acclaimed project in Northeast Brazil appeared to stem from a conscious strategy to "embed" health workers in their community (Dieleman, *et al*, 2006).

According to Schein, (2010) academics and practitioners have spent time focusing on the issue of corporate culture and have argued if a company's culture does impact on

its overall performance and effectiveness. Experiential literature and research meant to establish a direct relationship between organizational culture and effectiveness dates back to earlier studies addressing culture and change. Companies with progressive human resource management practices outperformed those with less progressive practices.

Denison (1984) observes that current and future financial performance can be predicted by looking at the apparent involvement and participation on the part of a company's employees. He also suggests that culture can be studied as an integral part of the change process and that certain cultural traits may be utilized as predictors of an organization's performance and effectiveness (Denison, 1984). In illustrating a theory of the relationship between culture and effectiveness, Denison identifies four major cultural traits; involvement, consistency, adaptability and mission. He observes that involvement and consistency focus mainly on the organization's internal composition and mission while adaptability and mission focus on the correlation between the organization and external environmental factors (Denison, 1984). However, despite the attention given to organizational culture in both academic and business management literature over the past several decades, it continues to be an area not fully researched and understood.

Accordingly, Denison (1984) further observes that organizational culture consists of shared beliefs and values established by the organization's leaders and then communicated and reinforced through various methods, ultimately shaping employee perceptions, behaviours and understanding. By this, He opines that a company's structure and design consists of its body, and its culture as its soul. He adds that due to industry and situational variations, it would be difficult and risky to propose there is a "one size fits all" culture template that meets the needs of all organizations.

Nonetheless, research does propose that if an organization's culture is to improve its overall performance and effectiveness, its culture must be strong and provide a strategic competitive advantage and its beliefs and values must be widely shared and firmly upheld (Denison, 1984).

Accordingly, Denison (1984), observes that there are benefits that accrue to an organization that develops and maintains a strong organizational culture. These include benefits such as enhanced mutual trust and cooperation, fewer disagreements and more efficient decision-making processes, an informal control mechanism, facilitation of open communication, a strong sense of identification, a shared understanding, assisting employees in making sense of their behaviour by providing justification for behaviours (ibid).

According to López-Fresno (2010) the main types of organization cultures found today include Normative Culture, Pragmatic Culture, Academy Culture and Baseball Team Culture. He observes that in a normative culture, the organization stresses on implementing the organizational procedures in a correct way, and according to the norms and rules defined. This kind of culture is perceived to portray, a high standard of business ethics; Pragmatic Culture in contrast to normative cultures, stress is laid on satisfying the wish of their clients. In this type of organizational culture, no norms are set by the company, and utmost importance is given to the needs of the client; In Academy Culture, employees are highly skilled, and the organization provides an environment for the development and honing of employee skills. Examples of this kind of culture are hospitals, universities, large corporations, etc. Employees tend to stay with the organization and grow within it. Finally, in Baseball Team Culture, the employees are "free agents" and are highly prized. These employees find employment easily in any organization and are very much in demand (Brown, 2009).

As an expression of values, beliefs and assumptions, organizational culture may pose a risk to policy implementation (Shannon, *et al.,* 2012). According to the authors, any reforms that threaten values shared between workers, whether this be a sense of team spirit, or a desire for autonomy due to one's professional status, are likely to be resisted, or, in the words of a famous quote attributed to Peter Drucker, 'culture eats strategy for breakfast'. The impact of organizational culture may be particularly relevant in health policy especially the context of complex organizations, where professionals hold considerable authority and autonomy (Braithwaite, 2011). The author concludes by noting that a plan for reform of the health system must take into account differing stakeholders' objectives and values.

More broadly, organizational culture has shown to have an impact on organizational performance and effectiveness in the healthcare environment (Bowen, *et al.,* 2011). Grissom, *et al.,* (2011) established that contracting out and the erosion of civil service protections reduce satisfaction, but that performance-based accountability, pay-for-performance, and innovativeness culture can actually produce improvements in public employee satisfaction. A view also supported by Yang *et al.,* (2006).

Normative beliefs refer to beliefs of an individual that are accepted by specific people or groups and dictate whether behaving in a particular fashion is appropriate. Ajzen and Fishbein proposed the theory of reasoned action and first used the term "normative belief" as antecedent variables of norms. Normative beliefs are individuals' beliefs about the extent to which other people who are important to them think they should or should not perform particular behaviours. Ajzen (1991) discusses behavioural, normative, and control beliefs in the theory of planned behaviour, which are antecedent variables of attitudes, subjective norm, and perceived behavioural control respectively. "While a social norm is usually meant to refer to a rather broad range of permissible,

but not necessarily required behaviours, normative belief refers to a specific behavioural act the performance of which is expected or desired under the given circumstances”.

In examining the relationships between social norms and behaviours, Lapinski *et al.,* (2005) conclude that findings of the effects of social norms (which include subjective norms, injunctive norms, and descriptive norms) on behaviour are mixed in normative influences. They confirmed that norms are also “dynamic phenomena and individuals, acting on either self-interest or altruistic motives, continuously alter the normative contours” in beliefs.

From the perspective of social psychology, social influence refers to the influence of external social factors on individual behaviours, and could be categorized into: (1) normative social influence; and (2) informational social influence. Rivis, *et al.,* (2003) have used the terms “injunctive norm” and “descriptive norm” to represent normative social influence, and informational social influence respectively. According to the definition of subjective norm (one of the social norms) in the theory of planned behaviour, people engage in various types of specific behaviour when they are under pressure to meet the requirement of normative social influence, which is also known as normative conformity. Thus, “subjective norm” in the theory of planned behaviour and “normative social influence” in social psychology share a similar meaning.

Cialdini *et al*., (2006) suggest that the concept of norms also include the constructs of “behaviour supported by groups” and “how groups themselves behave”. In other words, two concepts of “should do” and “how to do” could be considered, rather than simply “norms” as a single concept. In norms, descriptive norms are others’ practices that people follow when they are not familiar with particular situations or ideas. Thus, normative values are shared understandings of actions that are obligatory, permitted, or

forbidden. As such, people make judgment on whether a behaviour is typical, normal, effective, adaptive, or appropriate by observing the specific behaviour displayed by people around them. Furthermore, Bicchieri (2006) proposes that social norms should be understood as types of social interaction behaviours, and such behaviours enable people to understand what is acceptable in society or groups in a system of norms.

According to Xiong, 2019, when an organization has a strong culture, it keeps their employees actively and passionately engaged. A strong culture impacts the values and norms of an organization. It creates and supports the mission, vision and values. The type of culture you have influences your financial growth, internal communication, level of risk-taking, and innovation. Culture determines what clients expect from the organization and if you are the type of organization they could get along with. A successful organization takes more than just great products and a big bank account, a strong culture is also essential.

In conclusion, studies have defined norms to include standards and ideas that provide social order and affect behaviour and are developed following the cultural values of an organization. Norms develop over time and are based on organizational experiences. Literature has also drawn a distinction between norms and values by indicating that while norms are distinct and guided, values have been known to be abstract and general concepts. Additionally, studies have also pointed out that norms are learned. Two distinct types of norms have also been identified in the literature including descriptive and injunctive. Descriptive norms are based on perceptions of others' behaviour or the behaviour of significant others. On the other hand, injunctive norms are based on individual perceptions of what is right or wrong. For example, in compliance with ISO certification, all employees know that they are expected to comply (injunctive) but some employees will not comply since others are not complying. Literature has not

shown the dominant of two in terms of guiding behaviour. Additionally, studies have shown a link between norms and organizational culture and have demonstrated the importance of norms in determining organizational performance. However, there is not enough literature on norms and compliance behaviour specifically in the adoption of ISO 9001:2015 QMS. There is therefore need for studies that demonstrate the relationship between organizational norms and compliance behaviour especially in the public sector in Kenya.

2.6 Behaviour Control and ISO Compliance

There have been numerous definitions of behaviour control though there is general argument that Ajzen and Fishbein Theory of Planned Behaviour brought it to academic light. Behavioural control refers to facts that show whether there is a right to direct or control how the worker does the work. A worker is an employee when the business has the right to direct and control the worker. In psychology, control is how a person regulates themselves or wishes to regulate their environment. There are several types of control, including perceived control, cognitive control, emotional control, motivational control, control desire, inhibitory control, social control, ego control, and effortful control (Science Direct, 2022).

Perceived behavioural control is defined as the perception of the difficulty of enacting a behaviour. Perceived behaviour control is the key difference between the Theory of Planned Behaviour and the Theory of Reasoned Action. Perceived behavioural control is defined as the perception of the difficulty of enacting a behaviour. Perceived behaviour control is the key difference between the Theory of Planned Behaviour and the Theory of Reasoned Action. Indeed, some behaviours are outside of one’s volitional control and by incorporating perceived behavioural control into their theorizing, Ajzen (2011) is able to account for a wider array of behaviours more accurately. For example,

even though a teenager has positive attitudes toward going on a date, believes that it is normatively appropriate to date others, and has date plans with another (leading to the intention to go on a date), dating behaviour may not be likely if they have been grounded from leaving the house by their parent or guardian. In this example, the control is removed and despite the high degree of behavioural intention, the action is not likely. Other behaviourally intended actions may not come to fruition when decisions are out of the individual's direct control (e.g., getting hired at a job). Ajzen (2011) argued that perceived behavioural control is comprised of two highly related (and correlated) variables: perceived self-efficacy (one's belief about their own ability) and perceived controllability (the belief that one's behaviour is volitional). Taken together, both these variables make up perceived behavioural control which both directly predict behaviour and indirectly predict behaviour through intentions.

Standford professor of psychology Albert Bandura developed the theory of self-efficacy to address how an individual perceives his ability to perform a task within a specific context. Self-efficacy is similar to self-esteem, but differs from self-esteem in that it is specific to task performance. Self-efficacy refers to what you believe about yourself, rather than how you truly are. Out-of-balance self-efficacy affects productivity. An employee with low self-efficacy run the risk of performing tasks below her actual ability level because she believes she can only perform to that level, and she may not recognize her aptitude to do the work. On the other hand, self-efficacy that runs too high may give an individual an unrealistic picture of his ability to do a certain task.

Creating an environment that promotes healthy self-efficacy among workers increases their involvement with the work. According to Bandura, an effective way to build realistic, positive self-efficacy is by experiencing successes that build confidence in the

ability to perform. Rewards and constructive feedback are ways you can encourage self-confidence in your employees. Allowing employees to work on tasks at which they excel as well as offering opportunities to try new task challenges encourages a balance of success and personal and professional growth.

Self-efficacy is part of the larger social cognitive theory, which relates to how people learn in a social context. Another way to increase self-efficacy in the workplace is to create learning opportunities that allow workers to model behaviour. By watching others with experience performing a task, an individual learns the steps involved and is able to repeat those behaviours. Mentoring also takes advantage of the many of the benefits that social interaction brings to learning (Ajzen 1991).

Trial and error is another way of learning that creates a healthy self-efficacy by allowing an employee to test behaviours and patterns that lead to understanding the task he is learning. Workplace conditions, interactions with other workers or time pressures may cause an individual to perform a task differently in various contexts. The employee who is given the flexibility to try a task under various conditions builds a body of knowledge that increases both his natural ability to perform the task and the self-efficacy to believe in his ability to do it.

Ajzen, (2011) observes that Self-efficacy "…deals with the ease or difficulty of performing a behaviour, with people's confidence that they can perform it if they want to do so," while perceived control "… involves people's beliefs that they have control over the behaviour, that performance or non-performance of the behaviour is up to them"

Personal agency refers to "the sense that I am the one who is causing or generating an action" (Gallagher 2000:15). A person with a sense of personal agency perceives

himself/herself as the subject influencing his/her own actions and life circumstances (Bandura, 2006; Gallagher, 2000).

According to Bandura (2006), a low sense of efficacy to exercise control over things one values can give rise to feelings of futility and despondency through several pathways. In one pathway, a low sense of efficacy to fulfill personal standards of worth gives rise to self-devaluation and depression. A second pathway occurs through a low sense of social efficacy to develop social relationships that bring satisfaction to people's lives and enable them to manage chronic stressors. Another is through the exercise of control over depressing thoughts themselves. Low efficacy to regulate ruminative thought contributes to the occurrence of depressive episodes, how long they last, and how often they recur.

Additionally, the author notes that people's beliefs about their efficacy are constructed from four principal sources of information. The most effective way of instilling a strong sense of efficacy is through mastery experiences. Successes build a robust belief in one's efficacy. Failures undermine it. The development of resilient self-efficacy requires experience in overcoming obstacles through perseverant effort. The second method is social modelling. Models serve as sources of competencies and motivation. Seeing people similar to oneself succeed by perseverant effort raises observers' beliefs in their capabilities. Social persuasion is the third mode of influence. The fourth way of altering self-efficacy beliefs is to enhance physical strength and stamina and alter mood states on which people partly judge their capabilities.

These different modes of influence create and strengthen beliefs of personal efficacy across diverse spheres of functioning. Such beliefs predict the level, scope, and durability of behavioural changes (Bandura, 2001). Microanalyses of how given treatments work, reveal that the efficacy belief system is a common pathway through

which different types of treatment produce their effects. Knowledge of the determinants and processes governing the formation of efficacy beliefs provides explicit guidelines on how best to structure programs to achieve desired change.

In summary, behaviour control refers to the perception of the difficulty or ease of enacting a behaviour. Its main proponents are Ajzen and Fishbein in the Theory of Planned Behaviour. There is general agreement among scholars that behaviour control accounts for a wide array of behaviours. There is also agreement in the literature that control comprises self-efficacy and perceived controllability (personal agency). While behaviour control is important in determining behaviour, studies have failed to show how, in a given situation, where the worker is empowered through training and equipping still fails to comply with job requirements. Additionally, some factors determine behavioural control such as gender, age and job group that remain largely unexplored. Finally, the relationship between control, attitude and norms within the context of ISO compliance and public sector organizations also remains underexplored.

2.7 Kenyatta National Hospital: History, Present Situation and the Quality Journey

The first Hospital was constructed about 1901 and was called the Native Civil Hospital. It was situated opposite the Government Road along Kingsway (present-day University Way). The Hospital had two wards of 20 beds each. The Hospital had a treatment room, two different waiting areas for the Africans and the Asians. By 1908, the Hospital had a bed capacity of 45. The first epidemic to be managed at the Hospital was Plague that broke out in Nairobi in 1902. The plague had originated from the Indian bazaar. Three medical officers, Drs Haran, Radford and Spurrier, who were primarily concerned with the suppression of the disease, described the state of the Bazaar as being insanitary and favorable to the spread of the epidemic. From the Indian Bazaar, the disease spread to

other parts occupied by the Asians and Africans. They recommended the burning of the Bazaar to curb the spread of the epidemic. The Bazaar was consequently destroyed and a new one was built on a different site.

The period 1905-1912 witnessed outbreaks of plague, malaria and tuberculosis in Nairobi. High patient attendance at the Native Civil Hospital led to congestion. The available statistics for the period 1913-1914 indicate that 817 Africans and Indians were admitted. During the same period, a total of 2,419 outpatients including Asians and Europeans were seen at the Hospital. The number was high and above the capacity of the Hospital. By the time the Hospital was constructed, Nairobi had approximately 6,000 inhabitants.

In his report on sanitary matters dated 1915, Professor Simpson proposed the relocation of the Native Civil Hospital to a new site along Racecourse Road Junction, citing drainage problems, congestion and poor sanitation. He also recommended the provision of an isolation hospital with the necessary equipment for the isolation and observation of patients with infectious diseases. The proposed new Native Civil Hospital was to consist of an administration block, ward block and outpatient department. The plan to construct a new Native Civil Hospital was later abandoned in favour of a Group or Combined Hospital for all races.

Inpatient services were consequently relocated around 1922 to a vacated military hospital (number 87) originally built to take care of the Kings African Rifles personnel during the First World War. The Hospital was situated on Kings African Rifles area off Ngong Road, the present Kenya Medical Training College (KMTC). The Old Native Civil Hospital was converted into a dispensary called Nairobi General Dispensary to serve as the principal outpatient department for Nairobi.

The plan for a Group or Combined Hospital was modified to imply separate facilities for all the three races grouped in one area of land and in close proximity to each other. This system of grouping would facilitate the sharing of some of the facilities and would make available modern methods of treatment to all classes of every community in the colony. The plan, later referred to as the Nairobi Group Hospital Scheme was to cover construction of a European Hospital, an Asian and African Hospital and a Medical Research Laboratory. After careful consideration of the proposed sites, the Hospital Hill Site off Ngong Road was considered as the most suitable.

The Nairobi Group Scheme Hospital Kicked off in 1937 when the first foundation stone was laid for the medical block for Africans. But construction work was soon hampered by the Second World War (1939 – 1945). The new hospital under construction became in itself an important contribution towards the war effort. It was taken over by the Army as a hospital for the British Troops. The hospital was handed back to the civil authorities after the war and the construction resumed.

The medical block was completed and opened on 11th March 1947 by Sir Philip Mitchell, the then Governor of Kenya. The construction of the surgical block started after the war. This block was completed and opened on 16th February 1951 by Countess Mountbatten of Burma who was the Superintendent in chief of the St. John Ambulance Brigade. An X-Ray department was built as an extension of the surgical block. The medical and surgical wings consisted of two blocks each. Each block had 6 wards giving a total of 24 wards. Six operating theatres included two for orthopaedic operations; one for general operations; one for gynaecological operations; one for ENT operations and one emergency theatre. There was a total of 380 beds.

The Asian wing was constructed a few meters from the African Block. This was a three-storeyed building which provided the best hospital facilities for the Kenya’s Asian

communities. It also provided the Asian girls in the colony with a unique opportunity in the honoured nursing profession. The project was partially funded by the Ismail Rahimtullah Waljee Trust that provided 140,000 sterling pounds for the construction of the Wing and a hostel for the Asian girls on training nearby. The Asian Wing was thus named Ismail Rahimtullah Wing (present-day KNH Staff Training Center). The wing had a bed capacity of 123 beds. Each of the floors had accommodation for 41 beds. It also had an operating theatre. Lady Mary Baring, the wife of the then Governor Sir Evelyn Baring, officially opened the Ismail Rahimtullah Wing on 10th December, 1952.

The need to change the name Group Hospital was expressed by the Director of Medical and Sanitary Services since their initial intention was not achieved as the Hospital only accommodated Africans and Asians. Permission was sought from the colonial office in London to change the name to King George VI Hospital. During the opening ceremony of the surgical wing, Countess Mountbatten announced that His Majesty King George VI had graciously consented that the Hospital should be named after him.

Apart from the African Block and the Asian Wing, other extensions of the King George VI Hospital included a Mortuary, an Infectious Disease Hospital (IDH), an Orthopaedic Center, a Consultation Clinic for all races and a Medical Training School.

A new permanent mortuary (present-day KNH post office) was built and completed in 1955. This replaced the old temporary one made of stone and corrugated iron sheets. The Infectious Disease Hospital (present-day Mbagathi District Hospital) was built in close proximity to the Main Hospital Replacing the old one situated an industrial area. The hospital was opened in 1956. It had a bed capacity of 267 beds. All cases of infectious diseases were referred and treated at this Hospital. In 1995 the Hospital was transferred to the MoH and renamed Mbagathi District Hospital. It is currently under

the Nairobi City County Government. In 1953, the Colonial Development and Welfare Fund provided 55,000 Sterling pounds for the construction of a new Orthopaedic Rehabilitation Center. The center was opened in 1961.

The first consultative out-patient clinic was built in 1956 at the cost of 50,000 sterling pounds. The then deputy director of medical services, Dr. D.H. Mackay reported that the clinic patients will be treated by appointment not on a queue basis by a panel of the country's foremost medical and surgical specialists. In the same year, several medical personnel of consultancy status who were engaged in private practice in Nairobi was appointed as honorary physicians and surgeons by the Director of Medical Services. Some were allotted a few beds. This arrangement fostered a spirit of cooperation between the medical services and the private practitioners. Other clinics which were opened included the ENT, Eye, Dental and Physiotherapy. For accident and emergency cases, a casualty was also opened. The casualty was located at the present patient support center.

There was no laboratory in the main King George VI Hospital Building. Routine clinical examinations were carried out at the Medical Research Laboratory built close to the Hospital. The Medical Research Laboratory served the whole of the Colony for histology and other forms of investigations. The Laboratory had its own Vaccine Preparation Department and was also the center for various research projects by a number of international visiting teams.

By 1953, King George VI Hospital had 225 medical beds, 79 children cots and 281 surgical beds. By this time eight European doctors, three African Doctors, 27 European nursing sisters and an African Staff of 462 were serving the hospital. The Hospital received complicated cases, both medical and surgical which were beyond the range of

experience of the provincial physician or surgeon. Cases that required more detailed investigations than was possible at the provincial centers were referred to this hospital.

Kenya attained independence on 12th December 1963. On 17th April 1964, King George VI Hospital was renamed Kenyatta National Hospital in honour of the first president of Kenya, H.E. the late Mzee Jomo Kenyatta. Self-rule was attained on June 1st 1964. The new government declared its commitment to provide Kenyans with total healthcare services. Free outpatient treatment for all and free in-patient treatment for children at Government and county council health centres was introduced. This was formalized in the Sessional Paper No. 10 of 1965 on African Socialism and its Application to Kenya.

As a result, the number of patients attending hospitals and other medical centres rose. This tremendous increase in outpatients at Kenyatta National Hospital overstretched the capacity of the available medical staff and led to congestion. In the same year, 1965, clinical training of medical students started. The maternity unit was opened during the year. KNH also took over the British Military Hospital at Kabete and established an orthopaedic hospital.

In 1964, a decision to improve and expand the Hospital was undertaken. By then, the operational demands on the Hospital as a national referral centre were continuing to rise. In addition, facilities had to be provided for the clinical training of medical students in progressively increasing numbers. The expansion was done in phases and the first phase was expected to be completed by mid-1971 when a group of 100-120 students were expected to acquire clinical teaching.

The first phase was designed to increase and improve diagnostic and treatment facilities with only a minor increase in the number of beds. It was completed in 1971. It

comprised of the following: Clinical Science Block and Laboratories (Hostels for medical students, boiler house, filter clinics, medical records); Central Sterile Supplies Department (casualty, surgical outpatient, medical outpatient, gynaecology outpatient, paediatric outpatient, ENT outpatient, outpatient dispensary, anaesthetic department, outpatient laboratory and burns unit); operating theatres and theatre sterile services unit (intensive care unit, Maintenance department).

The second phase was completed in 1972 and comprised the following: Pharmacy and sterile preparation unit (central catering unit, the hospital mortuary, ophthalmology department, National medical library, hearing aids department, cardiopulmonary department); museum and medical photography department; electroencephalography department and the laundry. Another development during this phase was the opening of the spinal injury unit which became the National Spinal Injuries Unit in 1979.

The third phase involved the construction of the 1,209-bed capacity Tower Block, which was opened in 1981. Other departments established at that time included the department of physical medicine, department of occupational therapy, four operating theatres, completion of the X-ray department and completion of the admission unit.

For many years KNH operated under the Ministry of Health as a department. The ministry managed employment, procurement and day-to-day operations of the Hospital. This created a bureaucracy that led to inefficiencies and deteriorating service delivery. As a result, the country's first and largest referral hospital received a lot of criticism from the public and other stakeholders. Headlines such as 'hospital of shame', 'massive shortages strangling KNH' were not uncommon in the newspapers. Run-down equipment, rampant shortage of essential drugs and medicines, lack of basic items, congestion, squalid and stinking wards and demoralized staff is what characterized the Hospital. The strike by medical workers in the 80s made the situation worse.

On 10th April, based on recommendations of the Abdalla Committee and approval by the Parliament and the Cabinet, KNH was established as a State Corporation under the State Corporation's Act vide KHN Board Order, 1987 as contained in the Legal Notice No. 109(Kenya Gazette Supplementary No. 23 of 10th April, 1987). According to the Notice, the functions of KNH were to: receive patients on referral from other hospitals or institutions within or outside Kenya for specialized health care; provide facilities for medical education for the University of Nairobi and research either directly or through other cooperating health institutions; provide facilities for education and training in nursing and other health and allied professionals; and; participate as a national referral hospital in the national health planning.

A Board comprising of 10 members was established with the responsibility of administration, management and development of the Hospital. This paved way for KNH path of recovery. The Board formulates the Hospital policies and the administration executes them. Nowadays there are a few issues if any being referred to the Ministry for decision. (Source of Historical Data: Kenyatta National Hospital, 2001)

The KNH organization Structure has been changing with the establishment of new functions and departments/units. The current structure is summarized below: -

Table 2.1: KNH Departments

Division	Directorate	Departments
Prime Care	1. Prime Care	1. Prime Care (Private Wing)
Corporate Support	1. Affiliations and Institutional development 2. Internal Audit and Risk 3. Supply Chain Management 4. Human Resources 5. Facilities and Services 6. Finance 7. Planning and Strategy 8. Corporation Secretary	1. Marketing and Communications 2. Administration 3. Engineering 4. Planning 5. Strategy 6. ICT
Clinical Services	1. Surgical Services 2. Medical Services 3. Pharmaceutical Services 4. Nursing Services	1. Dental Services 2. Orthopedic Services 3. General Surgery 4. Obs and Gynecology 5. Specialized Surgery 6. Accident and Emergency 7. Anesthesia Theatres 8. Rehabilitative services 9. Pediatrics 10. Specialized medical Units 11. Medicine 12. Critical Care 13. Mental Health Services 14. Nutrition Services 15. Renal Medicine 16. Cardiology 17. Cancer Treatment Centre 18. Research and Programmes 19. Nursing Administration 20. Nursing School 21. Nursing medical Services 22. Nursing Surgical Services 23. Diagnostic Services and Health Information 24. Quality Health Care

Source: KNH Website

In total the Hospital has three Divisions, 13 Directorates and 31 Departments. The staff establishment was 4,700 full-time employees as of 2019, April. While the majority of the staff running KNH are full-time employees, it would be wrong to ignore the role played by the College of Health Sciences, the University of Nairobi and the Kenya Medical Training College (KMTC). The college of Health Sciences plays a vital role in the provision of highly qualified clinicians who take an equal load of clinical work in the wards and the various clinics. The KMTC, on the other hand provides manpower

in form of students, who, during their practical training, offer services in the various areas within the hospital.

Kenyatta National Hospital whose motto is ‘quality health care’ puts a lot of emphasis on efficiency and quality control. In November 1992 the Hospital established the Quality Assurance Unit under the auspices of the Deputy Director, Clinical Services. The role of the Unit is to monitor, analyse and improve the quality of healthcare and enhance efficiency in resource utilization. The ISO mandate, though driven by top management falls under this unit.

In the health care service delivery systems throughout the world, hospitals have an exclusive role, and individuals require their services in all stages of life. Accordingly, disregarding the quality of the health care system can cause irreversible damages and losses to humans. Implementation of high-quality care and services leads to patient satisfaction and the specialized effectiveness of service providers. Service quality is a necessary factor for the development, success, and survival of hospitals and patient safety is considered a key component for promoting the quality of the health care system and prevention and attenuation of unexpected events and injuries (Kronick, *et al.,* 2015). The importance of patient safety as one of the components of health care quality improvement has led to prioritizing accurate and conspicuous assessment of the performance of health care organizations to determine the efficiency of these services (Car *et al.,* 2008).

KNH has 50 wards, 22 outpatient clinics, 24 theatres (16 specialized) and Accident & Emergency Department. Out of the total bed capacity of 1800, 209 beds are for Private Wing. On average, the hospital caters to over 80,000 in-patients and over 500,000 outpatients annually.

ISO 9000 is defined as a set of international standards on quality management and quality assurance developed to help companies effectively document the quality system elements needed to maintain an efficient quality system. They are not specific to any one industry and can be applied to organizations of any size. ISO 9000 can help a company satisfy its customers, meet regulatory requirements, and achieve continual improvement. It should be considered to be a first step or the base level of a quality system. (ISO.Org, 2019)

ISO 9000 was first published in 1987 by the International Organization for Standardization (ISO), a specialized international agency for standardization composed of the national standards bodies of more than 160 countries. The standards underwent major revisions in 2000 and 2008. The most recent versions of the standard, ISO 9000:2015 and ISO 9001:2015, were published in September 2015.

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Quality management initiatives have been undertaken at the Kenyatta National Hospital.

Lean Six Sigma is a method of management employed to minimize operational waste to improve treatment outcomes while driving down costs of care and can be used in combination with KQMH, 5S Kaizen that KNH is already implementing. (GoK 2011). Six Sigma is a quality improvement system that strives to produce perfection in products and services. It uses facts, information and data to make decisions and manage business performance, identifies root causes of problems and determines permanent solutions. Both JCIASH and Lean Six Sigma are geared toward a journey of culture change and continuous quality improvement. Full implementation of the KQMH results in ISO Certification for the Health facility. (GoK, 2011)

In 2018 KNH attained ISO 9001:2015 certification. This represented an upgrade from the ISO 9001: 2008 certification. The certification was approved and issued by the Kenya Bureau of Standards after confirming that the Hospital had met all the requirements required in the revised. The key objectives of ISO 9000 are to help KNH satisfy its customers, meet regulatory requirements, and achieve continual improvement. It should be considered to be a first step or the base level of a quality system. (ISO.Org, 2019)

ISO 9000 was first published in 1987 by the International Organization for Standardization (ISO), a specialized international agency for standardization composed of the national standards bodies of more than 160 countries. The standards underwent major revisions in 2000 and 2008. The most recent versions of the standard, ISO 9000:2015 and ISO 9001:2015, were published in September 2015.

According to information and data available the process of upgrading to ISO 9001: 2015 at KNH took four distinctive stages. The first stage involved planning. During this stage, there were management reviews based on the requirements for the new standard. There was also an assessment of the status as concerns implementation and

performance of the 9001:2008 standard. There was noted improvement in the implementation of the Quality Management System (QMS).

During this phase, the management, with its commitment to ensuring a smooth transition appointed the deputy management representative, who was to support the management representative in the transition and implementation. The phase also involved the realignment of the scope, the quality policy and quality objectives alongside the selection of an interdepartmental team to prepare the QMS documents.

The second stage was the development phase. This is the phase where the 9001:2015 QMS for Kenyatta National Hospital was developed. It started with an awareness session for the executive management committee, followed by heads of departments, units, and sections at KNH. The sessions involved the requirements under the 9001:2015 standard. This was followed by staff awareness sessions that were held at the Hospital. However, it is important to note that at this stage there was no evidence of any follow-up mechanisms to ensure that all the staff has been sensitized.

The lead Auditors were trained during this stage. Lead auditors are critical since they are the drivers of the process as champions and they train other auditors to facilitate IQA. The lead auditors represented all the departments and were responsible for the training of internal auditors. After the training of auditors, departments then embarked on the process of aligning their standard operating procedures with the new requirements of the standard. The policies and procedures are what make the QMS. At this stage, it is assumed that the departments shall involve all their respective staff in the process.

Another important development in this stage is the continuous personal development with auditors trained in ISO 9001:2015. This ensures that the auditors are up to speed

with the requirements to drive the process. Once this was established, the process of preparation of Corporate QMS documents got underway. This included the development of the quality policy and quality manual among other documents. This was followed by the implementation of ISO 9001:2015 quality system documentation. This required that the user departments start using the amended documentation including the standard operating procedures and other requirements based on the quality manual. All staff receives communication on the revised quality objectives.

Implementation, which is the fifth stage, involved conducting internal audits to establish compliance with the QMS. Internal auditors did this. The stage also involved management review meetings that discussed the results of the internal quality audits and plans for addressing nonconformities and improving service delivery. The certification body, the Kenya Bureau of Standards (KEBS), to determine the extent to which there is compliance with the QMS, conducted the first surveillance audit. After the audit, the departments were required to prepare work plans on how the non-conformities will be addressed and a follow-up was done with the quality assurance office. After addressing the audit recommendations satisfactorily, KNH then applied to KEBS for transition to the 9001:2015 standard.

The final stage of the process involved assessment and certification. The process included a surveillance audit by KEBS and the identification of non-conformities. KNH was then given two months within which to ensure that corrective actions are addressed. After the implementation of corrective actions, a Recertification audit was conducted to establish the extent to which the QMS has been implemented. This was to pave way for the transition to the 9001:2015 standard. The recertification audit identified a few minor nonconformities that KNH was to implement. After the implementation and

submission of the report, KNH was then certified to the 9001:2015 Standard. The Hospital received its ISO 9001:2015 certificate on 28th August 2018.

To ensure compliance with the QMS the Hospital conducts regular internal audits to identify non-conformities as well as implementation gaps. Management review meetings are held after every internal audit to discuss the progress of implementation. Additionally, regular training of staff is conducted, not only for career development but also to ensure all staff can adequately implement the QMS. However, funding challenges were identified as the key bottleneck to the implementation of the QMS to meet the customer needs.

2.8 Overview of Theoretical Foundation

A theoretical framework is a collection of interrelated concepts. It guides research to determine what things to measure, and what statistical relationships to look for. Good research should be grounded in theory. This study will be anchored on the Theory of Planned Behaviour as developed by Ajzen and Fishbein.

Ajzen's and Fishbein's (1988) model has received substantial research support in recent years from social scientists (Ajzen, 2011). One of the major strengths of the Theory of Planned Behaviour is that it is widely applicable to a variety of behaviours in different contexts, including such diverse areas as health communications, environmental concerns, risk communication, mass transit use, and, more recently, technology adoption. The theory has been used successfully in hundreds of different studies in the last two decades (Ajzen, 2011), this is a theory about the link between beliefs and behaviour. The theory states that attitude toward behaviour, subjective norms, and perceived behavioural control, together shape an individual's behavioural intentions and behaviour (George, 2004). The Theory of Planned Behaviour (TPB) started as the

Theory of Reasoned Action in 1980 to predict an individual's intention to engage in a behaviour at a specific time and place.

According to the theory, human behaviour is guided by three kinds of considerations namely, beliefs about the likely consequences of the behaviour (behavioural beliefs), beliefs about the normative expectations of others (normative beliefs), and beliefs about the presence of factors that may facilitate or impede the performance of the behaviour (control beliefs). In their respective aggregates, behavioural beliefs produce a favourable or unfavourable attitude toward the behaviour; normative beliefs result in perceived social pressure or subjective norm; and control beliefs give rise to perceived behavioural control. In combination, attitude toward the behaviour, subjective norm, and perception of behavioural control lead to the formation of a behavioural intention.

As a general rule, the more favourable the attitude and subjective norm, and the greater the perceived control, the stronger should be the person’s intention to perform the behaviour in question. Finally, given a sufficient degree of actual control over the behaviour, people are expected to carry out their intentions when the opportunity arises. The intention is thus assumed to be the immediate antecedent of behaviour.

From the analysis, the key component of this model is behavioural intent. Behavioural intentions are influenced by the attitude about the likelihood that the behaviour will have the expected outcome and the subjective evaluation of the risks and benefits of that outcome. The TPB states that behavioural achievement depends on both motivation (intention) and ability (behavioural control). It distinguishes between three types of beliefs, behavioural, normative, and control.

The TPB is comprised of six constructs that collectively represent a person's actual control over the behaviour: i) Behavioural intention refers to the motivational factors

that influence a given behaviour where the stronger the intention to perform the behaviour, the more likely the behaviour will be performed; ii) Attitudes, which refers to the degree to which a person has a favorable or unfavorable evaluation of the behaviour of interest. It entails a consideration of the outcomes of performing the behaviour; iii) Subjective norms, which refers to the belief about whether, most people approve or disapprove of the behaviour. It relates to a person's beliefs about whether peers and people of importance to the person think he or she should engage in the behaviour; iv) Social norms, which refers to the customary codes of behaviour in a group of people or larger cultural context. Social norms are normative, or standard, in a group of people; v) Perceived power, which refers to the perceived presence to factors that may facilitate or impede the performance of a behaviour. Perceived power contributes to a person's perceived behavioural control over each of those factors; vi) Perceived behavioural control which refers to a person's perception of the ease or difficulty of performing the behaviour of interest. Perceived behavioural control varies across situations and actions, which results in a person having varying perceptions of behavioural control depending on the situation. This construct of the theory was added later, and created the shift from the theory of reasoned action to the theory of planned behaviour (Carver & Scheier, 2012).

Since its introduction to behavioural research, it has been applied to study a wide variety of situations and is now regarded as one of the most influential theories about volitional human behaviour. As the name of the theory implies, it "… is based on the assumption that human beings usually behave sensibly; that is, they take account of available information and implicitly or explicitly consider the implications of their actions ... the theory postulates that a person's intention to perform (or not perform) a behaviour is

the immediate determinant of that action; barring unforeseen events, people are expected to act following their intentions" (Ajzen 1988:117).

The immediate antecedent of any behaviour is the intent to perform it. The stronger the intention, the more the person is expected to try and therefore the greater the possibility that the behaviour will be performed, and thus the primary concern is with identifying the factors underlying the formation and change of behavioural intent (Fishbein & Manfredo, 1992). A person's intention to behave in a certain way is based on: their 'attitude' toward the behaviour in question and their perception of the social pressures on them to behave in this way, that is, 'subjective norms'. The relative contribution of attitudes and subjective norms varies according to the behavioural context and individual involved. Attitudes are determined by the beliefs about the outcomes of performing the behaviour and the evaluation of these expected outcomes. The subjective norm is dependent on beliefs about how others feel the individual should behave and their motivation to comply with these 'others' (Ajzen & Fishbein, 1980). The theory of planned behaviour is applied in many different settings and with many different behaviours, such as health-related behaviours, sustainable behaviours, traffic behaviours, organizational behaviours, political behaviours, and discriminatory behaviours (ibid).

2.9 Application of the Theory to the Study

Ajzen's (1988) Theory of Planned Behaviour can be broken down into three conceptually independent antecedents leading to behavioural intention (BI): Attitude toward the Behaviour (AAct), Perceived Behavioural Control (PBC) and Subjective Norms (SN) (Ajzen, 1991, in Knabe, 2012). Attitude toward the behaviour measures the degree to which a person has a negative or positive evaluation of his/her performance of the behaviour. Perceived Behavioural Control refers to people's

perceptions of whether or not they can perform that specific behaviour and how easy it is to perform. Subjective Norms refer to what individuals believe other key people in their lives think about whether or not the individual should perform the behaviour. The perceived opinions of these key people help determine whether a person will perform the behaviour. The equation can be expressed as:

AAct wi + SNwi + PBCwi = BI

(note: wi = weights that are based on multiple regression analyses)

In Ajzen's model, behavioural beliefs lead to the AAct, normative beliefs lead to SN, and control beliefs lead to PBC. While some researchers lump all of these together, Ajzen keeps them separate.

Ajzen explains it in his own words and notes "Theoretically, personal evaluation of a behaviour (attitude), socially expected mode of conduct (subjective norm) and self-efficacy concerning behaviour (perceived behavioural control) are very different concepts each of which has an important place in social and behavioural research" (Ajzen, 1991:199).

2.9.1 Theory of Planned Behaviour Variable: Behavioural Intention (BI)

Behavioural intention (BI) is an indication of a person's readiness to perform a given behaviour or action. Behavioural intention is considered to be the immediate antecedent of behaviour. This intention is based on attitude toward the behaviour, subjective norm, and perceived behavioural control, with each predictor weighted for its importance concerning the behaviour and population of interest. In previous studies using the Theory of Planned Behaviour, behaviour intention variables included communication behaviours, health-related risk prevention actions, and specific technological adoptions.

Ajzen’s behavioural model requires the target behaviour to be as specific as possible, including the time and, if appropriate, the context. As applied in this study, behavioural intention is a person’s intent to comply with the ISO 9001:2015 QMS procedures. The context in this study is understood to be the hospital setting while the time is during working hours.

To increase reliability, several items are used on a questionnaire to assess behavioural intention (Ajzen, 2002). Based on examples given by Ajzen, the study analyses expectation (I expect to comply), Intention (I anticipate to Comply) and Desire (I want to comply) to assess behaviour intention. The timeframe and context are on the implementation of ISO QMS procedures at the hospital during work.

The scale ranges from 1 to 7, with strongly disagree a 1, and strongly agree a 7. As prescribed by Ajzen (2006) intention items in this study have psychometric qualities the final questionnaire items about behavioural intention had high correlations with each other.

2.9.2 Theory of Planned Behaviour Variable: Perceived Behavioural Control (PBC)

Perceived behavioural control refers to people's perceptions of their ability to perform a given behaviour (Ajzen, 2006). The construct encompasses the perceived ease or difficulty a person associates with a specific task or behaviour. In this study, some items have to do with a person’s sense of self-efficacy toward a specific behaviour, and other items measure a person’s perceived controllability of the behaviour. In this study, questionnaire items used to measure Self-efficacy include decision making, ability and skills. On the other hand, questionnaire items used to measure personal agency include confidence, ease of doing and choice.

2.9.3 Theory of Planned Behaviour Variable: Subjective Norms

The subjective norm (SN) construct is the perceived social pressure to engage or not to engage in a behaviour (Ajzen, 2006). It is assumed that subjective norm is determined by the total set of accessible normative beliefs concerning the expectations of important referents. Normative referents can be elicited through questions about certain groups of people that would approve or disapprove of the individual performing the specific behaviour (Ajzen, 2006).

Subjective norms are assessed with the usual single item for each behaviour as suggested by Ajzen (1988). Higher values represent perceptions that important others expect the individual to comply with ISO 9001:2015 QMS procedures. Ajzen (2002) recommends the use of both Injunctive and Descriptive norms when measuring subjective norms. The inclusion of items to capture descriptive norms helps alleviate this. Injunctive norms refer to people's beliefs about what others think "ought to be done" (Ajzen, 1988). In this study statements used to measure the strength of subjective norms include what important people think, whether ISO is good for the organization and what important people want the individual to do. Descriptive norms, in contrast, do not refer to what individuals think ought to be done, but what most people do. Descriptive norms "describe" what may be popular in the social environment, and are based on perceptions of what is done by most members of one's social group (Ajzen 2002). In this study, statements used to measure descriptive norms include feelings that one should always comply, what the individual thinks is expected of him and whether the individual feels under social pressure to comply.

2.9.4 Theory of Planned Behaviour Variable: Attitude toward the Act (AAct)

Attitude toward the act (or attitude toward a behaviour) is another predictor of behavioural intention. Attitude toward the act (AAct) is the degree to which

performance of the behaviour is positively or negatively valued by an individual. Past research shows overall evaluation contains two separate components: one that is instrumental (i.e., valuable vs. worthless), and one that has to do with experiential quality (i.e., pleasant vs. unpleasant). In this study questionnaire statements that were used to evaluate experiential attitude include motivation feelings, the will to comply, and feelings of stress when complying. On the other hand, statements that were used to measure the instrumental or cognitive aspects of attitude include the importance of compliance to the individual work, improvements in performance as well as usefulness in increasing staff satisfaction.

2.9.5 Usefulness of the Theory of Planned Behaviour

The status and utility of the Theory of Planned Behaviour are reflected in its recent use across numerous social scientific disciplines. Many of the behaviours studied with the Theory of Planned Behaviour include health-related behaviour, such as condom use, breast self-examination, and exercise. Other popular areas of theory application include research on AIDS-related risk-taking behaviour, charitable giving, controlled burning, coupon usage, drug and alcohol abuse, fast food consumption, moral behaviour, smoking cessation, violence control and women's career issues (Ajzen, 2004).

More recently, the Theory of Planned Behaviour has been applied to technology and Internet-related behaviours. For example, George (2002) found "general support" for the model when the researcher examined the relationship between privacy and online purchasing, using a partial test of the model (p. 177). Li *et al.,* (2010) used the theory to study teachers' decisions to create and deliver lessons using computer technology, and Moss *et al.,* (2010) used it to examine students' intentions to use podcasting as a learning tool in a college course.

In some cases, the model has been compared with competing theories, and "decomposed" for further study. Chau and Hu (2001) examined the Theory of Planned Behaviour, the Technology Acceptance Model, and a decomposed version of the Theory of Planned Behaviour when studying information technology acceptance. Their adaptation of the Theory of Planned Behaviour decomposed attitude by incorporating perceived usefulness and perceived ease of use as its mediating variables. This decomposed model did not appear to substantially increase the power or utilities to explain or predict behavioural intent.

The Theory of Planned Behaviour has received substantial research support (Ajzen, 2011). One of the major strengths of the theory is that it was widely applicable to a variety of behaviours in different contexts, including such diverse areas as health communications, environmental concerns, risk communication, mass transit use, and technology adoption.

The Theory of Planned Behaviour does not rely on external variables, such as emotion or affect-related constructs. This, in itself, strengthens the theory. The disadvantage of relying on external variables is that different kinds of variables have to be invoked for different behavioural domains (Ajzen & Fishbein, 1980). Thus, a theory becomes weakened when external variables are introduced. This is not the case with the Theory of Planned Behaviour, because external variables are not used in the model proposed by Ajzen.

The Theory of Planned Behaviour is also parsimonious, an important characteristic because the simplicity of a theory is a quality associated with its strength and utility of theories. The Theory of Planned Behaviour is also easy to understand and subsequently has been used by hundreds of researchers. While a sense of understanding each theory primarily lies in each scientist's mind, previous use of a theory is a strong indicator of

its understandability and utility. In other words, the more times a theory is used and understood, the more it is accepted by the scientific community. In the case of the Theory of Planned Behaviour, the model's use has increased significantly in the last decade, with more than 1,000 published studies utilizing the theory.

In broad terms, the theory is well-supported with empirical evidence. Intentions to perform behaviours of different kinds can be predicted with high accuracy (Ajzen, 1991). However, expectancy-value formulations are found to be only partly successful in the model, but rescaling of expectancy and value measures is offered as a way of dealing with measurement to test the theoretical sufficiency of the model (Ajzen, 1991).

2.10 Conceptual Framework

The conceptual framework is a structure that the researcher believes can best explain the natural progression of the phenomenon being studied. It is linked with the concepts, empirical research and important theories used in promoting and systemizing the knowledge espoused by the researcher. The conceptual framework illustrates what the researcher expects to find through the research. It defines the relevant variables for the study and maps out how they might relate to each other.

The conceptual framework for this study is illustrated in figure 2.1.

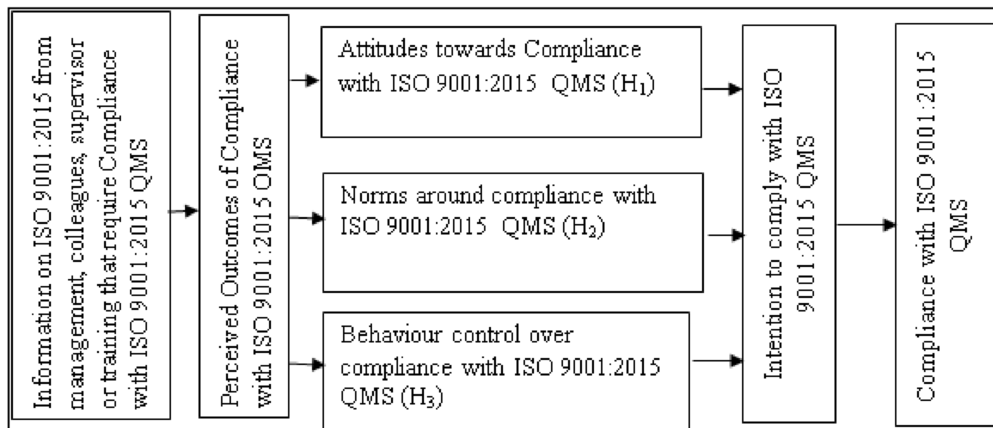

Figure 2.1: Conceptual Framework

Source: Author's Own

The model above provides a directional relationship between the variables under study. Compliance with ISO 9001:2015 QMS is the study's dependent variable and is measured by assessing the intention to comply among the workers. On the other hand, independent variables in the study included workers' attitudes towards compliance with ISO 9001:2015 QMS, the norms around compliance with ISO 9001:2015 QMS and the behaviour control over compliance with ISO 9001:2015 QMS.

2.11 Study Hypothesis

Evidence suggests that there have been attempts to improve service delivery in public sector organizations through various initiatives (Oyugi 2006; Hope 2012). It is also evident that these efforts have taken the shape of reforms. These reforms were largely aimed at adjusting the functions and roles of the state in society as well as improving the efficiency, effectiveness, legitimacy and accountability of the state (Therkildsen, 2008). The approach has largely been top-down, through successive governments though there have been attempts in the latter years to bring the state agencies and

employees into the reform agenda through initiatives such as the rapid results initiative and performance contracting (Government of Kenya 2017).

Studies have also shown that these reforms have changed the face of the public sector but quality service delivery remains a major concern for the citizenry (Hope 2012; Kilelo, 2015; Schroiber 2015; Government of Kenya, 2017). The health sector in particular has been a recipient of major government reforms that included both fiscal and structural changes. It has been noted that despite the significant achievements recorded in this sector in terms of coverage, service delivery standards have remained below citizen expectations. (Rigoli *et al.,* 2013). Gaps and weaknesses in the implementation of reforms in the public sector have also been noted. These include challenges of integration and managing competing interests and the use of size fits all approach among notable impediments. (Christensen *et al.,* 2012; Poliitt *et al.,* 2011; Shukla 2008; Ostorm 2008; Lipsky 2010). The implementation of ISO 9001 certification to public sector organizations was seen as an attempt at ensuring services are offered in line with international standards. All public organizations including those in the health sector were required to become certified and maintain certification with the international standards (Ndirangu, 2011; Njenga 2013). However, evidence indicates that despite attaining ISO Certification, the quality of services within the health facilities remains poor (GoK 2017).

The need for the involvement of staff in the design, implementation and monitoring of reforms has also been documented in various studies. (Wild *et al* 2012; D'ortezio, 2012; Bently *et al.,* 2010). The studies also note that implementation of successful changes in an organization requires the support and buy-in of both the management and staff. The buy-in by staff is mainly influenced by their ability to implement the change, their

attitudes towards the changes and the organizational culture that supports the change (norms).

Over the past few decades, both academics and practitioners have spent time focusing on the issue of organizational culture and whether a company's culture does affect its overall performance and effectiveness. However, most researchers and practitioners have failed to recognize the role of individual workers, and how their behaviour affects overall service delivery. Studies and reform initiatives have looked at the worker as a passive recipient of instructions and guidelines to implement and have failed to recognize the worker as an independent agent capable of making rational decisions and choices. This study attempts to understand the worker as an independent agent and the factors that influence his adoption and/or rejection of certain behavioural expectations.

Additionally, the behaviours of employees towards organization reforms need also to be understood in the context of planned behaviour. There is a lack of adequate information on the application of the theory of planned behaviour in organizational studies and this creates a research gap that the current study intends to address. The current study will seek to bridge the existing knowledge and research gaps by exploring compliance behaviour towards ISO 9001:2015QMS as a part of wider reforms in the public sector and how it is influenced by attitude, norms and behaviour control of workers at Kenyatta National Hospital.

This study was therefore guided by the following hypotheses: -

H_1 There is a positive relationship between workers' attitudes and compliance with ISO 9001:2015 QMS at Kenyatta National Hospital.

H_2 There is a positive relationship between organizational norms and compliance with ISO 9001:2015 QMS at Kenyatta National Hospital.

H_3 There is a positive relationship between the workers' behaviour control and compliance with ISO 9001:2015 QMS at Kenyatta National Hospital.

2.12 Operational Definition of Variables

The study is guided by a set of variables drawn from the hypotheses of the study and the theoretical framework. The dependent variable in the study is compliance with ISO 9001:2015 QMS procedures. On the other hand, independent variables are attitude, norms and behaviour control. A seven-point Likert scale was adopted in this study for two main reasons. Finstad (2010) stated that seven-point Likert items are more accurate, easier to use and a better reflection of a respondent's true evaluation. In light of all these advantages even when compared to higher-order items, 7-point items appear to be the best solutions for questionnaires. Secondly, Ajzen (2013) recommended the adoption of a 7-point Likert scale in the measurement of items under the Theory of Planned Behaviour. This he opined provides a better evaluation of attitudes, norms and behaviour control amongst the respondents.

Compliance with ISO 9001:2015 QMS procedures refers to the degree or the extent to which workers can apply the various provisions of the quality management system developed by Kenyatta National Hospital (KNH). This involves adhering to documented procedures and applying the quality management principles in their work. This is measured by assessing the behaviour of the workers towards compliance. In this study behaviour is measured on the strength of the individuals' intention to comply and is measured in a continuum that moves from weakest intention to strongest intention on a seven-point Likert scale with 7 representing the strongest intention and 1 the weakest intention.

Attitude measures the degree to which a person has a negative or positive evaluation of his/her performance of the behaviour (Compliance with ISO 9001:2015 QMS). In this

study, attitude is measured in a continuum that moves from weak (negative) to strong (positive) on a seven-point Likert scale with 7 representing the Strongest (positive) attitude and 1 the weakest (negative attitude). The midpoint of the scale represents moderate attitude.

Norms refer to what individuals believe other key people in their lives think about whether or not the individual should perform the behaviour. The perceived opinions of these key people help determine whether a person will perform the behaviour. In this study norms are measured on the strengths of the influence of others on an individual's decision to comply with ISO 9001:2015 QMS. This is measured in a continuum that moves from weakest influence to strongest influence on a seven-point Likert scale with 7 representing the strongest influence and 1 the weakest influence.

Behavioural Control refers to people's perceptions of whether or not they can comply with ISO 9001:2015 QMS and how easy it is to comply. Behavioural control is an individual's perceived amount of control over behavioural performance. In this study, behaviour control is measured in a continuum that moves from weakest ability to strongest ability on a seven-point Likert scale with 7 representing the strongest ability and 1 the weakest ability.

2.13 Conclusion

This chapter reviewed existing literature on reforms, ISO 9001 QMS, Compliance with ISO, Attitudes towards ISO, Norms towards ISO as well as behaviour control towards ISO 9001 QMS. The gaps in knowledge have been identified therein. The chapter also discusses the Theory of Planned Behaviour as advanced by Ajzen and Fishbein while at the same time outlines the conceptual framework as used in the study. Finally, the chapter outlines the three hypotheses that were tested in this study and provides an

operational definition of the variables under study. The methodology used in the study is discussed in the next chapter.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter sets out the research design that was followed in conducting the study. It includes site description, sampling, sampling procedures, data collection, measurement, and analysis of data.

In terms of philosophy, the study adopted a positivist approach. Collins (2010) observes that as a philosophy, positivism adheres to the view that only “factual” knowledge gained through observation (the senses), including measurement, is trustworthy. In positivist studies, the role of the researcher is limited to data collection and interpretation objectively. In other words, the researcher is an objective analyst and she distances herself from personal values in conducting the study. In these types of studies, research findings are usually observable and quantifiable.

Collins (2010) further observes that positivism depends on quantifiable observations that lead to statistical analyses. It has been a dominant form of research in business and management disciplines for decades. It has been noted that “as a philosophy, positivism is per the empiricist view that knowledge stems from human experience. It has an atomistic, ontological view of the world as comprising discrete, observable elements and events that interact in an observable, determined and regular manner.

3.2 Study Site

The study was conducted at Kenyatta National Hospital in Nairobi, Kenya. Kenyatta National Hospital, one of the oldest public institutions in Kenya provided a perfect setting for this study for two reasons. First, Kenyatta National Hospital has, being one of the oldest public institutions in Kenya, been a target for reforms in the larger health sector since the early ‘80s. It would provide an ideal setting to understand the behaviour

of the workers towards the reforms. Secondly, due to the heterogeneity of its workforce that combines both clinical and non-clinical staff, it provides an opportunity to explore the behaviour of workers towards reforms from different categories of workers working within a single institution. This may provide an insight as to why successive reforms have failed to achieve desired results.

Within the KNH complex is the College of Health Sciences (University of Nairobi); the Kenya Medical Training College; the Kenya Medical Research Institute and the National Laboratory Service (Ministry of Health). However, the study focused only on the Kenyatta National Hospital. This is because these institutions, although they provide services and work hand in hand with KNH, have their independent establishments and therefore have their quality management systems. KNH has 50 wards, 22 out-patient clinics, 24 theatres (16 specialized) and Accident & Emergency Department. The Hospital has a total bed capacity of 1800 out of which 209 beds are for Private Wing.

Within the organizational structure of KNH, there are three Divisions; the Clinical Services Division, the Corporate Support Services Division and the Prime Care Division. Since Prime Care provides clinical services, it was merged with Clinical Services in this study. Clinical Services is concerned with the technical mandate of the institution, which is to provide preventive and curative health services to Kenyans. Corporate support services provide the support required to implement the mandate of the institution, which is non-medical. From the responses, 58% of the respondents were from Clinical Services Division while 42% of the respondents were from the Corporate Support Division. When compared across gender, among the males, 56% are from Clinical Services while 44% were from Corporate Support. On the other hand, amongst the females, 70% were from clinical services while 30% were from corporate support.

This is an indication that the clinical services division has more female employees. According to the Human Resources Department at KNH, the backbone of clinical service lies in nursing with a doctor to nurse ratio of 1:8.24. The department notes that previously nursing was considered a preserve for women and hence the reason for the high numbers. However, there are more males now taking up the nursing profession and an increase in male clinical staff is envisaged soon.

KNH has 17 job groups that run from K1 to K17. For this study, the job groups were banded together based on levels of responsibilities. The first category constituted management staff. These included all the staff from job groups K1 to K5 and are those with supervisory responsibilities. The second category constitutes the officer-level staff. These are technical staff, who have the responsibility of undertaking various specialized tasks in both the clinical and corporate support divisions and include Job groups K6 to K10. The third category comprised the Clerical staff. They provide support to the technical staff. This is also an entry-level position for most of the technical staff in the organization and includes Job groups K11 to K13. The fourth category of staff is the Support staff. These provide non-technical support to the entire organization and are distributed across all the divisions. They are in Job Group K14 to K17.

3.3 Sampling and Sampling Procedures

This section covers the methods that were used in the selection of the respondents for the study. It covers the description of the study population, the sample size as well as the sampling procedure that was employed to select the respondents.

3.3.1 Study Population

The study population comprised 4700 employees working at KNH (Kenyatta National Hospital Report, 2015). Kenyatta National Hospital is composed of divisions,

directorates and departments. The structure comprises two divisions namely clinical services and corporate services. Additional data was collected from key informants that included a representative from the Public Sector Performance Management Division that is responsible for performance contracting and a representative from ACAL Consulting, a consultancy firm that has guided over 50 public sector institutions in attaining ISO 9001:2015 certification. The population at KNH is summarised in table 3.1: -

Table 3.1: KNH Population Distribution

Division	Directorate	Total Population
Corporate Support	2. Affiliations and Institutional development 3. Internal Audit and Risk 4. Supply Chain Management 5. Human Resources 6. Facilities and Services 7. Finance 8. Planning and Strategy 9. Corporation Secretary	1783
Clinical Services	5. Surgical Services 6. Medical Services 7. Pharmaceutical Services 8. Nursing Services	2917

Source: KNH HR Records 2019

The unit of analysis for this study is the employees of Kenyatta National Hospital. On the other hand, the individual employees were the observation units.

3.3.2 Sample Size

To determine the desired sample size from the population, the Slovin formula was used. Slovin's formula was selected for this study because it allows a researcher to sample the population with a desired degree of accuracy. It gives the researcher an idea of how large his sample size needs to be to ensure reasonable accuracy of results (Stephanie,

2016). Stephanie (2016) further notes that Slovin's formula is used when nothing about the behaviour of a population is known at all.

Slovin's formula is represented thus:

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

n = Number of samples N = Total population e = Error tolerance

Therefore, using 4700 as the study population and 0.05 as the error tolerance levels, a Sample of 370 was selected for the study.

3.3.3 Sampling Procedure

A multistage sampling procedure was used to arrive at the individual respondents. This is due to the complexity of the organization and the diversity among its staff. The procedure allowed for information to be collected from the different categories of staff at KNH.

First, stratified sampling was employed to cater to the different categories of staff at KNH. The stratified technique is advantageous as it samples each subpopulation (stratum) independently by grouping members of the population into relatively homogeneous subgroups before sampling. This improves the representativeness of the sample by reducing sampling error.

The first level of stratified sampling involved the establishment of two strata that is clinical and corporate support, which are the two main divisions at KNH. Based on the population of each, the sample size was proportionately allocated to the two divisions. The proportionate technique was selected because the study population was large. Additionally, it helped in reducing costs and time and increased efficiency. It also allowed for the different population segments to have an equal opportunity of being

represented in the final sample. This allowed for a proportionate representation of each division, which resulted in clinical services having a sample of 222 and corporate support 148.

The different staff was classified into the next strata based on job categories. There are 17 job groups at KNH. Sampling was also done proportionately to the population of each job category except for support staff who have minimum interactions with ISO Certification standards. For purposes of this study clusters of job groups were created and they included Management Staff (JG 1-5), Officer level Staff (JG 6–10), Clerical level Staff (JG 11-13) and Support Staff (JG 14-17). The final sample allocation included 8 management staff, 186 officer level staff, 116 clerical level staff and 60 support staff. To allow for significant representation, the sample size was adjusted to 377. The final allocation of the sample is summarised in table 3.2:

Table 3.2: Total Sample Distribution

Job Category	Number	Proportion	Sample Size	Adjusted	Final Sample	
					Clinical	Corporate
Director/Asst. Director	15	0.32%	1	2	1	1
Heads of Departments	30	0.64%	2	4	2	2
Middle level Managers	70	1.49%	6	6	3	2
Officer Level	1500	31.91%	120	120	72	48
Technician/Clerical Level	1600	34.04%	128	128	77	51
Support Level	1485	31.60%	119	119	71	48
Total	4700	100.00%	377	379	227	150

Source: Authors Computation, 2019

Due to the expansive nature of the hospital, the departments from which the respondents were selected were sampled randomly. A sample size of 11 departments out of 30 or 30% was considered representative. From the list of departments simple random sampling using the lottery method was used to select the departments to participate in the study. The following departments were therefore selected, from where respondents were sampled. (Table 3.3)

Table 3.3: Departments Sampled

No	Department	Depts/Sections/Units	No. of Staff Selected
1	Quality Health Care	Infection Prevention and Control; Quality Assurance; Medical Social Work; Public Health; Patient Affairs	44
2	Nursing Services	Nursing School; Nursing Medical Services; Nursing Surgical Services; Nursing Administration;	44
3	Diagnostic and Health Information	Lab Medicine; Radiology; Health Information; Funeral Home	44
4	Surgical Services	General Surgery; Dental; Orthopedic; Obs and Gyn; Rehabilitative Services	44
5	Medical Services	Pediatrics; Nutrition; Cardiology	44
6	Research and Programmes	All	18
7	Supply Chain Management	All	18
8	Human Resources	All	16
9	Administration	Transport; estate management; catering; Security	75
10	Finance	All	8
11	Planning and Strategy	Planning; Strategy, ICT	15

Source: Authors Creation from HR Data, 2019

From a list of staff provided by the human resource department, the final respondents were selected systematically until the desired sample size was achieved. Systematic sampling is more straightforward and can also be more conducive to covering a wide study area. Additionally, results are representative of most normal populations, unless a random characteristic disproportionately exists with every "nth" data sample, which is less likely to occur.

3.4 Methods and Tools for Data Collection

To collect data, the survey method was used. Survey research is a unique way of gathering information from a large cohort. Advantages of surveys include having a

large population and therefore a greater statistical power, the ability to gather large amounts of information and having the availability of validated models.

The cross-sectional research design of the survey method was adopted for this study. This is where data was collected from many different individuals at a single point in time. In cross-sectional research, the researcher observed variables without influencing them. The study employed both descriptive and analytical methods.

Several techniques were used in the collection of qualitative and quantitative data for the study. This section discusses the types of data collected and the tools employed.

3.4.1 Quantitative Data

The primary data was quantitative and was collected through structured questionnaires. The questionnaire was used to collect information on demographics, behaviour intention, attitude, subjective norms as well as organizational culture. The questionnaire was constructed and designed following the guidelines for TPB as described by (Ajzen, 2013). It was then modified to collect additional information required in the study.

The questionnaire was divided into 5 broad sections and 8 subsections, each meant to capture different types of information from the staff of KNH. The first subsection captured demographic data from the respondents including age, gender, job group, years of service and department. This information is useful for understanding the basic demographic characteristics of the staff in the institution and their distribution. The second subsection was used to capture levels of awareness and attendant attributes. The questions in this section were both closed and open-ended to allow the staff to give information on levels of awareness at the institution.

The third, fourth, fifth and sixth subsections were used to capture information on compliance with ISO certification, attitudes, norms and behaviour control. This section

was done using guidelines of the theory of planned behaviour as described by Ajzen (2013). For this section, a set of statements were given to the respondents. Respondents were required to list their responses on a 7-point Likert scale. Scoring was done based on the responses with 7 being the highest score and 1 being the lowest score. To ensure internal validity and reliability there were negative statements included in the set of statements. Scoring for the negative statements was inverted to get the actual score. For example, if the respondent selected 1 on a negative question, the score would be 7; 2 would attract a score of six while 5 would attract a score of 3 and 4 would remain 4.

To assess the strength of attitude, different aspects of instrumental and experiential attitude were posed to the respondents. The respondents scored on a 7-point Likert Scale where 1 represented very weak and 7 represented very strong attitude. A seven-point Likert scale was used to evaluate the strength of the norms on compliance with ISO procedures where 1 represented a weak influence on norms while 7 represents a strong influence of norms. To determine the strength of behaviour control, statements on self-efficacy and personal agency were posed to the respondents. A 7-point Likert scale was used to determine the strength where 1 represented very weak control while 7 represented very strong control. Finally, three parameters were used to assess the intention to comply with ISO procedures (BI). These were expectation; intention and desire. The mean scores represent the strength of the intention with 1 being the weakest and 7 being the strongest. The overall mean score represents the strength of the Behaviour Intention which is compliance with ISO 9001:2015 QMS.

The seventh subsection covered organizational culture. A set of questions were posed to the respondents. The respondents were asked to state their level of agreement with various statements on a three-point scale. The overall score was plotted on a four-point matrix according to the matrix provided by Goffee and Jones (1996). Finally, the eighth

section was on the general performance of the organization in the implementation of ISO 9001:2015 QMS standards. The questions were open-ended and the respondents were also required to give a recommendation based on their experiences.

The use of the questionnaires was appropriate for the study since they collected information that is not directly observable as they inquired about the feelings, motivations, attitudes, accomplishments, as well as experiences of individuals. The use of Questionnaires was also less costly, using less time as an instrument of data collection, and useful in obtaining objective data. The questionnaires were self-administered to all the respondents in the study. For the lower cadre staff who were unable to complete the questionnaire on their own, the researcher and trained research assistants provided the support.

3.4.2 Qualitative Data

Qualitative data was collected by the use of key informant interviews, in-depth interviews, observations, document review and one focus group discussion. In-depth interviews were conducted with 12 staff of KNH. The 12 comprised of staff who headed different sections and were purposively selected. These are the staff who support the quality manager in the documentation of ISO procedures as well as ensuring the procedures are made available to staff within their departments. Information sought from them was on their experiences in processes and procedures at the departmental level and was not contained in the main questionnaire. One Focus Group Discussion was held. This was sufficient as it brought together staff from the different divisions at the hospital. Focus group discussion (FGD) involved 10 staff selected from both clinical and corporate support staff at different job categories. The focus group discussion and in-depth interviews focused more on gaining an in-depth understanding of the reforms being implemented at KNH and the response of the workers focusing more on ISO

9001:2015 QMS. Additional information was also sought on the challenges faced and recommendations to improve the delivery of reforms at KNH. An interview guide was used for the in-depth interviews. The FGD was important in using group dynamics to identify areas of convergence and areas of divergence across different staff at KNH. It also helped elaborate on some of the issues that would not ordinarily be adequately covered by a structured questionnaire. An FGD guide was used to guide the discussions.

Purposive sampling was used to select the respondents to participate in the FGD and the in-depth interviews. The criteria set out included knowledge of ISO 9001:2015 QMS being implemented at KNH; gender; departmental representation and number of years in service. This was done to achieve a diversity of opinions from the staff at KNH.

Two key informants also participated in the study. These included the Head of Reforms at the Public Sector Performance Management Unit (PSPMU) and the Head of Business Management from ACAL Consulting. The key informants provided information on public sector reforms and the rationale behind the introduction of ISO 9001 certification as a performance target. Additionally, they provided information on the challenges faced by public sector institutions in implementing ISO 9001:2015 QMS. The key informants were selected purposively based on their knowledge and expertise in implementing government reforms (PSPMU) and in the implementation of ISO QMS in the public sector (ACAL). The choice of the external key informants was based on their knowledge of the subject matter and more importantly on the operations of KNH. The PSPMU was responsible for the design and development of performance contract targets and during the formative years, at the introduction of ISO certification as a target, they were responsible for vetting targets and evaluations of performance. Secondly, ACAL was subcontracted by the Kenya Bureau of Standards to prepare public sector organizations for ISO certification, this included sensitizations, training,

documentation and pre-certification audits. Their knowledge in this area is unmatched. The Key informants, therefore, provided useful information for the study, which could not be found in any other source.

Key documents that were reviewed included the KNH Strategic Plans (2013-2017 and 2018 – 2022) and ISO management reports for 2019. The documents provided an insight into the strategic direction the hospital is taking and the role of reforms in driving the Hospital strategy. The management reports provided details of implementation and progress in the implementation of the QMS.

While conducting interviews, the researcher made unobtrusive observations in key service areas such as the accident and emergency centre. The observations were mainly to see the implementation of quality management systems especially patient reception and the general equipment and infrastructure put in place.

3.4.3 Ethical Considerations in Data Collection

Before the process of data collection, the researcher sought permission/authorization letters to collect data. After approval from the University was obtained to conduct the study, permission was obtained from the Ethics Review Committee at KNH and NACOSTI before data collection commenced. Data was collected from 8th April to 30th April 2019 at KNH. This was after all the necessary protocols and approvals had been granted.

To enhance the response rate, the study kept into consideration the research ethical issues. To enhance the response rate, two main strategies were employed. The first was to get informed consent. The researcher explained to the respondents the importance of the study and sought consent before administering the instruments. The data collection method was free from emotional harm to respondents and only respondents competent

enough to address the objectives were considered. The respondents were required to sign the informed consent form before proceeding to complete the questionnaire. The form explained the purpose of the study and the inherent risks therein and how they will be addressed. Respondents were only required to sign the form if they understood the study and its objectives. Secondly was the issue of confidentiality. To address this, the researcher had to assure the respondents that the information they provide will be treated with the utmost confidentiality and there shall be no reference whatsoever to the individual respondent.

To address possible emotional harm to respondents, the questionnaire was designed to ensure none of the questions made the respondents feel uncomfortable. The tool was also subjected to various tests and a final pre-test was conducted at the study site.

3.5 Pilot Study

The questionnaire was subjected to a pilot test before actual field work could begin. A total of 26 questionnaires were administered to staff of various cadres at KNH. While some staff endeavoured to complete the questionnaire fully some filled in and left some questions blank. Overall, the staff indicated that the questionnaire was based on issues that they understood and that the language was simple. The staff also indicated that completing the questionnaire did not take a long time with the minimum time being 7 minutes and the maximum time being 15 minutes. None of the respondents had challenges in completing the questionnaire. The analysis involved running tests for reliability as well as best fit tests to get a feel of the emerging trends.

The reliability tests were administered using the Cronbach's Alpha on the questionnaires that were fully completed. The results yielded a Cronbach's Alpha value of .757. A score of .7 and above indicates high reliability. The questionnaire was therefore considered reliable and consistent.

3.6 Data Analysis

After data collection, the filled-in and returned questionnaires were edited for completeness. Invalid questionnaires were removed based on an established criterion. This included questionnaires that were more than 40% incomplete; questionnaires that presented inconsistent responses (the tool had in built mechanisms for detecting inconsistencies) and questionnaires that had a large number of corrections. From 377 questionnaires that were administered, a total of 300 questionnaires were returned and after clean-up, a total of 291 questionnaires were found to be valid. This represented a response rate of 77% and was found to be representative of the sample size.

The quantitative data was coded and entries were made into Excel worksheets. The data was later transferred to the Statistical package for social sciences (SPSS version 20) for analysis. Coding ensured that the data is accurate, uniformly entered, complete and arranged to simplify tabulation. Analysed data was presented using frequency tables. Tests for central tendency and dispersion including standard deviations and means were conducted. Cross tabulations and chi-square tests for different variables were conducted against demographic characteristics of age, gender, job group, divisions and years of service. Relationships among variables were determined using correlation analysis and regression analysis with attendant tests of significance including the p-value and Pearson's r. Factor analysis was also used to determine the significance of each of the constructs being measured under the variables. The advantages of factor analysis include the identification of groups of interrelated variables to see if they are related to each other and it can be used to identify hidden dimensions or constructs which may or may not be apparent from the direct analysis. This study used psychometric questions extensively and therefore the choice of factor Analysis. Multiple Regression was

conducted to determine the predictive value of each of the independent variables as well as the model fit. For this study, the statistical levels of significance were set at $p \leq 0.05$.

On the other hand, qualitative data was obtained through in-depth interviews and FGD and Key informant interviews. The data was transcribed and grouped into thematic areas for further analysis. The data has been presented in the form of narratives (i.e. direct quotes).

3.7 Conclusion

This chapter discussed the framework for data collection and analysis as used in the study. The study used a cross-sectional survey design. The study site was Kenyatta National Hospital being at the centre of health provision in Kenya. Data was collected from the employees of Kenyatta Hospital, who were selected through a multistage sampling procedure. Self-administered questionnaires were used to collect quantitative data while interview guides and FGD guides were used in the collection of qualitative data. Statistical data was collated, entered and analysed through SPSS. Several tests were conducted to establish the relationship between variables under study and these included cross tabs, factor analysis and regression analysis. The results of the analysis have been presented in chapters four and chapter five of this report. Chapter four discusses the assessment of compliance with ISO 9001:2015 QMS at Kenyatta National Hospital whereas chapter five discusses the influence of attitudes, norms and behaviour control on compliance with ISO 9001:2015 QMS by workers at Kenyatta National Hospital.

CHAPTER FOUR

COMPLIANCE WITH ISO 9001:2015 QMS BY WORKERS AT KENYATTA NATIONAL HOSPITAL

4.1 Introduction

This chapter presents findings on the first specific objective of the study that sought to assess compliance with ISO 9001:2015 QMS implementation by workers at Kenyatta National Hospital. The chapter specifically, looks at demographic characteristics of the workers, ISO 9001:2015 QMS awareness levels, perceived outcomes of compliance with ISO 9001:2015 QMS, Compliance levels of ISO 9001:2015 QMS as well as organizational challenges affecting compliance with ISO 9001:2015 QMS at Kenyatta National Hospital.

4.2 Social Demographic Characteristics of the Study Population

This section provides an analysis of the study population in terms of socio-demographic characteristics. These entail age, gender, number of years in service, and highest education levels attained.

4.2.1 Gender

From the analysis, 52% of the respondents were male while 48% were female. It is important to note that there were more females (54%) compared to males in the clinical services division. Additionally, within the age bracket of 25-31, 39-45 and 53-59 there were more females than males at 58%, 57% and 83% respectively. The distribution according to gender is presented in detail in table 4.1.

Table 4.1: Distribution According to Gender (N=231)

		Division		**Age**					
Gender	Total	Clinical Services	Corporate Support	18–24	25–31	32–38	39–45	46–52	53–59
	231	145	86	7	77	29	28	14	6
Male	52%	46%	60%	71%	42%	62%	43%	64%	17%
Female	48%	54%	40%	29%	58%	38%	57%	36%	83%

Source: Field Data, 2021

4.2.2 Age

Generally, the bulk of the respondents (48%) were between 25 – 45 years. The mean age group for the staff at KNH was computed to be 32 – 38 years. From the responses given majority (27%) were between 25-31 years while those between 18-24 years and 53 – 59 years were 2% respectively. KNH therefore has a balanced workforce with a mixture of younger employees and older employees (Table 4.2).

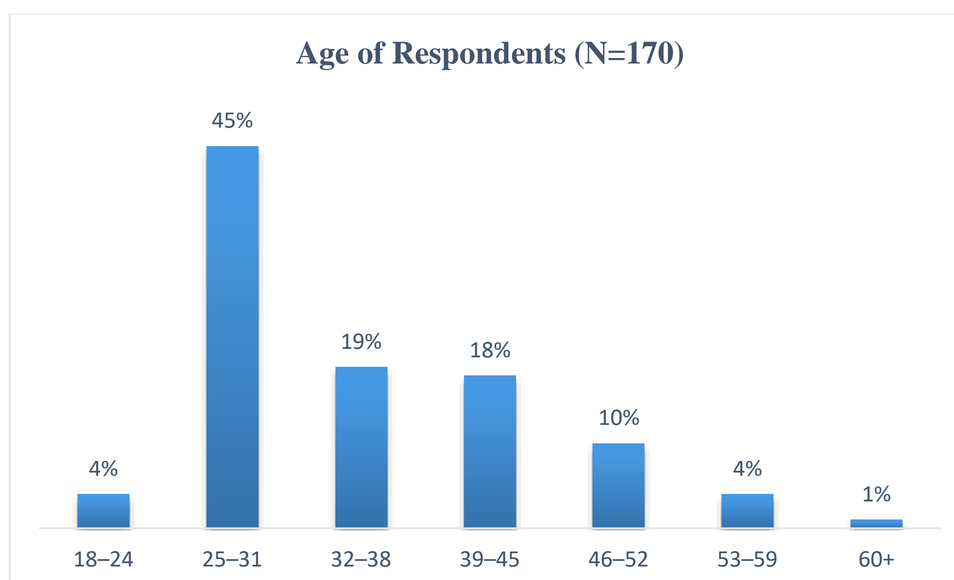

Figure 4.1: Age of respondents
Source: Field Data, 2021

According to Finkelstein and Block (2015), an older employee is advantageous to the company for various reasons. Firstly, older workers bring a level of experience, critical thinking and sheer knowledge that cannot be taught. Secondly, they stay in jobs longer and take fewer days off. Thirdly, they have a strong work ethic and they retain a business's knowledge and networks. The authors further note that because older

workers did not grow up with computers and the internet, they are perceived as slower or more resistant. Businesses who have expected all workers to adapt to new technology and provide support versus allowing some to lag, report better success, as do those who “think about the team,” pairing workers with stronger and weaker technology skills together. Older workers play a critical role in training the next generation of workers. This is in addition to the critical role they play in providing customers with consistency and personal attention. They are also known to attract more business as well as being older workers, are part of the business brand.

On the other hand, younger employees are also advantageous to an organization in various ways. Firstly, Young employees can bring fresh perspective and a different way of thinking to your business. Secondly, young people are used to learning. Thirdly, wages for a young employee are less expensive than those for an older more experienced worker. Fourthly, younger staff have grown up around technology. Their natural affinity for tech and their ability to apply and understand different technologies quickly sets them apart from other generations in the workforce. Fifthly, when unexpected circumstances arise, younger people are better equipped to respond to sudden change. With economic, social and political boundaries in a state of flux, adaptability gives young people an advantage in a work environment that is more agile, changeable and fast-paced than ever before. (Alba, 2019, Heather, 2019). While KNH is adopting reforms and implementing ISO 9001:2015, both sets of employees need to be closely involved to enable the hospital to optimize their strengths. Missing out on a certain age category may hinder the effective implementation of reforms.

4.2.3 Number of years in service

The mean number of years of service was 7-9 years. This means that majority of staff have served the institution for a long time. Across the divisions, there was more staff

with 1-3 years of service (43%) within the clinical division compared to 22% from the corporate support. This can be partly attributed to the expansion of services provided within the hospital in the past three years. There is also a significant proportion of the staff 12% with over 16 years of work experience. There are advantages and disadvantages associated with long-serving employees.

Table 4.2: Employee Length of Service

Length of Service	Total	Division	
		Clinical	Corporate Support
	242	153	89
Less than 1 year	13%	15%	9%
1-3	27%	31%	20%
4–6	19%	16%	24%
7-9	12%	9%	17%
10–12	8%	8%	9%
13-15	7%	8%	4%
16+	14%	13%	17%

Source: Field Data, 2021

According to Prowse (2019), the advantages of long-serving employees are numerous. Firstly, they have a sound knowledge base of the company's culture, and its products and services. They know what works within the organisation, and therefore their productivity can be higher. Secondly, long-serving employees can also pass on their knowledge to new employees and provide additional support during the onboarding process. This has the benefit of decreasing the time it takes for a new hire to become familiar with the business and reach a peak in performance and productivity. Lastly, companies that are seen to have a core of long-serving employees can give positive indications about their workplace environment.

He (ibid) also identifies the disadvantages of long-serving employees. Firstly, he observes that long-serving employees are often very resistant to change. This can be counter-productive to the growth and development of the company.

Secondly, when change is taken up by long-serving employees, it is often slow – reducing the effectiveness of any initiatives and increasing business costs. The key reason for this is that their long service creates self-assurance that is ill-founded. They don't believe change is necessary and don't expect others to 'rock the boat'. When they are faced with the prospect of change, conflict can ensue. Finally, long-serving employees present a challenge to move from any post. The expense of moving them can also be greater than a shorter serving employee.

4.2.4 Level of Education

KNH is a specialist institution. Therefore, 97% of the staff have a post-secondary level of education. Additionally, 64% of the respondents have a diploma or degree level of education. Of this category, 70% of staff in the clinical division have diploma or degree qualifications while 55% of the staff in corporate support have diploma or degree qualifications. Figure 4.2 provides a summary of the academic qualifications of respondents.

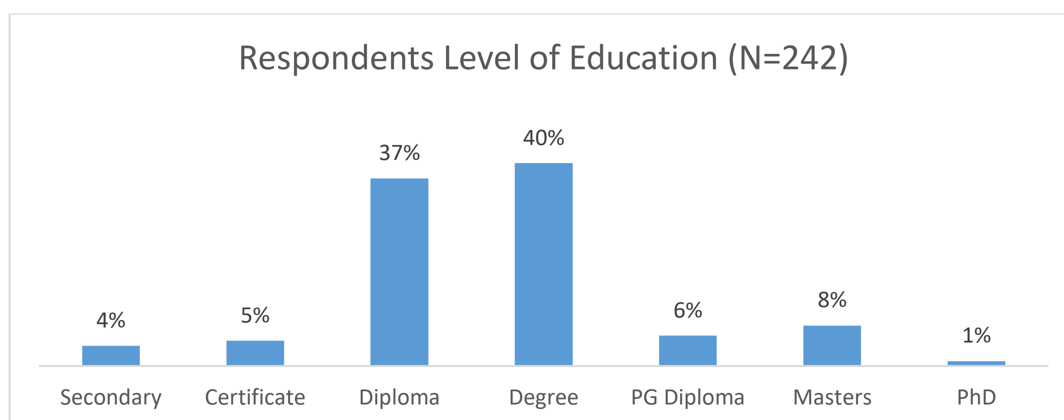

Figure 4.2: Respondents Education Level
Source: Field Data, 2021

Having a high number of educated staff implies that communication and dissemination of information through multimedia channels are possible. Additionally, Cipoletti, (2017) identifies various advantages linked with a highly educated workforce. She

notes that educated employees exhibit a greater aptitude for handling large, complex projects more productively and efficiently as compared to their less-educated workers. In addition to the bonus of a pre-existing skill set, educated employees generally exhibit higher levels of motivation, which in turn leads to higher quality output and fewer errors. Secondly, she notes that increasing employee awareness of company policies, products and developments enables employees to be more knowledgeable on company values and increases their ability to anticipate and predict client needs. Thirdly, the author observes that well-educated individuals are more goal-oriented, delivering better work performance than less-educated employees. Moreover, companies can benefit from the dynamic perspective and innovative thinking of high performers. Finally, ongoing training promotes the employees' understanding of company values and processes. Employee empowerment through education will lead to greater employee engagement and will encourage employees to take leadership within the company. The biggest downside with a highly educated workforce is that if not well managed it can lead to a fragmented culture that is characterised by highly formal relationships and silos. This type of culture makes the implementation of changes in the company difficult.

4.3 Workers' level of awareness of ISO 9001:2015 QMS

Awareness of any initiatives undertaken by the organization is key to how the employees will perceive the initiative. This is largely what determines buy-in and subsequently implementation of the initiatives. General awareness of ISO certification was high at 82%. This shows that the majority of the staff are aware of ISO 9001:2015 being implemented at the hospital. There were high levels of awareness among corporate support staff (92%) compared to clinical support staff (73%) as shown in Table 4.3.

Table 4.3: Awareness of ISO per Division, Education and Job Group

		Division		Highest Academic Qualification							Job Group			
	Total	Clinical	Corporate Support	Secondary	Certificate	Diploma	Degree	PG Diploma	Masters	PhD	Management	Officer	Clerical	Support
	287	164	123	10	11	89	96	14	18	2	13	96	25	10
YES	82%	74%	92%	40%	73%	80%	81%	93%	83%	100%	85%	91%	72%	40%
NO	18%	26%	8%	60%	27%	20%	19%	7%	17%	0%	15%	9%	28%	60%

Source: Field Data, 2021

Across the different job groups, on the other hand, there was higher levels of awareness among staff at the officer level (91%) compared to other job groups with management (85%), clerical (72%) and Support (40%). The differences in levels of awareness can be attributed to participation in the implementation of the QMS. Across gender, there were no significant differences between males and females in awareness levels as shown in table 4.4.

Table 4.4: Awareness of ISO QMS across Gender

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.109[a]	1	.741		
Continuity Correction[b]	.029	1	.866		
Likelihood Ratio	.109	1	.742		
Fisher's Exact Test				.751	.433
Linear-by-Linear Association	.108	1	.742		
N of Valid Cases	233				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 23.97.

b. Computed only for a 2x2 table

Source: Field Data, 2021

The value of the chi-square statistic is.109 and the *p*-value is 0.710. The result is significant if this value is equal to or less than the designated alpha level which is 0.05. In this case, the *p*-value is greater than the standard alpha value and in our case, the

result is *not significant*. The data suggests that the variables gender and awareness of ISO certification are not associated with each other.

While it is an organization-wide system, the staff at the officer level are responsible for the day-to-day delivery of services to the clients at the KNH. Most of the training and awareness sessions at the hospital have targeted this cadre of employees the most compared to the other categories of staff.

In this study, the level of awareness was found not to translate to the levels of knowledge. Employees that indicated awareness of ISO certification were asked to state their understanding of the process. The majority (57%) of the respondent could not define what ISO is. This is an indication that despite being aware of the ISO process, the bulk of the employees have not understood what ISO QMS entails. Awareness levels depend on the methods that the management of the hospital used for employee engagement. Focus group discussions with the staff indicated that the hospital conducted awareness sessions for all employees. Departmental meetings and publications including notices were placed in strategic locations within the hospital to complement this. They however, indicated that the messaging was not targeted to different cadres of staff within the hospital. External parties conducted the training. They also indicated that there was no system put in place to track if all the staff attended the training or the effectiveness of the training. As one participant put it

> *"The ISO trainings and sensitizations were not properly conducted; we were many people in one room and the trainers assumed we were at the same level of understanding. I believe the management should have trained people in small groups which are homogenous in nature. That way the levels of understanding would have been much higher for all cadres…"* FGD Participant

The study also found out that the strategies being used by the hospital in ensuring employees have adequate knowledge of ISO were largely ineffective. This was

indicated by the source of information on ISO by the staff. From the findings, 52% of the employees attributed their awareness levels to efforts by the institution. These included 25% from training at the institution, 15% from the management sensitizations, and 12% from internal circulars and memos. On the other hand, staff indicated that they learned of ISO QMS from sources outside of the formal institutional structures. These included 20% from attending training outside of KNH.; 21% from peers and 11% from other sources of information including media, friends and own initiatives. The main sources of information on ISO are summarized in table 4.5.

Table 4.5: Source of Information on ISO

Source of Information on ISO	Average	Division	
		Clinical	Corporate Support
	117	66	51
From training at KNH	25%	20%	30%
From colleagues and friends	21%	20%	22%
From own training	17%	20%	14%
The management	15%	21%	6%
Sensitization through circulars and memos	12%	10%	14%
From own initiative	9%	3%	18%
News/media	3%	5%	0%
Learnt in College	3%	6%	0%

Source: Field Data, 2021

This implies that the dissemination of ISO QMS to employees lacks uniformity. This has led to different interpretations and some extent different applications of the QMS at KNH, an indication of poor internal marketing.

Awareness is one of the basic requirements for leadership in the implementation of the QMS and by extension, any reforms. “Engagement of people” is one of the stated quality management principles mentioned in the ISO 9001:2015 standard, while Section 7 of the standard deals with “Resources” and the role of people and the environment that those people create as a result. ((ISO 2015). Awareness creation is the

first basic step to the engagement of the people. Gaining the hearts and minds of the organization’s employees can make the difference between a smooth, efficient, and beneficial QMS implementation and operation, and a frustrating and problematic one. The habits, relationships, and disciplines that the management establishes with the employee team during the implementation of the QMS can set the foundation for future performance, so employee engagement must be established early in the implementation phase.

In terms of employee involvement, only 22% of the respondents indicated that they were involved in the development of the procedures within their respective departments. Involvement of employees took various forms including training, consultations, direct development of documentation and providing support services.

Nolan (2015) identifies various strategies that employees can get involved in successfully implementing the QMS. The first strategy is to involve employees in the initial communication. This he notes is to create buy-in and have all employees getting involved from the onset. Secondly, is to explain the benefits. This he notes will help manage change and resistance to change therein. The third strategy is to demonstrate and involve. This involves engaging the employees at every stage whenever possible. The management should illustrate the “why and how” and elicit employee opinions wherever possible. The fourth strategy is to share objectives and results and ensure that employees see the output of the processes that support the QMS. Continual improvement means good news for stakeholders, shareholders, customers, and suppliers.

The fifth strategy involves engaging and eliciting opinions. In this strategy, processes like corrective action and internal audit are at the heart of the QMS and its activity. Increased involvement means increased knowledge and heightened opinion, and

suggestions for continual improvement will be the result. Finally, he notes that it is important to celebrate with employees. Here the management should ensure that employees share the success stories and sense of achievement that success brings. Increased involvement brings an increased sense of responsibility, which is a huge positive. The majority of the participants in the focus group discussion noted that although the hospital did very well in the initial communications, there was little that was done in the subsequent strategies as enumerated to them. The implication is that in as much as there are high levels of awareness, knowledge remained low thus affecting the engagement of the people.

Awareness is a key pillar in enhancing employee engagement with the ISO 9001:2015 Standard and it is a key determinant of compliance behaviour. Authors like Mukwakungu (2018) have observed that it fosters staff integrity and corporate culture as well imparts practical knowledge on enacted corporate policies and workplace procedures. When QMS awareness is not high and is not translated to knowledge, then gaps in compliance behaviour will begin to emerge. This is manifested in a lack of integrity as well as poor implementation of policies and procedures at the workplace.

4.4 Perceived Outcomes of Compliance with ISO 9001:2015 QMS

The purpose is to establish the motivation to comply with the ISO QMS procedures among the workers at KNH. The literature review and pre-study discussions with KNH staff identified three key motivating factors for compliance that influences behaviour outcomes. The first factor is compliance with ISO 9001:2015 QMS makes the workplace efficient and worker-friendly and is linked with behavioural beliefs. This is consistent with section 7.1 of the standard that requires the organization to determine and provide the resources needed for the implementation, maintenance and continual

improvement of the QMS. (ISO, 2015). As a result, the hospital has been able to make improvements in the workplace.

The second motivating factor identified as compliance improves communication within the hospital. This is linked with normative beliefs. This is also consistent with section 7.3 of the ISO 9001:2015 standard which states that organizations shall determine the internal and external communications relevant to the QMS. The workers believe that by KNH implementing this requirement, then reciprocal communication improves in the institution. Finally, the third motivating factor identified was improved decision-making at the institution. This is linked with control beliefs.

ISO 9001 draws on the Plan-Do-Check-Act (PDCA) cycle for continual improvement. The standard aims to control the organization's processes by planning, implementing, measuring and corrective analysis of activities. The four phases of the PDCA cycle underpin management control and form a learning process hence improved decision making. (ISO, 2015). The strength of each of the three motivating factors is summarised in table 4.6:

Table 4.6: Perceived Outcomes of Compliance

Outcomes (N=286)			
	Mean	Standard Deviation	Factor Loading
ISO Certification has made the workplace more efficient and worker friendly	5.665	1.681	0.765
ISO Certification has promoted reciprocal communication at KNH	3.418	2.201	0.968
With ISO Certification decision making at KNH has been effective and coherent	5.329	1.664	0.747
Average Mean Score	**4.804**		

Source: Field Data, 2021

All three beliefs contributed significantly to the overall beliefs concerning compliance with ISO 9001:2015 QMS. Factor loading analysis revealed that improved communication (normative beliefs) was the biggest determinant with a factor loading

of 0.968 out of a possible 1, followed by making the workplace more efficient and effective (behavioural beliefs) with a loading of 0.765 and decision making (control beliefs) with loading of 0.747. However, the findings also return low ratings on normative beliefs (communication) with a mean of 3.418 compared to behavioural beliefs (workplace factors) with and mean of 5.665 and control beliefs with a mean of 5.329. An overall mean score of 4.804 indicates that the workers have positive beliefs about the outcomes associated with compliance with ISO 9001:2015 QMS procedures. Despite their significant influence on the overall outcomes, there were lower ratings on decision-making by the staff at KNH. Overall ratings however indicate that staff has strong beliefs on the outcomes of ISO 9001:2015 QMS implementation.

The findings are consistent with studies that have shown that the implementation of ISO can result in positive outcomes for both the organization and the workers. Benefits that accrue to the organization include greater efficiencies, cost reduction and improved productivity (Kazilunas, 2010; Moturi, 2015; Ochieng 2015). On the other hand, positive outcomes that accrue to individual workers include improved workplace relationships, employee involvement, staff morale and job satisfaction (Norehha *et al.,* 2017). The Theory of Planned Behaviour observes that for the behaviour to be assessed, there have to be positive beliefs about the outcomes of the behaviour. The data has been able to establish that the staff of KNH have positive beliefs about outcomes associated with compliance with ISO 9001:2015 QMS. This then paves way for the assessment of the behaviour in question in this case compliance.

4.5 Compliance with ISO 9001:2015 QMS Procedures

ISO 9001:2015 seeks to ensure that organizations conform to international standards as prescribed in their quality management system. Conformity is seen as adherence to accepted behaviours, norms, standards, and values; acting as expected; maintaining the

status quo. Organizations seek to conform to laws, regulations and standards simply because they want to maintain legitimacy as well as provide goods and services that are acceptable to the general public. ISO audits are undertaken to establish conformity to the QMS and where there is no conformity, a non-conformity report is issued to the organization with corresponding corrective action reports. At the employee level, organizations expect employees to comply with the QMS requirements. Compliance is therefore a form of social influence that makes employees change their behaviour in response to explicit demands of the QMS. This is what is referred to as compliance behaviour.

Guided by the Theory of Planned Behaviour, compliance is measured by looking at the behavioural intention. Behavioural intention (BI) is an indication of a person's readiness to perform a given behaviour or action. Behavioural intention is considered to be the immediate antecedent of behaviour (Knabe, 2009). In previous studies using the Theory of Planned Behaviour, behaviour intention variables included communication behaviour, health-related risk prevention actions, and specific technological adoptions. Ajzen's behavioural model requires the target behaviour to be as specific as possible, including the time and, if appropriate, the context. (Ajzen, 2002). As applied in this study, behavioural intention is a worker's intention to comply with the ISO 9001:2015 QMS at KNH.

Ajzen (2013) contends intention items should have psychometric qualities when developing pilot studies, and final questionnaire items about behavioural intention should have high correlations with each other. The behavioural intention of the participants in this study was measured by three items on a 7 –point unipolar self-reporting scale with possible responses ranging from strongly disagree (1) to strongly agree (7). These were expectation; intention and desire. Expectation refers to the extent

to which the staff expects to comply with ISO procedures. Intention refers to the extent to which the staff intends to comply with the ISO procedures while Desire refers to the extent to which the staff wants to comply with ISO procedures.

Table 4.7: Compliance with ISO procedures (N=286)

Compliance with ISO 9001:2015 QMS Procedures			
	Mean	Standard Deviation	Factor Loading
I Expect to comply with all ISO procedures at KNH	5.97	1.46	0.728
I intend to comply with ISO procedures at KNH	2.35	2.16	0.222
I want to comply with ISO procedures at KNH	6.07	1.55	0.690
Overall Mean Score	4.80		

Source: Field Data, 2021

The study revealed strong intentions to comply with ISO 9001:2015 procedures with a mean of 4.8. From the parameters assessed, the desire to comply registered the highest score 6.07 followed by expectation (5.97) and intention (2.35). Factor Analysis revealed that intention had a low factor loading of 0.22 and does not therefore contribute significantly to the overall mean. The adjusted mean minus intention shows a very strong behaviour intention with a mean of 6 (or a score of 86%). It therefore evident that the employees at KNH have a strong intention to comply with ISO 9001:2015. When cross-tabulated with gender, there was no difference noted between the means of males and females. This is as shown in table 4.8.

Table 4.8: Compliance and Gender (N=233)

Behavior Intention	Mean	Male	Female
I expect to comply with all ISO procedures at KNH	5.97	5.91	6.13
I intend to Comply with ISO procedures at KNH	2.35	2.53	2.17
I want to comply with ISO procedures at KNH	6.07	6.03	6.19

Source: Field Data, 2021

Based on the argument by the Theory of Planned behaviour, that intention is the immediate antecedent of actual behaviour, we can conclude that there is strong compliance behaviour towards ISO 9001:2015 QMS procedures at Kenyatta National Hospital. However, this still falls short of the required compliance level of 100%. This essentially leads to service delivery gaps at KNH. Focus Group Discussions, Internal Key Informants and External Key Informants pointed out some key challenges that have made the achievement of required compliance levels difficult.

Firstly, is the general perception that the effort and investment to implement QMS were forced upon institutions through the annual performance contracts in which every government agency was required, as one of its performance contract indicators, to pursue certification to ISO 9001. The purpose of adopting a QMS is a strategic decision by the top management to implement systems that demonstrate the ability to consistently provide products and services that meet customer, statutory and regulatory requirements while also enhancing customer satisfaction (ISO 9001:2015 clause 0.1). Although it has been removed as a PC requirement, the very perception of coercion, whether real or imagined should go away and give way to a new realization and total reorientation.

Secondly, lack of commitment by the top management hence not providing resources and other support. Further, impunity at the high echelons of KNH leadership and governance in which processes and systems matter the least while the individual leaders' influence and scheming matter the more. The mastery of impunity interferes with established systems to benefit the whims of those in position.

Thirdly, employees will be allocated extra tasks during an ISO 9001 implementation, and this extra workload can cause unrest, stress, and bad feeling. The resources required

must be scoped out with the top management and middle managers at the start of the project e.g lack of any form of motivation for internal quality auditors who undertake audits regularly besides other duties. To sum this up, one of the internal key informants made the following observation:

> *'The management does not sanction nor reprimand incidences of non-compliance. In fact, I think those who do not comply are favored more when it comes to promotions and other goodies….'* Key Informant, 2019.

Fourth, it is the expectation of customers and interested parties that once an organization is ISO 9001 certified all its products and services become "quality" immediately. This is fueled by the perception created by the glamour with which they launch and celebrate the certification. The truth is that a quality culture that is eventually experienced in service and products is a whole ecosystem that is nurtured over time. A QMS introduces a culture of continual improvement, one step at a time while preserving the quality gains attained at every step.

Finally, poor training of staff who therefore don't understand the concept. Lack of competence, appropriate training, and awareness drive QMS in the wrong direction. Sometimes departments don't close out internal audits otherwise known as addressing non-conformities through corrections and corrective actions as per the corrective action plans.

One focus group discussion participant summarizes the challenges in implementing the QMS at KNH:

> *'Strucuring QMS as the work of a department or an exclusive role of the Management Representative (MR) instead of a collective responsibility for all members…in addition there is too much documentation especially in non-automated environments…and finally there is poor communication within the Hospital on QMS and the roles of each staff. The ISO QMS should be integrated into our day-to-day activities.'* (FDG Participant)

Additionally, the respondents also identified some challenges in compliance as summarised in table 4.9.

Table 4.9: Challenges in implementing ISO Procedures (N=121)

Challenges	Proportion of Respondents citing challenge	Clinical	Corporate Support
	121	67	54
Inadequate knowledge about ISO	26%	31%	20%
Inadequate resources and infrastructure	20%	24%	15%
Inadequate trainings	16%	6%	28%
Shortage of staff and suppliers	14%	25%	0%
Poor staff involvement and team work	13%	16%	9%
Resistance to adapt to changes	9%	4%	15%
Poor staff sensitization	8%	7%	9%
Machine breakdown and inadequate essential equipment	5%	4%	6%
Weak budgetary Support	4%	1%	7%
Poor working conditions and communication	3%	4%	2%
Poor / bad attitude	2%	3%	2%

Source: Field Data, 2021

These findings are consistent with other studies that looked at challenges in implementing ISO 9001 QMS. Almeida *et al.,* (2018), identified top management commitment, team commitment, training, responsibilities and authority defined, integration between departments and awareness regarding ISO as factors that can hinder the successful implementation of the QMS. Additionally, Helgi (2015) and Noreha *et al.,* (2017) also identified management commitment and employee participation as key impediments to a successful implementation of the QMS. Finally, Aamer *et al.,* (2021) identified awareness and inconsistency in understanding certification purpose as challenges in attaining full compliance with the quality standards.

4.6 Conclusion

This chapter sought to assess compliance with ISO 9001:2015 QMS procedures by workers at Kenyatta National Hospital. Findings on sociodemographic characteristics revealed a balanced gender ratio and a young and productive workforce with a majority of workers being between 25-45 years. Additionally, the majority of the workers have worked longer for the Hospital (7-9 years) and have post-secondary education.

There were high levels of awareness of ISO 9001:2015 QMS amongst the workers. However, awareness levels were higher among workers in the corporate support division (92%) compared to the clinical services division (74%). This is worrying considering the clinical services division is responsible for delivering the core mandate of the hospital. There were no significant differences in awareness amongst male and female employees. The awareness levels still fall short of the requirements of 100% awareness levels. This has been attributed to the poor strategies that the hospital has employed in training and sensitizations.

On perceived outcomes of compliance with ISO 9001:2015QMS, the study established a strong motivation to comply amongst the workers at KNH. Key motivating factors for compliance included QMS makes the workplace efficient and worker-friendly; and; compliance improves communication within the hospital. Concerning the Theory of Planned Behaviour, these are linked to behavioral beliefs (attitudes) and normative beliefs (norms) respectively. The third perceived motivating factor (decision making), which is linked to controlling beliefs did not have any significant contribution toward perceived outcomes of compliance with ISO 9001:2015 QMS at KNH.

Finally, on compliance with ISO 9001:2015 QMS by workers at KNH, the study uses intention to comply as a proxy measure to compliance behaviour. This is as prescribed

by the Theory of Planned Behaviour. Findings show a strong intention to comply with the ISO 9001:2015 QMS by workers at KNH with a score of 82%. However, this still falls short of the required level of compliance which is 100%. The gaps in compliance are detrimental to effective service delivery at the Hospital. Organizational factors that affect compliance at KNH were identified as perceptions of coercion; inadequate resourcing; lack of incentives linked to compliance; high customer expectations; and; poor staff training and awareness on ISO. There are also individual influences on compliance that are attributed to the workers. These include attitudes, norms and behaviour control and they form the basis of discussion in the subsequent chapter.

CHAPTER FIVE

INFLUENCE OF ATTITUDES, NORMS AND BEHAVIOUR CONTROL ON COMPLIANCE WITH ISO 9001:2015 QMS AT KENYATTA NATIONAL HOSPITAL

5.1 Introduction

This chapter addresses the influence of attitudes, norms and behaviour control on compliance with ISO 9001:2015 QMS procedures. The chapter addresses specific objectives 2, 3, and 4 and includes the analysis model used, attitudes and compliance, norms and compliance and behaviour control and compliance. Additionally, the study hypotheses are tested in this chapter.

5.2 The Model

The study sought to establish the Influences on Compliance Behaviour towards ISO 9001:2015 QMS Implementation by Workers at Kenyatta National Hospital. The theory of the planned behaviour model developed by Ajzen and Fishbein has been used to determine the relationship between attitudes, norms and behaviour control. According to the theory, human behaviour is guided by three kinds of considerations namely, beliefs about the likely consequences of the behaviour (behavioural beliefs), beliefs about the normative expectations of others (normative beliefs), and beliefs about the presence of factors that may facilitate or impede the performance of the behaviour (control beliefs). In their respective aggregates, behavioural beliefs produce a favourable or unfavourable attitude toward the behaviour; normative beliefs result in perceived social pressure or subjective norm; and control beliefs give rise to perceived behavioural control. In combination, attitude toward the behaviour, subjective norm, and perception of behavioural control led to the formation of a behavioural intention. This is following the conceptual framework presented in figure 2.1.

The immediate antecedent of any behaviour is the intent to perform it. The stronger the intention, the more the person is expected to try and therefore the greater the possibility that the behaviour will be performed, and thus the primary concern is with identifying the factors underlying the formation and change of behavioural intent (Fishbein & Manfredo, 1992). As a general rule, the more favourable the attitude and subjective norm, and the greater the perceived control, the stronger should be the person's intention to perform the behaviour in question.

International standard ISO 9001 is the most widely-used quality management standard. It is a generic standard that applies to all kinds of organizations, in the form of a Quality Management System (QMS). The standard is "certifiable": meaning to gain ISO 9001 certification, organizations undergo an audit of their QMS' compliance with the standard by an external body, and are issued with a certificate (ISO 2014). Kenyatta National Hospital achieved the ISO 9001:2015 certification in September 2018. To maintain the certification and ensure that the organization achieves its quality objectives, workers are required to comply with laid down standard procedures and other system requirements.

In this study, the desired behaviour from the workers is compliance with the ISO 9001:2015 QMS at Kenyatta National Hospital. The study therefore, sought to test the following hypothesis: -

H_1 There is a positive relationship between workers' attitudes and compliance with ISO 9001:2015 QMS at Kenyatta National Hospital.

H_2 There is a positive relationship between organizational norms and compliance with ISO 9001:2015 QMS at Kenyatta National Hospital.

H3 There is a positive relationship between the workers' behaviour control and compliance with ISO 9001:2015 QMS at Kenyatta National Hospital.

The theory of planned behaviour states that attitude toward behaviour, subjective norms, and perceived behavioural control, together shape an individual's behavioural intentions and behaviour (George, 2004) Although there is not a perfect relationship between behavioural intention and actual behaviour, intention can be used as a proximal measure of behaviour. The target behaviour should be defined carefully in terms of its Target, Action, Context and Time (TACT).

For example, consider the behaviour, of 'referring patients with back pain for a lumbosacral spine x-ray'. Here the target is the patient, the action is the referral, the context is the clinical condition (back pain) and the time is (implicitly) during the consultation. (Francis, *et al.,* 2004; Hall, *et al.*, 2006). In the case of this study, the target is ISO 9001:2015 QMS Procedures; the Action complies with the QMS procedures; the context is service delivery while the time is during work.

To test for the hypotheses, correlation analysis and multiple regression were used. Correlation analysis was used to test the relationship between the variables under study while regression analysis was used as a model to establish the predictive value of each of the variables and the extent to which attitudes, norms and behaviour control can be used to predict compliance with ISO 9001:2015 QMS procedures. Correlation analysis was undertaken to determine the existing relationship between the independent variables and the dependent variable as well as the relationship between the independent variables. This was done to determine the strength of the correlation and hence rule out cases of multicollinearity. The correlation matrix was used to show the strength of the relationships. Pearson correlation coefficients were used to show the

strength of the relationships. Correlation values are from -1 to 1. Generally, a value of r greater than 0.7 is considered a strong correlation. Anything between 0.5 and 0.7 is a moderate correlation, and anything less than 0.4 is considered a weak correlation.

Findings from the study have established that there is strong compliance with ISO 9001:2015 QMS by workers at KNH with a composite score of 82%. This is as indicated in section 4.7 of this report. However, the compliance levels are below the required level of 100%. The influence of attitudes, norms and behaviour control on compliance are discussed hereunder.

5.3 Relationship between workers' attitude and compliance with ISO 9001:2015 QMS at Kenyatta National Hospital

The attitude was defined as an individual's overall perception of favourableness or un-favourableness towards a behaviour comprised of affective (experiential) and cognitive (Instrumental) dimensions. Experiential attitude (or affect) is the individual's emotional response to the idea of performing the behaviour while Instrumental attitude (or cognitive) is determined by beliefs about outcomes of behaviour. Table 5.1 presents the findings under attitude including the overall attitude score as well as cognitive and experiential attitude scores.

Table 5.1: Overall Attitude

	Attitude Constructs	Mean	Standard Deviation	Factor Loading
Experiential	I feel motivated when complying with ISO Procedures	5.50	1.74	0.673
	I will apply ISO procedures to all processes in my work	2.42	2.06	0.674
	I don't feel stressed when I am complying with ISO procedures	3.61	2.16	0.632
Cognitive	I believe that ISO procedures are important for achieving organizational goals	6.12	1.37	0.588
	Compliance with ISO procedures improves motivation of workers	5.45	1.69	0.727
	I believe that workers are motivated with the application of ISO procedures	5.55	1.72	0.588
	Overall Mean Score	**4.78**		

Source: Field Data, 2021

The overall mean score for attitude was 4.78. Considering 7 as the highest score, this represents a mean score of 68%. This implies a moderately positive attitude towards compliance with ISO Standards. A stronger attitude is preferred.

Cognitive attitude towards compliance with ISO procedures was measured using three constructs that were based on the outcome, importance, and motivation. The analysis revealed a high mean score of 5.71 or 82%. The outcome component (improves motivation of workers) recorded the highest factor loading of 7.27 compared to motivation (0,587) and importance (0.587).

Experiential attitude is influenced largely by prior outcomes while undertaking similar behaviour and social norms. The overall mean score which reflects the strength was moderate with 3.84 or 54%. The constructs returned mixed strengths with motivation (5.5) returning the highest while norms returning the least (2.42). Lower experiential scores were responsible for returning a lower attitude score.

Across the different genders, there was no major difference in the means of attitudes between male and female workers as shown in table 5.2:

Table 5.2: Attitudes across Gender

Attitude Constructs	Total	Male	Female
I feel motivated when complying with ISO Procedures	5.50	5.54	5.60
I will apply ISO procedures to all processes in my work	2.42	2.28	2.56
I don't feel stressed when I am not complying with ISO procedures	3.61	3.49	3.73
I believe that ISO procedures are important for achieving organizational goals	6.12	6.12	6.12
Compliance with ISO procedures improves motivation of workers	5.45	5.38	5.52
I believe that workers are motivated with the application of ISO procedures	5.55	5.55	5.55
	4.78	4.73	4.85

Source: Field Data, 2021

The attitude of employees towards KNH was therefore largely influenced by instrumental or cognitive factors. According to Fishbein, (1992), the cognitive component of an attitude refers to the beliefs, thoughts, and attributes that we would associate with an object. It is the opinion or belief segment of an attitude. It refers to that part of attitude related to the general knowledge of a person. Typically, these become known in generalities or stereotypes, such as 'all babies are cute', 'smoking is harmful to health' etc. Affect has a direct effect on attitude, as well as an indirect effect that is mediated by the individual's belief. In addition, when individuals are concerned about a specific issue, the attitudes they hold about that issue are more likely to be strong. Cognition reflects a group of information processes that occur in our minds, which directly or indirectly influence attitude. Additionally, Huang *et al.,* (2015) observe that concern involves values, an attitude toward facts, or a cognitive evaluation of one's behaviour.

From the findings, the biggest determinant of cognitive attitude is the belief that compliance with the QMS improves worker motivation. The staff corroborated this in the focus group discussions. The discussions further revealed that the introduction of ISO QMS has increased employees' participation in internal processes. Additionally, data collected from the respondents indicated that 82% of the staff believed that employees' ability to complete tasks effectively had improved with the introduction of ISO 9001:2015 QMS as shown in table 5.3.

Table 5.3: Changes in Employees' Ability

Changes in the employee's ability to effectively complete tasks as a result of ISO 9001:2005 introduction			
	Total	**Clinical**	**Corporate Support**
	270	151	119
Has Changed for the better	82%	79%	85%
Has not Changed at all	15%	16%	13%
Has changed for the worse	3%	5%	2%

Source: Field Data, 2021

On the other hand, experiential attitude is the negative and positive emotional response to the idea of performing the behaviour (Montano *et al*., 2008). Those with a strong positive emotional response are likely to perform the behaviour, while those with a negative emotional response are unlikely to perform the behaviour. For example, an individual might feel that physical activity is energizing (positive experiential attitude) or an individual might associate physical activity with feeling disgusting (negative experiential attitude).

The weak attitude scores could be due to several factors as revealed by the employees. Firstly, the staff feels that there is no adequate management support for the implementation of the QMS. This is evidenced by a lack of necessary equipment, lack

of adequate training as well as lack of resources to implement the QMS requirements. This negates some of the timelines provided in the documented procedures.

In summary, a moderately positive attitude towards compliance with ISO 9001:2015 QMS was expressed by the workers at KNH. Among the attributes of cognitive and experiential attitudes, there was strong cognition as a result of what the workers believe are the positive outcomes associated with compliance with the QMS procedures. On the other hand, experiential attitude returned lower scores or weak attitudes. Workers attributed this to low management support in the implementation of the QMS. This was evidenced by inadequate budget allocations for QMS activities and the absence of basic working tools and equipment.

Hypothesis testing

The study sought to test the following hypothesis:

H_1 There is a positive relationship between workers' attitudes and compliance with ISO 9001:2015 QMS at Kenyatta National Hospital.

Attitude returned fairly high scores with an overall mean score of 4.78 (68%). Attitude consisted of experiential and instrumental attitudes as defined by (Ajzen and Fishbein, 1980). From the previous analysis, instrumental attitude returned higher mean scores of 5.71(81%) compared to the experiential attitude which returned fairly low scores of 3.84 (55%). Correlation analysis was used to test the relationship between attitudes towards compliance with ISO 9001:2015QMS procedures and compliance with ISO 9001:2015 QMS procedures. The results are summarised in table 5.4.

Table 5.4: Correlation between workers' attitudes and compliance with ISO 9001:2015 QMS

Dependent Variable	Tests	Workers' Attitude
Compliance with ISO 9001:2015	Pearson Correlation	.522**
QMS procedures	Sig. (2-tailed)	.000
	N	287

Source: Field Data, 2021

The analysis revealed a positive relationship between attitudes and compliance with ISO 9001:2015 QMS procedures ($r = 0.522$ and $p = 0.00$). Considering the value of r to be 0.522, we can conclude that there is a moderate correlation between the two variables. The study's hypothesis that there is a positive relationship between workers' attitudes and compliance with ISO 9001:2015 QMS at KNH was therefore confirmed as true.

Ajzen (1991) explains attitude toward behaviour as the degree to which a person has positive or negative feelings about the behaviour of interest. It entails a consideration of the outcomes of performing the behaviour. Studies have shown that all attitude-related factors positively affect employee performance. Motivation and job commitment have a highly significant impact on the performance of employees (Imran, 2014). The attitudes of employees in the workplace can have a significant effect on the business as a whole. Attitude is one of the hidden, hard-to-measure factors that end up being crucial to the success of a company. Whether for better or for worse, employee attitudes tend to have a drastic impact on the productivity of a business, both directly and through the effect of other job-related factors (Imran 2014).

Ray (2017) in an article published on employee attitude notes that employee attitude affects staff in several ways. The first factor subject to employee attitudes is engagement. She notes that employees that have a negative attitude toward their

company are far more likely to be disengaged, fulfilling their jobs with the least amount of work possible and at the lowest quality level. This results in lost productivity. The second aspect identified is retention. Based on their attitudes toward work, employees feel more or less committed to the job. Those with a generally negative outlook on their work situation have no reason to feel invested in a future with the company. Thirdly is the aspect of the work environment. Workplace attitudes, both positive and negative, are infectious and can easily spread to co-workers. Negative employee attitudes can have a ripple effect. Decreased trust and goodwill toward co-workers' harms collaboration, decreasing productivity. A negative social environment isolates individual employees and creates incentives to avoid or leave the job. By contrast, positive attitudes make interaction and collaboration more pleasant and productive.

Finally, she identifies customer engagement. Not all employees interact directly with customers and clients, but when they do, their attitude is a reliable predictor of customer satisfaction. Even the employees who don't have direct contact with clients can influence through their attitudes the level of care and customer service. A negative attitude is likely to manifest in disengagement from customers and a lack of concern for their needs. Customers are an annoyance and an inconvenience to employees with a bad attitude. On the other hand, a positive and engaged attitude is likely to result in courtesy, emotional engagement and a real concern for the well-being and satisfaction of the customer.

According to Fishbein (1979) Katz, a leading Functionalism Scholar identified various functions that attitude play. First is the adjustment function where attitudes often help people to adjust to their work environment. Secondly is the ego-defensive function which helps people to retain their dignity and self-image. Thirdly, the value-expressive

function provides individuals with a basis for expressing their values. Finally, the knowledge function that provides standards and frames of reference that allow people to understand and perceive the world around them. Katz's functionalist theory also explains why attitudes change. According to Katz, an attitude changes when it no longer serves its function and the individual feels blocked or frustrated. That is, according to Katz, attitude change is achieved not so much by changing a person's information or perception about an object, but rather by changing the person's underlying motivational and personality needs.

Attitude comprises both experiential and instrumental aspects. Both instrumental and experiential attitudes contribute significantly to the overall attitude towards compliance with ISO procedures at KNH. Studies on the Theory of Planned Behaviour have found measures of attitude to be more closely linked to intentions and behaviour. (Ajzen and Timko, 1986; Ajzen and Driver, 1992). This is based on previous experiences with the object in question. Staff at KNH have developed these attitudes towards ISO 9001:2015 based on their experiences with how the management handles quality reforms at the institution.

Discussions with the staff revealed other reasons for the observed differences in staff attitude. One of the reasons that were advanced by the respondents is the perception of the differences between clinical staff and corporate support staff.

Kenyatta National Hospital is a health care institution and there were accusations that clinical staff have some sense of entitlement and look down upon the corporate support staff as inferior. Some of the corporate support staff feel discriminated against, especially in job grading and remuneration. As one staff from the corporate support put it

> *"Nurses are equivalent of diploma holders but some of them earn even more than master's degree holders who are in corporate support…this really demoralizes other staff…"* (KNH Staff)

Additionally, implementation of ISO is mainly driven on the clinical side and there are no elaborate rewards and sanctions that accompany compliance or non-compliance with the ISO procedures. However, there was general agreement that the outcomes of ISO certification especially as regards customer outcomes are beneficial. The lack of management support also affects the attitudes of staff towards compliance with ISO procedures. It was noted that the lack of budgets to upgrade hospital equipment and provide some basic working tools has led to some of the employees questioning the commitment of the management to ensuring that the quality management system is implemented successfully. This has also affected the attitude of the staff.

Similar studies have also pointed out some of the issues affecting staff attitude, especially as concerns implementation of quality management systems in the health sector. Sivansakar (2013) in her study on the employees' attitude towards the implementation of quality management systems with special reference to K.G. Hospital, Coimbatore concluded that employees had a positive attitude towards the implementation of quality management systems. She further noted that successful implementation of QMS depends on the active participation of the employees whose attitude plays a pivotal role in its better execution throughout the hospitals. She concludes by recommending health care professionals' participation and development is the important factor for quality improvement in hospitals.

In summary, therefore, an improvement in workers' attitudes is bound to have a positive effect on compliance. This can be undertaken by management by improving their

approach to implementation of the quality management systems at Kenyatta National Hospital.

5.4 Relationship between norms and compliance with ISO 9001:2015 QMS at Kenyatta National Hospital.

Perceived norm refers to the social pressure one feels to perform or not perform a particular behaviour Ajzen (2013). He further notes that norms are either injunctive or descriptive. To him, the Injunctive norm (similar to the subjective norm) refers to normative beliefs about what others think one should do and the motivation to comply. Descriptive norm refers to perceptions about what others in one's social or personal networks are doing. These are meant to capture situations where there is a strong social identity.

The constructs evaluated for injunctive norms include what the significant other thinks, what is expected by the significant other and perception of what the significant other wants the worker to do. On the other hand, the constructs under descriptive norms included what the respondents think they should do, perception as to whether ISO procedures are good for all and whether there is social pressure to comply with ISO procedures.

To understand norms, it is important to identify who are the most significant persons in the workers' place of work. This is important as it will help understand where the biggest influence on behaviour of workers lies. Respondents were therefore asked to identify the most important people in their work and rank them in order of priority. The results are in table 5.5:

Table 5.5: Important People in My Work

Important People in my work	Percent	Division	
		Clinical	Corporate Support
My supervisor	78%	74%	94%
My colleagues	72%	82%	29%
Patients/customers	44%	48%	29%
My professional body	23%	15%	59%
My friends	10%	10%	12%
My family	10%	10%	12%
Stakeholders	8%	7%	12%

Source: Field Data, 2021

The supervisor was identified as the most important person overall, with 78% of the mentions followed by colleagues (72%), and customers (44%). Other people identified included professional bodies, friends, family and other hospital stakeholders. Among the clinical staff, colleagues were identified as the most important people (82%) followed by supervisors (74%). On the other hand, among the corporate support staff, the supervisors (94%) were identified as the most important person at work followed by the professional body (59%) and colleagues. This shows some differences in the significant other among the staff in corporate support and clinical divisions. This therefore implies that among the clinical staff, colleagues are an important influence at the place of work compared to the supervisors among the corporate support staff. Important people in one's workplace usually shape the normative behaviour of the group by determining the expected standards of behaviour.

The analysis of the strength of the norms returned a mean score of 4.62 (66%), which is a moderate score. The Factor loadings amongst all the constructs assessed revealed lower contributions on factors related to social pressure. This essentially means that there is no social pressure amongst the significant others to comply with ISO 9001:2015 QMS procedures. These are summarised in table 5.6:

Table 5.6: Norms around compliance with ISO procedures

	Norms	Mean	Standard Deviation	Factor Loading
Injunctive Norms	Most people who are important to me think that I should comply with ISO procedures	2.43	2.11	0.659
	The ISO procedures are good for all people	3.98	2.19	0.426
	People who are important to me want me to comply with ISO procedures	5.54	1.76	0.477
Descriptive Norms	I should always comply with ISO procedures	6.08	1.49	0.648
	It is expected of me that I comply with ISO procedures	6.17	1.43	0.577
	I feel under social pressure to comply with ISO procedures	3.48	2.33	0.475
	Overall Mean Score	**4.62**		

Source: Field Data, 2021

From the analysis of injunctive norms, the overall mean score was 3.99 (57%). Considering a score of 7 is the highest score, this represents moderate strength. A look at the factor loading reveals that the belief that the significant other expects one to comply is the strongest contributor to of injunctive norms. However, from the analysis, it registered a low mean score (38%). This means that most of the staff do not believe that they comply because of pressure from people who are important to them. On the other hand, the belief that whether ISO is good for all people does not contribute significantly to injunctive norms.

As discussed earlier, descriptive norms refer to the perception of what is or, in other words, perceptions about how people do behave. Descriptive norms registered a high mean score of 5.25 (75%), meaning compliance with ISO procedures is perceived as a social expectation. Across the different gender, there was no difference in the means of male and female workers as shown in table 5.7.

Table 5.7: Norms and Gender

Norms Constructs	Total	Male	Female
Most people who are important to me think that I should not comply with ISO procedures	2.43	2.45	2.41
The ISO procedures are good for All people	3.98	3.91	4.05
People who are important to me want me to comply with ISO procedures	5.54	5.49	5.59
I should always comply with ISO procedures	6.08	6.03	6.13
It is expected of me that I comply with ISO procedures	6.17	6.32	6.02
I feel under social pressure to comply with ISO procedures	3.48	3.44	3.52
Score	4.61	4.61	4.62

Source: Field Data, 2021

The biggest influence on descriptive norms was the belief among the staff that they should always comply with ISO procedures. Several reasons were given by the employees for this. First, was that employees believe that ISO procedures are good for organizational and patient outcomes. The second factor was the expectations. The employees felt that it is expected of them to comply with ISO procedures from both the significant others and the hospital management. This underscores the important role played by supervision at KNH since the supervisor was identified as the most significant person in the workplace by the staff. Factor analysis revealed that social pressure does not significantly contribute to descriptive norms at KNH.

In summary, norms around compliance with ISO 9001:2015 returned moderate scores. The analysis revealed lower contributions of factors related to social pressure and a higher contribution of self-driven factors such as the expectation from the workers. Studies (Feldman, 1984) have shown that norms arise due to critical events in a social group’s history that established a precedent. For example, among the challenges identified as facing the implementation of ISO QMS was the culture of compliance versus commitment.

In the provision of health care, hospitals adhere to external compliance with government policies; national laws and standards; international laws and standards and declarations on human rights. Internally, the hospital has its standard operating procedures; protocols and organizational policies. Focus Group Discussions with various respondents indicated that the introduction of ISO has brought the feeling that it is more of a compliance issue from the staff rather than a commitment to improving service delivery and patient outcomes. A statement from one of the respondents summarized the perception of the implementation of the QMS at KNH.

> *"..I hate this ISO thing especially when it comes to the audits. During this time, there is a let of frenzy in preparing documents and ensuring that they are in order. Everybody is expected to put their best foot forward and follow all documented procedures…however, after the audits everything goes back to normal….we should make implementation of ISO our everyday lives…"* (FGD Participants)

The respondents note that ISO certification was first introduced at KNH as a performance-contracting requirement and that management was only concerned with earning positive scores and higher ratings rather than the overall improvement in service delivery. This further entrenched the culture of compliance as opposed to commitment.

Hypothesis Testing

The study sought to test the following Hypothesis:

H_2 There is a positive relationship between organizational norms and compliance with ISO 9001:2015 QMS at Kenyatta National Hospital.

As discussed earlier, norms around compliance with ISO procedures returned moderate scores with a mean score of 4.62 (66%). Norms comprise injunctive or descriptive aspects. Earlier findings indicate that descriptive norms returned very strong strengths with a mean of 5.27 (75%) while injunctive norms returned moderate scores with a

mean of 3.99 (57%). Correlation analysis was used to test the relationship between organizational norms and Compliance with ISO 9001:2015 QMS procedures at KNH. The results are summarised in table 5.8.

Table 5.8: Correlation between Norms and Compliance with ISO 9001:2015 QMS Procedures

Dependent Variable	Tests	Organization Norms
Compliance with ISO 9001:2015 QMS procedures	Pearson Correlation	.477**
	Sig. (2-tailed)	.000
	N	285

Source: Field Data, 2021

The findings revealed a positive relationship between norms and Compliance with ISO 9001:2015 QMS procedures at KNH (r = .477 and p = 0.00). With an r value of .477 we can conclude and say that there is a moderate correlation between the two variables. The study hypothesis that there is a positive relationship between the organization norms and compliance with ISO 9001:2015 QMS at KNH was therefore confirmed as true.

Subjective norms refer to the belief about whether significant others think he or she will perform the behaviour. It relates to a person's perception of the social environment surrounding the behaviour. Ajzen (1991). In other words, subjective norms are the person's perception of social normative pressures and relevant others' beliefs about whether the adopter should adopt or not. These people can be professional peers, colleagues, subordinates, parents, and people of authority. To understand the effect of social pressure the respondents identified whom they considered as significant others. Staff from the clinical services division listed their colleagues followed by supervisors and patients as the most significant people in their work in order of priority. On the other hand, staff from the corporate support division listed their supervisors followed by professional bodies and colleagues as the most significant people in their work in

order of priority. It is important to note that amongst the clinical staff all the social pressure comes from within the organization while among the corporate support there are external pressures that influence their normative beliefs. This could be a potential source of individual conflict especially when the ideals of the external influence are not in congruence with the dominant normative beliefs within KNH.

The influence of norms could be traced to the organizational culture at KNH. Kitts (2008) observes that injunctive norms develop over a period of time and tend to be considered informal rules that have no formal enforcement mechanisms. Organizations that are strong in sociability as described by Goffee and Jones (2003), exhibit this kind of behaviour. It is also important to note that general acceptance by significant others reinforces the performance of certain behaviours. From the findings of this study, supervisors and peers (co-workers) therefore play a big role in determining compliance with ISO procedures at KNH. On the other hand, most of the staff have been employed at KNH for a long period with the average being 7-9 years. These long periods of working together have resulted in a pattern of acceptable behaviour within the institution. The study has established that this influences compliance with ISO 9001:2015 QMS procedures.

These findings are consistent with findings from Borsai *et al*., (2003) who opined that norms are constructed from observable behaviour, communication and self-knowledge. As noted in the discussions on awareness, different sources about norms can sometimes lead to inaccurate perceptions about other behaviours and attitudes. On observable behaviour the staff is more likely to copy what their supervisors are doing. This therefore means that if the supervisor, who has been noted as the most significant person, fails to comply then the staff are more likely going to follow suit. Finally, norms

can also be a strategy for self-preservation especially by the more experienced workers. This is what Stamper *et al.,* (2006) call self-maintaining behaviour or autopoiesis. The failure to comply could also be interpreted from a normative perspective as manifestation of autopoiesis. From the findings, the study can therefore conclude that positive organizational norms have a positive influence on compliance with ISO 9001:2015 QMS. by reinforcing the norms therefore there is a likelihood that compliance levels will increase.

5.5 Relationship between the workers' behaviour control and Compliance with ISO 9001:2015 QMS procedures at KNH (H_3)

Perceived behaviour control is defined as an individual's perceived amount of control over behavioural performance. It is determined by control beliefs (an individual's perception of the degree to which various environmental factors make it easy or difficult to perform a behaviour). Analysis of the responses returned a higher strength of control over compliance with ISO procedures with an overall mean of 4.9 (70%). This is as shown in table 5.9.

Table 5.9: Behaviour Control

	Behaviour Control Constructs	Mean	Standard Deviation	Factor Loading
Personal Agency	I am confident that I can comply with ISO procedures if I wanted to	5.70	1.85	0.558
	For me, compliance with ISO procedures is easy	5.60	1.64	0.656
	Whether I comply with ISO procedures is entirely up to me	3.69	2.36	0.438
Self-Efficacy	The decision to comply with ISO procedures is beyond my control	3.60	2.46	0.565
	I have the ability to comply with ISO procedures	5.75	1.61	0.692
	KNH has given me adequate skills to implement ISO procedures	4.89	2.14	0.47
	Overall Mean Score	**4.87**		

Source: Field Data, 2021

Behaviour control is a function of personal agency and self-efficacy. Personal agency refers to an individual's capability to originate and direct actions for given purposes. Self-efficacy is an individual's belief in his/her effectiveness in performing specific tasks as well as their actual skill.

The personal agency returned a stronger mean of 71% compared to self-efficacy (67%). Across the divisions, the results indicated stronger behavioural control amongst corporate support staff compared to the clinical services staff. This implies that staff within the corporate support services demonstrated a stronger sense of personal responsibility as far as compliance with ISO 9001:2015 QMS is concerned. Across the gender dimensions, there was no difference in the scores between males and females as far as behaviour control was assessed as shown in table 5.10.

Table 5.10: Behaviour Control and Gender

Behavior Control Constructs	Total	Male	Female
I am confident that I can comply with ISO procedures if I wanted to	5.70	5.58	5.82
For me, compliance with ISO procedures is easy	5.60	5.42	5.78
Whether I comply with ISO procedures is entirely up to me	3.69	4.39	2.99
The decision to comply with ISO procedures is beyond my control	3.60	3.97	3.41
I have the ability to comply with ISO procedures	5.75	5.32	6.18
KNH has given me adequate skills to implement ISO procedures	4.89	4.59	5.19
Score	**4.87**	4.88	4.90

Source: Field Data, 2021

Individual agency is closely related to what Psychologist Julian Rotter (1982) referred to as an internal locus of control. It is characterised by statements such as I can make things happen, look what I can do or I can determine my future among other psychometric statements. He notes that people with a strong internal locus of control believe that the responsibility for whether or not they get reinforced ultimately lies with

themselves. Internals believe that success or failure is due to their efforts. In contrast, externals believe that the reinforcers in life are controlled by luck, chance, or powerful others. Therefore, they see little impact of their efforts on the amount of reinforcement they receive.

From the analysis of the constructs, the personal agency returned strong scores with a mean of 5 (71%). Factor loading showed only two constructs, confidence and ease of performing the task, being significant in the determination of the personal agency. There were various reasons advanced for this. During focus group discussions, staff noted three main reasons why they feel implementation of ISO 9001:2015 QMS procedures is easy. Firstly, the staff felt that they have the right professional training and education to both understand and implement the QMS. Secondly, they observed that the documented procedures under the QMS are simplified and easy to understand hence the ease of implementation. Finally, the staff observed that the support from supervisors and co-workers make the implementation of the QMS easy.

Self-efficacy was the other construct measured under behavioural control. As Ajzen (1991) stated in the theory of planned behaviour, knowledge of the role of perceived behavioural control came from Bandura's concept of self-efficacy. It refers to the conviction that one can successfully execute the behaviour required to produce the outcome. Bandura has defined self-efficacy as one's belief in one's ability to succeed in specific situations or accomplish a task. One's sense of self-efficacy can play a major role in how one approaches goals, tasks, and challenges. In the context of this study, respondents were asked psychometric questions that tested their belief that they can comply with ISO procedures. This included control over decisions, ability and skills. Overall, self-efficacy returned moderate strengths with a mean of 4.74 (67%). Factor

analysis on the three constructs revealed that the skills provided by KNH are not significant in self-efficacy. The majority of the staff (82%) at KNH revealed that they can comply with ISO 9001:2015 QMS requirements. However, only 49% indicated that compliance with ISO 9001:2015 QMS is within their control. This they noted is because the implementation of the QMS involves all other staff and they don't have control over what their colleagues are doing.

In summary, factor analysis on the attributes used to evaluate perceived behaviour control over ISO procedures revealed that personal agency attributes (confidence in, ease of compliance and decision to comply) had a significant contribution to overall perceived behaviour control with the strongest attribute being ease of compliance. On the other hand, attributes used to evaluate self-efficacy (control over decisions, ability to comply and skills to comply) also registered significant contributions with ability being the strongest attribute. This implies that the workers at KNH have demonstrated control over their decisions to comply with ISO procedures.

The majority of the respondents noted that implementation of the ISO QMS was easy and was based on their day-to-day work. However, they also noted that despite being easy to implement, it involved a lot of work to achieve full compliance. On the other hand, the workers also demonstrated self-efficacy by expressing the ability to comply with the ISO 9001:2015 QMS. This is mainly due to their training in the various professional fields. As indicated earlier, the majority of staff at KNH have post-secondary education and a high level of understanding of their jobs which in turn gives them the ability to comply with the QMS.

Hypothesis testing

The study sought to test the following hypothesis:

H_3 There is a positive relationship between the workers' behaviour control and compliance with ISO 9001:2015 QMS at Kenyatta National Hospital.

Perceived behaviour control refers to the individual's perception of the extent to which performance of the behaviour is easy or difficult. It increases when individuals perceive they have more resources and confidence (Ajzen, 1985). Behaviour control over compliance with ISO procedures comprised of personal agency and self-efficacy. Earlier assessments showed that overall workers' behaviour control returned a strong mean score of 4.87 (70%). The personal agency returned a stronger mean score of 5.0 (71%) compared to self-efficacy which returned a lower mean score of 4.74 (68%). Correlation analysis was used to test the relationship between the workers' behaviour control and Compliance with ISO 9001:2015 QMS procedures at KNH. The results are shown in the table 5.11.

Table 5.11: Relationship between workers' behaviour control and Compliance with ISO 9001:2015 QMS procedures.

Dependent Variable	Tests	Workers' Behaviour control
Compliance with ISO 9001:2015	Pearson Correlation	.305**
QMS procedures	Sig. (2-tailed)	.000
	N	286

Source: Field Data, 2021

The analysis revealed a positive relationship between the workers' behaviour control and intention to comply with ISO 9001:2015 QMS procedures at KNH ($r = .305$ and $p=0.00$). However, an r value of .305 indicates a weak correlation between the two variables. The study hypothesis that there is a positive relationship between the

workers' behaviour control and compliance with ISO 9001:2015 QMS at KNH was therefore confirmed as true.

Judgements of perceived behaviour control are influenced by beliefs concerning access to the necessary resources and opportunities to perform the behaviour successfully. The perception of factors likely to facilitate or inhibit the performance of the behaviour is referred to as control beliefs. These factors include both internal control factors (information, personal deficiencies, skills, abilities, and emotions) and external control factors (opportunities, dependence on others, barriers). People who perceive they have access to the necessary resources and perceive that there are opportunities (or lack of obstacles) to perform the behaviour are likely to perceive a high degree of behavioural control (Ajzen, 1991). Ajzen (1988) introduced the construct 'perceived behavioural control' into his theory of planned behaviour as a determinant of both behavioural intention and the behaviour itself. On a conceptual basis, perceived behavioural control is similar to self-efficacy—both constructs refer to the person's belief that the behaviour in question is under his or her control—but, operationally, perceived behavioural control is often assessed by the ease or difficulty of the behaviour (e.g., 'I find it difficult to exercise three times a week'), while self-efficacy is operationalized by the individual's confidence in being able to carry out the behaviour in the face of extenuating circumstances (e.g., 'I am confident that I can exercise three times a week even when I am away on vacation) (Wallston 2001).

Focus group discussions with staff revealed that by nature of their professional training, most staff within the corporate support division are exposed to management concepts such as quality management systems. Corporate support staff includes staff that performs administrative functions that support the clinical services to deliver on their

mandate. These include professions such as accountants, procurement officers, engineers, human resource managers, estate managers, planners, communication experts among others. Some of the clinical staff that we spoke to admitted encountering some of the concepts such as ISO and total quality management during their time in employment at KNH. They indicated that their training focuses much of delivering clinical outcomes and management of patients as patients and not as customers. Others indicated that the Hospital has made efforts to expose them to additional training and this has exposed them to these newer concepts. However, both categories of staff indicated that the training is very intermittent and not all members of staff benefit noting that managing a workforce of close to 5,000 employees with limited resources has been the biggest challenge. There was however concurrence that, with involvement and the right training and support, compliance with ISO procedures is easy.

Finally, we also note that external control factors that are related to opportunities, dependence on others and barriers impact compliance with ISO 9001:2015 QMS procedures. For example, a nurse may want to comply with the procedures laid down, but her efforts are slowed down by others within the value chain and yet she is dependent on them for compliance. A classic example is when she is supposed to administer medication to a patient at exactly one o'clock in the afternoon. This coincides with visitation hours and the security officer may allow visitors to overstay their visit. The result is that the nurse is unable to deliver the needed medication at the required time leading to a non-conformity. Another classic example is barriers that inhibit compliance. Medical staff handling patients with infectious diseases are required to be fully equipped with protective gear. However, the hospital has not provided enough protective gear for the medical staff and therefore you will find medics without

full protective gear handling infectious disease patients also leading to non-conformities.

In summary therefore, there were high levels of behaviour control. Internal factors related to individuals (self-efficacy) recorded higher scores compared to personal agency factors. There was a positive relationship between behaviour control and compliance with the ISO 9001:2015 QMS. The strength of the correlation was however weak. In the Theory of Planned Behaviour, perceived behaviour control is concerned with the characteristics of an individual or the environment that helps or hinders the performance of the behaviour. Accordingly, compliance with ISO 9001:2015 is dependent on the skills the individual has to comply with as well as the tools and equipment that are provided to him during the performance of his duties. From the findings, we can therefore conclude that behaviour control factors have a positive effect on compliance with the ISO 9001: 2015 QMS amongst the workers at KNH. By reinforcing behaviour control, there is bound to be an increase in compliance levels at the hospital.

5.6 Prediction Analysis

Regression analysis was used to test the predictive value of attitudes, norms and behaviour control on Compliance with ISO 9001:2015 QMS procedures at KNH. As a predictive analysis, multiple linear regression was used to explain the relationship between one continuous dependent variable and two or more independent variables. The independent variables can be continuous or categorical (dummy coded as appropriate) Chandran (2008). Certain assumptions are upheld in its use. These include regression residuals must be normally distributed; A linear relationship is assumed between the dependent variable and the independent variables; the residuals are

homoscedastic and approximately rectangular-shaped and the absence of multicollinearity is assumed in the model, meaning that the independent variables are not too highly correlated.

The regression model was used to determine how well the model fits. R-squared is a measure of the proportion of variability explained by the regression. It is a number between zero and one, and a value close to zero suggests a poor model. In multiple regression, each additional independent variable may increase the R-squared without improving the actual fit. An adjusted R-squared is calculated that represents the more accurate fit with multiple independent variables. The adjusted R-squared takes into account both the number of observations and the number of independent variables. It is always lower than R-squared. The model summary is presented in table 5.12 and 5.13.

Table 5.12: Regression Model Summary

Model Summary

Model					Change Statistics				
	R	R Square	Adjusted R Square	Std. Error of the Estimate	R Square Change	F Change	df1	df2	Sig. F Change
	.620[a]	.384	.378	.86691	.384	58.298	3	280	.000

a. Predictors: (Constant), Behaviour control, Norms, Attitude

Source: Field Data, 2021

From the model summary, attitudes, norms and behaviour control explain 37.8% of the variation in Compliance with ISO 9001:2015 QMS procedures. This implies that there is a possibility of other factors including demographic characteristics, work environment and other environmental factors that affect the compliance with ISO certification at KNH. These however, were not the focus of the study.

The analysis of the regression coefficients was done to determine the strength and predictive value of each of the coefficients using the beta value. The beta value is a

measure of how strongly each predictor variable influences the criterion (dependent) variable. The beta is measured in units of standard deviation. For example, a beta value of 2.5 indicates that a change of one standard deviation in the predictor variable will result in a change of 2.5 standard deviations in the criterion variable. Thus, the higher the beta value the greater the impact of the predictor variable on the criterion variable. The regression output is presented in table 5.13 below:

Table 5.13: Regression Coefficient Analysis

Coefficients

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	.765	.385		1.987	.048
	Attitude	.334	.058	.318	5.757	.000
	Norms	.351	.056	.334	6.327	.000
	Behaviour control	.258	.065	.195	3.949	.000

a. Dependent Variable: Behaviour Intention

Source: Field Data, 2021

From the analysis, attitudes had a beta value of .318, norms had a beta value of .334 while behaviour control had a beta value of .195 which were all statistically significant at $p \leq 0.05$. This implies that behaviour control had the least predictor value of Compliance with ISO 9001:2015 QMS procedures followed by attitude while norms had the highest predictor value. Based on the findings, norms around ISO 9001:2015 QMS procedures then become the biggest predictor of compliance with the ISO 9001:2015 QMS procedures.

5.7 Conclusion

The Theory of Planned Behaviour (TPB) posits that individual behaviour is driven by behaviour intentions, where behaviour intentions are a function of three determinants: an individual's attitude toward behaviour, subjective norms, and perceived behavioural control (Ajzen, 1991). The study established that attitude and norms have a moderately

positive influence on workers' behaviour towards reforms which is represented by the compliance with ISO procedures. On the other hand, the study established that behaviour control has very weak influence on compliance with ISO 9001:2015 QMS.

Finally, the hypothesis testing confirmed that attitudes, organization norms and behaviour control are positively correlated with compliance with ISO 9001:2015 QMS procedures at KNH. Increasing positive attitudes would have a corresponding influence on compliance. As noted, earlier attitude is a function of perceived positive outcomes associated with the behaviour and how the information is received by the workers. On the other hand, organization norms need to be supportive of the changes being introduced. Norms are part of the wider organization culture hence the need to ensure that the culture is positive and is driven from the management. This way, any changes being introduced will not be met with resistance. Finally, when employees feel they have less control over the changes being introduced, such as ISO 9001:2015 QMS, adoption and implementation becomes difficult. Though the correlation was found to be weak, it is imperative that workers feel they have opportunities to perform a given task.

The study findings can be best summarised by the following TBP chain of reason for one John Kamau (not his real name) who is a laboratory technician at KNH.

> *"If John has a positive attitude towards compliance with ISO 9001:2015 QMS; IF his supervisors think it's a good idea OR he does not care what his colleagues think; AND he feels he has the capacity and capability to comply having been provided with the right tools, THEN the likelihood that he will comply is high."*

CHAPTER SIX

SUMMARY OF FINDINGS, DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

6.1 Summary of Findings

The main objective of the study was to investigate the factors that influence compliance behaviour towards ISO 9001:2015 QMS by workers at Kenyatta National Hospital. Specifically, the study sought to assess 1) compliance behaviour towards ISO 9001:2015 QMS at KNH; 2) the effects of workers' attitudes on compliance towards ISO 9001:2015 QMS procedures at KNH; 3) the influence of organization norms on compliance with ISO 9001:2015 QMS procedures at KNH; and; 4) the extent workers' behaviour control affects compliance with ISO 9001:2015 QMS procedures at KNH. Guided by the Theory of Planned Behaviour, the study hypothesized that 1. There is a positive relationship between workers' attitudes and compliance with ISO 9001:2015 QMS procedures at KNH; 2. There is a positive relationship between norms and compliance with ISO 9001:2015 QMS procedures at KNH; and; 3. There is a positive relationship between behaviour control and compliance with ISO 9001:2015 QMS procedures at KNH. Data was collected from 291 staff at KNH using self-administered questionnaires.

On demographic characteristics, the bulk of the workers 40% are between 25 – 40 years with a gender representation of 52% male and 48% female. The mean number of years in service for the employees was 7-9 years an indication of longevity in service. Lastly, 97% of the workers have post-secondary education of which 64% are holders of diploma and degree qualifications and above.

On compliance, the findings also indicated a high level of awareness amongst the workers with 82% awareness levels. There was a high level of awareness amongst the corporate support staff (92%) compared to clinical support staff (73%). Awareness levels of 100% are preferred. The study also established perceived outcomes with compliance as: ISO makes the workplace efficient and worker-friendly; and; ISO compliance improves communication within the hospital. Although improved decision-making was sighted as an outcome, it was not found to be significant. Compliance behaviour was assessed by measuring the behaviour intention as prescribed by the Theory of Planned Behaviour. Findings of the study revealed strong intentions to comply with ISO 9001:2015 QMS procedures at KNH with an average mean score of 86%. It was expected that compliance levels would be 100%. A gap in compliance implies gaps in service delivery. The study also identified institutional challenges that hinder compliance including the perception of ISO as a compliance issue; inadequate top management commitment; lack of incentives linked to compliance; high customer expectations and poor staff training on ISO QMS.

On the relationship between workers' attitudes and compliance with ISO 9001:2015 QMS procedures at KNH, findings indicate moderately positive attitudes towards compliance with a composite score of 68%. Attitude scores were stronger on instrumental (Cognitive) aspects compared to experiential (affective) aspects. The workers noted that the introduction of ISO has improved their ability to work better. On the other hand, factors that elicit negative emotions include inadequate budgets as well as a lack of adequate working tools. Hypothesis testing confirmed that there is a positive relationship between workers' attitudes and compliance with ISO 9001:2015 QMS at Kenyatta National Hospital. A Pearson's Coefficient Correlation (r=0.522)

shows that the strength of the correlation is moderate. Therefore, positive workers' attitudes have a positive effect on compliance with ISO 9001:2015 QMS at KNH.

On the relationship between norms and compliance with ISO 9001:2015 QMS procedure at KNH, the study established that the most significant person in the workers' jobs were the supervisors and colleagues. Normative social influences returned a moderate score (66%). Descriptive norms (perceptions of how people do behave) returned higher scores compared to injunctive norms (social pressure). Norms were also found to be closely linked to the organizational culture which may be attributed to the longevity of employment. Stronger subjective norms were returned due to the high level of sociability. As noted earlier, sociability thrives on friendships and informal work groups. Hypothesis testing confirmed that there is a positive relationship between an organization's norms and compliance with ISO 9001:2015 QMS at KNH. A Pearson's Coefficient Correlation (r=0.477) shows that the strength of the correlation is moderate. In summary, positive organizational norms have a positive influence on Compliance with ISO 9001:2015 QMS at Kenyatta National Hospital.

On the relationship between behaviour control and compliance with ISO 9001:2015 QMS procedures at KNH, the study established stronger behaviour control scores with a mean of 70%. This was expressed through abilities, skills and personal beliefs. Personal agency (individual capability to originate and direct actions) returned stronger scores of 71% compared to self-efficacy (belief in one's effectiveness in performing specific tasks as well as actual skills) which returned scores of 67%. Hypothesis testing confirmed that there is a positive relationship between workers' behaviour control and compliance with ISO 9001:2015 QMS procedures at Kenyatta National Hospital. A Pearson's Coefficient Correlation (r=0.305) shows that the strength of the correlation

is weak. Therefore, the findings of the study conclude that behaviour control affects compliance with ISO 9001:2015 QMS positively. An increase in behaviour control factors such as skills will lead to a marginal increase in compliance levels at KNH.

6.2 Discussions

The study was conducted against the backdrop of increased efforts by the Government of Kenya to reform the public sector and improve service delivery. The reform process has taken different forms and has been implemented in various phases since 1965. The study focused on the implementation of ISO 9001 QMS at Kenyatta National Hospital in Kenya. ISO certification was introduced as part of service delivery reforms to ensure that the public sector delivered goods and services that meet international standards. To ensure compliance, this requirement was put in as a performance contract requirement. After a majority of public sector organizations became ISO certified, the onus was now left to individual organizations to pursue further upgrades.

However, anecdotal evidence has suggested that quality service delivery has continued to elude most government institutions. There has been little impact on actual service delivery. Structures have changed, new names and job titles have emerged, the rhetoric and jargon adapt to new expectations, but service realities remain stubbornly resistant to change. Kenyatta National Hospital upgraded to the ISO 9001:2015 standard in 2019. However, the services at the hospital still fell below customer expectations with emerging cases of malpractice being reported in the media. This is an indication that whereas the hospital is certified, there are challenges to compliance with the ISO 9001 QMS by workers at the Hospital. This study sought to establish compliance behaviour amongst the workers at KNH while at the same time identifying factors that influence compliance behaviour amongst the workers.

Although compliance levels with ISO 9001:2015 QMS procedures were found to be high, they still fell below the expected threshold of 100% compliance. Several factors were attributed to this. The strategies used by the hospital to train and engage workers were found to be ineffective since not all the staff interviewed were aware of the QMS. There was evidence of inadequate engagement of employees especially in the development of the documented procedures. This essentially affects the ownership of the processes and leads to the perception that ISO QMS is separate from the workers' daily engagements. Additionally, poor management support in providing resources required to successfully implement the QMS has had a negative impact on the levels of compliance. In as much as the workers acknowledge the positive outcomes associated with compliance, the lack of adequate and modern working tools has affected compliance levels with the QMS procedures.

The findings confirmed that attitude towards behaviour, subjective norms and perception of behaviour control led to the formation of behaviour intention as proposed by the theory of planned behaviour. As a rule, the more favorable the attitude and subjective norm and the greater the perceived control, the stronger should be the Compliance with ISO 9001:2015 QMS procedures. The study also established that the biggest determinants of compliance with ISO 9001:2015 QMS procedures are the employees' attitudes and the organizational norms.

Employees' attitudes are greatly been influenced by their previous experiences in the implementation of ISO standards. These experiences include lack of management support, lack of provision of adequate equipment and tools as well as a lack of sanctions towards compliance. These experiences have led to the development of organizational norms that are not supportive of compliance with ISO Standards. The problem is

exacerbated further by the lack of adequate involvement of employees in the design and implementation of the ISO Standards by extension many other reforms within the organization. Studies have shown that a strong positive attitude is advantageous to an organization (Joseph, 2019; Magd, 2003). Among the advantages identified include fostering management change and adaptability, enhancement of team works as well as innovation. These advantages increase positive behaviour towards compliance by the workers at KNH.

Secondly, norms are enduring patterns of behaviour within an institution. The study established that the average period that the staff has been together is 7-9 years. This long period has resulted in the establishment of both professional relationships and social ties among the staff. There is a strong sense of sociability among the members of staff and it would be therefore unwise to ignore the informal communication channels that exist within the institution. To ensure that there is the acceptability of the reforms being introduced, there is a need to understand the existing culture of the institutions and try to integrate the reforms within the culture rather than try to out rightly change it. Studies have observed that there is no “bad” culture in an organization. The most important thing is to understand the strengths of each culture and use them to build a strong institution.

Predictive analysis revealed norms have the biggest predictive value compared to attitudes and behaviour control. Descriptive norms had stronger influences on the overall normative behaviour. This is evidence that people behave regardless of whether the behaviour is approved or disapproved as also discussed by Borisal *et al.,* (2003) and Ciadini *et al.,* 2006. The authors also observed that norms are constructed from three sources including observable behaviour, direct/indirect communication, and self-

knowledge. Improvement of norms around compliance with ISO 9001:2015 QMS at KNH requires improvements in communication and self-knowledge amongst the workers. Norms have a significant bearing on the organizational culture of an organization. The impact of organizational culture may be particularly relevant in health policy, especially in the context of complex organizations such as KNH, where professionals hold considerable authority and autonomy. A plan for reform of the health system including implementation of the Quality Management Systems must take into account differing stakeholders' objectives and values.

On behaviour control, the positive relationship albeit weak between behaviour control and compliance with ISO 9001:2015 QMS procedures at KNH is an indication that staff feels they have the capacity and ability to comply. The challenge noted is the unavailability of working equipment. Ajzen, (2011) observes that behavioural intended actions may not come to fruition when decisions are out of individuals' direct control. The decisions in this case include the availability of the required budgets, tools and equipment to enhance compliance. This goes hand in hand with the institutional challenges affecting compliance that have been identified. Workplace conditions, interactions with other workers or time pressures may cause an individual to perform a task differently, a view also supported by Bandura, (2006) and Gallagher, (200).

It is also important to note that background factors could also influence behaviour intention. These factors could be demographic that include age, sex, occupation, status, religion and education or they could be personality traits that include but are not limited to extraversion, agreeableness, consciousness, neuroticism or openness. This study did not control for these variables. Other factors that have been identified in this study and other studies that influence compliance with ISO procedures include the availability of

working equipment and tools; incentives linked to compliance; bureaucracy; the complexity of internal processes as well as organizational culture.

To achieve the desired results in ISO 9001 QMS implementation and the reform agenda at KNH, there is a need to ensure that workers are involved in the process. This involvement includes providing the right information to ensure that the staff internalizes the favorable outcomes associated with the implementation of the reforms. If this is done correctly and using the right channels of communication, then positive attitudes towards the reforms develop and subsequently adoption and compliance are easier.

6.3 Conclusions

The adoption of ISO 9001:2015 by Kenyatta National Hospital was not intended to be a performance contracting fulfillment. It was meant to ensure that KNH offers quality health services to patients. These services are to meet international standards as espoused in the quality policy at the institution. These can only be assured if the hospital complies 100% with the QMS requirements. Although compliance levels were high, they still fell short of the required threshold. This implies that there is a likelihood of a service delivery gap which has been seen through documented reports. At the institutional level, some bottlenecks have been identified that impact compliance.

The employees at KNH are important in the achievement of the desired compliance levels since they are the main implementers of the QMS. Their compliance behaviour is largely influenced by their attitudes and norms around ISO 9001:2015 QMS. Behaviour control was established to have a positive but weak correlation with compliance behaviour. Stronger positive attitudes and organizational norms will subsequently lead to an improvement in compliance with ISO 9001:2015 QMS. On the

other hand, although employees are willing and can comply, there is a need for an improvement in workplace conditions to enhance Compliance with ISO 9001:2015 QMS at KNH.

6.4 Recommendations

Based on the findings and conclusions, the study makes the following recommendations to improve compliance with ISO 9001:2015 QMS and the adoption of reforms at KNH and by extension the public sector.

6.4.1 Policy Recommendation

There should be meaningful participation of workers in the formulation and implementation of changes at KNH. This includes the introduction of ISO QMS. This is because the workers are the implementers of these changes. Involvement can be achieved in two ways. Firstly, is direct involvement in the design and development of the reforms. Secondly, involvement can include taking into consideration of the attitudes and norms that exist within the Hospital and incorporating reforms therein. Most reform packages like ISO have met resistance within the public sector as evidenced by the lack of total compliance. This is because they try to change existing relationships and do not take cognizance of informal structures that exist therein.

There is a need to improve communication of policy changes for both internal and external stakeholders. Sometimes the public expectation of the policy is not aligned with the workers' expectations. There is also need to ensure that awareness amongst the workers translates to knowledge. Communication is key in the introduction and implementation of reforms in an organization. Successful sustained reform requires the alignment of citizens, stakeholders, and voices. Reformers must overcome adaptive challenges such as public opinion, self-interested forces and inertia, and this requires

skilled communication. The main contribution communication can make to governance reform is to influence the opinions, attitudes and ultimately the behaviour of key stakeholders (including leaders, bureaucrats, and citizens). This is important because all reform requires behaviour change on the part of stakeholders. KNH must therefore invest in robust communication strategies that reach all the stakeholders with the right messages at the right time.

6.4.2 Operational Recommendations

The study established that there are no incentives nor sanctions as far as compliance with ISO procedures is concerned. The absence of rewards and sanctions acts as a demotivating factor in compliance with ISO procedures. Implementation of the ISO 9001:2015 QMS should be accompanied by an elaborate system of rewards and sanctions. Additionally, KNH should invest in studies that would evaluate the effectiveness of the reforms that have been introduced. In this study, aside from the audit reports and management review meetings, there was insufficient evidence of any study that has evaluated the impact or effectiveness of the introduction of ISO standards on service delivery.

Implementation of reforms aims at modernizing public service and increasing efficiency. However, efficiency and modernization cannot take place while the implementers are using outdated technology, poor equipment and dilapidated infrastructure. The participants in this study noted that while the ISO 9001:2015 standards at good for enhanced customer experience, the lack of modern equipment and infrastructure makes implementation difficult. It was observed that there is inadequate budget allocation even for the maintenance of the current equipment. KNH should

therefore ensure that reforms are implemented with the corresponding upgrade in technology, equipment as well as adequate infrastructure.

Enhance the participation of employees in the development and implementation of the QMS and reforms within KNH. Most reforms like ISO certification have taken a top-down approach and in most instances have met resistance from the users who are the workers. Employees can be positively engaged through training, development of procedures as well as participating in exchange and learning forums internally or externally. Employee engagement will not only ensure buy-in but will also provide the management with important feedback on what needs improvement. This will ultimately lead to the successful implementation of the QMS and other reforms.

6.5 Areas of Further Research

To improve on the effectiveness of the findings using the TPB model, it is recommended that an expanded model be used that will consider opportunities and resources, demographic and personality factors as well as environmental and economic factors. This will also increase the model fit from the current 37.8%.

Secondly, data provided in this study provide useful baseline information on factors that influence compliance with ISO procedures at KNH and give an indication of the public sector in general. This study therefore recommends a detailed qualitative study that will provide a deeper understanding of attitudes, norms and behaviour control, especially in the adoption of reforms in the public sector.

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APPENDICES

Appendix I: Questionnaire

KNH-UoN/ERC/FORM/IC01 | Consent Form and Questionnaire

UNIVERSITY OF NAIROBI (UoN)
COLLEGE OF HEALTH SCIENCES
P O BOX 19676 Code 00202
Telegrams: varsity (254-020)
2726300 Ext 44355

KNH-UoN ERC
Email: uonknh_erc@uonbi.ac.ke
Website: http://www.erc.uonbi.ac.ke
Facebook:
ttps://www.facebook.com/uonknh.erc
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ttps://twitter.com/UONKNH_ERC

KENYATTA NATIONAL HOSPITAL (KNH)
P O BOX 20723 Code 00202
Tel: 726300-9
Fax: 725272
Telegrams: MEDSUP, Nairobi

PARTICIPANT INFORMATION AND CONSENT FORM

ADULT CONSENT

FOR ENROLLMENT IN THE STUDY

Title of Study:

Workers construction of organizational reforms in the public sector: a case study of Kenyatta National Hospital.

Principal Investigator\and institutional affiliation:

Benjamin Karume, PhD Student, Moi University.

Introduction:
I would like to tell you about a study being conducted by the above listed researchers. The purpose of this consent form is to give you the information you will need to help you decide whether or not to be a participant in the study. Feel free to ask any questions about the purpose of the research, what happens if you participate in the study, the possible risks and benefits, your rights as a volunteer, and anything else about the research or this form that is not clear. When we have answered all your questions to your satisfaction, you may decide to be in the study or not. This process is called 'informed consent'. Once you understand and agree to be in the study, I will request you to sign your name on this form. You should understand the general principles which apply to all participants in a medical research: i) Your decision to participate is entirely voluntary ii) You may withdraw from the study at any time without necessarily giving a reason for your withdrawal
iii) Refusal to participate in the research will not affect the services you are entitled to in this health facility or other facilities. We will give you a copy of this form for your records.

This study has approval by The Kenyatta National Hospital-University of Nairobi Ethics and Research Committee protocol No. **P832/12/2018**

WHAT IS THIS STUDY ABOUT?

The researchers listed above are interviewing individuals who are employed within Kenyatta National Hospital. The purpose of the interview is to find out how employee perceive the introduction and implementation of ISO 9001:2015 quality management system. Participants in this research study will be asked questions about their perception, attitudes and behaviour towards implementation of the ISO quality management system. Participants will not undergo any test.

There will be approximately 365 participants in this study randomly chosen. We are asking for your consent to consider participating in this study.

WHAT WILL HAPPEN IF YOU DECIDE TO BE IN THIS RESEARCH STUDY?

If you agree to participate in this study, you will be issued with a questionnaire that requires you to answer all the questions. Completing the questionnaire takes approximately 8 minutes. The questionnaire will cover topics such as your opinions on ISO certification, how it has affected your attitude and behaviour and how the certification influences norms at KNH.

Should you encounter any difficulty, the researcher will be around to help you through.

ARE THERE ANY RISKS, HARMS DISCOMFORTS ASSOCIATED WITH THIS STUDY?

Medical research has the potential to introduce psychological, social, emotional and physical risks. Effort should always be put in place to minimize the risks. One potential risk of being in the study is loss of privacy. We will keep everything you tell us as confidential as possible. We will use a code number to identify you in a password-protected computer database and will keep all of our paper records in a locked file cabinet. However, no system of protecting your confidentiality can be absolutely secure, so it is still possible that someone could find out you were in this study and could find out information about you.

Also, responding to some questions in the questionnaire may make you feel uncomfortable. If there are any questions you do not want to answer, you can skip them. You have the right to refuse the interview or any questions in the questionnaire.

ARE THERE ANY BENEFITS BEING IN THIS STUDY?

The information you provide will help us better understand implementation of reforms at KNH and the role the staff play. This information is a contribution to science and management of public sector institutions, KNH included.

WILL BEING IN THIS STUDY COST YOU ANYTHING?

The study is undertaken in the course of your day to day activities and therefore there will be no cost accruing to yourself.

WILL YOU GET REFUND FOR ANY MONEY SPENT AS PART OF THIS STUDY?

As stated above, there are no costs to the participants and therefore we do not anticipate any claims for refunds.

WHAT IF YOU HAVE QUESTIONS IN FUTURE?

If you have further questions or concerns about participating in this study, please call or send a text message to the study staff at the number provided at the bottom of this page.

For more information about your rights as a research participant you may contact the Secretary/Chairperson, Kenyatta National Hospital-University of Nairobi Ethics and Research Committee Telephone No. 2726300 Ext. 44102 email uonknh_erc@uonbi.ac.ke.

The study staff will pay you back for your charges to these numbers if the call is for study-related communication.

WHAT ARE YOUR OTHER CHOICES?

Your decision to participate in research is voluntary. You are free to decline participation in the study and you can withdraw from the study at any time without injustice or loss of any benefits.

CONSENT FORM (STATEMENT OF CONSENT)

Participant's statement

I have read this consent form or had the information read to me. I have had the chance to discuss this research study with a study counselor. I have had my questions answered in a language that I understand. The risks and benefits have been explained to me. I understand that my participation in this study is voluntary and that I may choose to withdraw any time. I freely agree to participate in this research study.

I understand that all efforts will be made to keep information regarding my personal identity confidential.

By signing this consent form, I have not given up any of the legal rights that I have as a participant in a research study.

I agree to participate in this research study:	**Yes**	**No**
I agree to have (define specimen) preserved for later study:	Yes	No
I agree to provide contact information for follow-up:	Yes	No

Participant printed name:
(optional)____

Participant signature / Thumb stamp _________________Date _______________

Researcher's statement

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has willingly and freely given his/her consent.

Researcher's Name: BENJAMIN KARUME **Date**: 11th FEB 2019

Signature:

Role in the study: PRINCIPAL INVESTIGATOR

For more information contact **BENJAMIN KARUME** at **0722 682688** during working hours.
Name of R/A administering the questionnaire:
……………………………………………….

If in agreement, please proceed to the next page and complete the questionnaire attached.

SCHOOL OF ARTS AND SOCIAL SCIENCES
DEPARTMENT OF SOCIOLOGY AND PSYCHOLOGY
PhD RESEARCH WORK (QUESTIONNAIRE)
BENJAMIN KARUME SASS/DPHIL/100/14

My Name is Benjamin Karume, I am a PhD student at Moi University undertaking studies in Sociology. As part of my studies, I am conducting a study on *Workers construction of organizational reforms in the public sector: a case of Kenyatta National Hospital.* The study focuses on compliance with ISO 9001:2015 Procedures as part of the reforms.
You have been selected as a respondent in this study through a random selection process. I am therefore requesting for your time to respond to the following set of questions that will help me gather information on my study area. I also wish to inform you that the information collected here will be confidential and is solely for academic purposes and will not be used for any other purposes. This study has been approved by the Ethics Review Board of KNH and by the School of Postgraduate Studies, Moi University. The questionnaire is divided into three parts. Part A on Demographic Information; Part B is on behaviour assessment; Part C is on organization Culture and Part D on recommendations. Kindly answer the questions as truthfully as you possibly can.

PART A: DEMOGRAPHICS (Please indicate your response on the response column provided)

1.0	**DEMOGRAPHICS**				
No.	**FACTOR**	**RESPONSE**	**No.**	**FACTOR**	**RESPONSE**
1.1	Division		1.2	Department	
1.3	Section		1.4	Unit	
1.5	Age		1.6	Gender	
1.7	No. of Years in Service		1.8	Highest Academic Qualifications	
	1. Less than I Year			1. Primary	
	2. 1 - 3Years			2. Secondary	
	3. 4 - 6 Years			3. Certificate	
	4. 7 - 9 Years			4. Diploma	
	5. 10 - 12 Years			5. Degree	
	6. 13 - 15 Years			6. Post Graduate Diploma	
	7. 16 + Years			7. Masters	
1.9	Job Group			8. PhD	

PART B: ASSESSMENT OF BEHAVIOUR
This section assess the various perceptions about ISO 9001:2015 that is widely used at the hospital. There are different sections with some sets of responses.

B1: a) Are you aware of ISO 9001:2015 being implemented at KNH? **1. Yes** **2. No**

B1 b) What do you understand by ISO 9001:2015 Certification?

B2: a) If Yes in 1a) above, how did you learn of ISO 9001:2015 certification?

B2: b) Were you involved in the development of the ISO 9001:2015 procedures?
1. Yes **2. No**

B2: c) If Yes How?

B2: d) If No Why?

B2: e) Do you understand the ISO 9001:2015 procedures relevant to your work?

B3- Behaviour Intention: On a scale of 1 – 7 where 1 represents strongly disagree and 7 represents strongly agrees, State your level of agreement with the following statements. Kindly tick in only **ONE Box** on the responses column for each of the statement. Kindly provide a reason for your rating

NO.	STATEMENT	RESPONSE							REASON
		1 Strongly disagree	2	3	4	5	6	7 Strongly Agree	
1	ISO Certification has made the workplace more efficient and worker friendly								
2	I Expect to comply with all ISO procedures at KNH								
3	ISO Certification has not promoted reciprocal communication at KNH								
4	I do not intend to comply with ISO procedures at KNH								
5	With ISO Certification decision making at KNH has been effective and coherent								
6	I want to comply with ISO procedures at KNH								

B4 – Attitude: On a scale of 1 – 7 where 1 represents strongly disagree and 7 represents strongly agrees, State your level of agreement with the following statements. Kindly tick in only **ONE Box** on the responses column for each of the statement. Kindly provide a reason for your rating

NO.	STATEMENT	RESPONSE							REASON
		1 Strongly disagree	2	3	4	5	6	7 Strongly Agree	
1	I feel motivated when complying with ISO Procedures								
2	I will not apply ISO procedures to all processes in my work								
3	Compliance with ISO procedures improves motivation of workers								
4	I feel stressed when I am not complying with ISO procedures								
5	I believe that ISO procedures are important for achieving organizational goals								
6	I believe that workers are motivated with the application of ISO procedures								

B5 – Subjective Norms

a) Kindly list the most important people to your work in order of importance:

i)
ii)
iii)
iv)

b) On a scale of 1 – 7 where 1 represents strongly disagree and 7 represents strongly agrees, State your level of agreement with the following statements. Kindly tick in only **ONE Box** on the responses column for each of the statement. Kindly provide reasons for your rating

NO.	STATEMENT	RESPONSE							REASONS
		1 Strongly disagree	2	3	4	5	6	7 Strongly Agree	
1	Most people who are important to me **think** that I should not comply with ISO procedures								
2	I should always comply with ISO procedures								
3	The ISO procedures are good for some people								
4	It is expected of me that I comply with ISO procedures								
5	I feel under social pressure to comply with ISO procedures								
6	People who are important to me **want** me to comply with ISO procedures								

B6: Perceived Behaviour Control - On a scale of 1 – 7 where 1 represents strongly disagree and 7 represents strongly agrees, State your level of agreement with the following statements. Kindly tick in only **ONE Box** on the responses column for each of the statement.

NO.	STATEMENT	RESPONSE							REASONS
		1 Strongly disagree	2	3	4	5	6	7 Strongly Agree	
1	I am confident that I can comply with ISO procedures if I wanted to								
2	For me, compliance with ISO procedures is easy								
3	The decision to comply with ISO procedures is beyond my control								
4	Whether I comply with ISO procedures is entirely up to me								

NO.	STATEMENT	RESPONSE							REASONS
5	I have the ability to comply with ISO procedures								
6	KNH has given me adequate skills to implement ISO procedures								

PART C: ORGANIZATION CULTURE

The Introduction of ISO Certification was expected to result to a change in the organization culture. From the statements below, please indicate the effect of ISO procedures by ranking on a scale of 1-3 where a score of **1** denotes **Agree** and **2** denotes **Neutral** while **3** denotes **Disagree**.

No.	STATEMENT	SCORE		
		Agree	Neutral	Disagree
	SOCIABILITY			
1	Due to ISO Certification, people at KNH try to make friends and keep their relationships Strong			
2	People at KNH get along very well as a result of introduction of ISO procedures			
3	ISO certification has enabled people at KNH to often socialize outside the office			
4	As a result of ISO certification people at KNH really like one another			
5	When people exit KNH, we stay in touch			
6	People at KNH do favors for others because they like one another			
7	People at KNH often confide in one another about personal matters			
	SOLIDARITY			
1	Due to ISO certification, our organization understands and shares the same business objectives			
2	Following the introduction of ISO, Work at KNH gets done effectively and productively			
3	Our organization takes strong action to address poor performance			
4	Our collective will to succeed is high			
5	When opportunities for competitive advantage arise (such as new technology), we move quickly to capitalize on them			
6	As a result of ISO certification, we share the same strategic goals			
7	ISO procedures has led us to know our customer expectations			

How would you describe changes in the following areas as a result of introduction of ISO 9001:2015 at KNH?

		Changed for the better	Not changed at all	Changed for the worse
1	The general attitude of staff towards work			
2	The general behaviour of employees at the workplace			
3	The employees ability to effectively complete tasks			

PART D- RECOMMENDATIONS

D1: In your opinion, has the adoption of ISO certification improved service delivery at KNH?

D2: Briefly explain your answer in D1 above.

D3: What have been the challenges in implementing ISO Standards at KNH?

D4: How should KNH implement reforms in future?

END - Thank you

Appendix II: Guide for Key Informant Interviews and FGDs

My Name is Benjamin Karume, I am a PhD student at Moi University undertaking studies in Sociology. As part of my studies, I am conducting a study on *Workers construction of organizational reforms in the public sector: a case of Kenyatta National Hospital.* The study focuses on compliance with ISO 9001:2015 Procedures as part of the reforms.
You have been selected as a respondent in this study purposely because I believe you may provide insights into the reform process at KNH specifically the implementation of ISO 9001:2015 QMS.
I am therefore requesting for your time to respond to the following set of questions that will help me gather information on my study area. I also wish to inform you that the information collected here will be confidential and is solely for academic purposes and will not be used for any other purposes. This study has been approved by the Ethics Review Board of KNH and by the School of Postgraduate Studies, Moi University.

1. Reforms that KNH has undertaken to improve service delivery between 2003 to date.
2. Who have been the initiators of the reforms?
3. What informed the decision to implement the reforms?
4. How successful have the reforms been?
5. Have the reforms been embraced by the workers? Why and/or why not?
6. What are the challenges faced by KNH in implementing reforms?
7. What should KNH do to improve implementation of reforms?

Appendix III: Approvals

NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

Telephone:+254-20-2213471, 2241349,3310571,2219420
Fax:+254-20-318245,318249
Email: dg@nacosti.go.ke
Website : www.nacosti.go.ke
When replying please quote

NACOSTI, Upper Kabete
Off Waiyaki Way
P.O. Box 30623-00100
NAIROBI-KENYA

Ref: No. **NACOSTI/P/19/65229/29158**

Date: **23rd April, 2019**

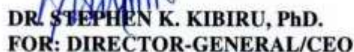
Benjamin Anyonga Karume
Moi University
P.O. Box 3900-30100
ELDORET.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ***"Workers construction of organizational reforms in the public sector; a case study of Kenyatta National Hospital"*** I am pleased to inform you that you have been authorized to undertake research in **Nairobi County** for the period ending **23rd April, 2020.**

You are advised to report to **the Chief Executive Officer, Kenyatta National Hospital, the County Commissioner and the County Director of Education, Nairobi County** before embarking on the research project.

Kindly note that, as an applicant who has been licensed under the Science, Technology and Innovation Act, 2013 to conduct research in Kenya, you shall deposit **a copy** of the final research report to the Commission within **one year** of completion. The soft copy of the same should be submitted through the Online Research Information System.



DR. STEPHEN K. KIBIRU, PhD.
FOR: DIRECTOR-GENERAL/CEO

Copy to:

The Chief Executive Officer
Kenyatta National Hospital.

The County Commissioner
Nairobi County.

National Commission for Science, Technology and Innovation is ISO9001:2008 Certified

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Ref: KNH-ERC/A/65

25 February, 2019

Benjamin Anyong'a Karume
Reg. No. SASS/DPHIL/100/4
PhD Candidate
Dept.of Sociology and Psychology
School of Arts and Social Sciences
Moi University

Dear Benjamin

RESEARCH PROPOSAL – WORKERS' CONSTRUCTION OF ORGANIZATIONAL REFORMS IN THE PUBLIC SECTOR: A CASE STUDY OF KENYATTA NATIONAL HOSPITAL (P832/12/2018)

This is to inform you that the KNH- UoN Ethics & Research Committee (KNH- UoN ERC) has reviewed and **approved** your above research proposal. The approval period is 25th February 2019 – 24th February 2020.

This approval is subject to compliance with the following requirements:

a) Only approved documents (informed consents, study instruments, advertising materials etc) will be used.
b) All changes (amendments, deviations, violations etc.) are submitted for review and approval by KNH-UoN ERC before implementation.
c) Death and life threatening problems and serious adverse events (SAEs) or unexpected adverse events whether related or unrelated to the study must be reported to the KNH-UoN ERC within 72 hours of notification.
d) Any changes, anticipated or otherwise that may increase the risks or affect safety or welfare of study participants and others or affect the integrity of the research must be reported to KNH- UoN ERC within 72 hours.
e) Clearance for export of biological specimens must be obtained from KNH- UoN ERC for each batch of shipment.
f) Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. (*Attach a comprehensive progress report to support the renewal*).
g) Submission of an *executive summary* report within 90 days upon completion of the study. This information will form part of the data base that will be consulted in future when processing related research studies so as to minimize chances of study duplication and/ or plagiarism.

For more details consult the KNH- UoN ERC website **http://www.erc.uonbi.ac.ke**

Protect to discover

Yours sincerely,

PROF. M.L. CHINDIA
SECRETARY, KNH-UoN ERC

c.c. The Principal, College of Health Sciences, UoN
The Director, CS, KNH
The Chairperson, KNH- UoN ERC
The Assistant Director, Health Information, KNH
Supervisors: Prof. Jamin R.M. Masinde, Dept.of Sociology and Psychology, Moi University
Dr.Eric Masese, Dept. of Sociology and Psychology, Moi University