IMPLEMENTATION OF PUBLIC HEALTH POLICIES IN BARINGO COUNTY, KENYA.

BY

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A THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF MASTER OF PUBLIC ADMINISTRATION AND POLICY, SCHOOL OF ARTS AND SOCIAL SCIENCES, MOI UNIVERSITY.

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DECLARATION AND APPROVAL

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DEDICATION

To my father Mzee Paul Cheronge, my mother Tarkok and my brothers and sisters for their endless financial and moral support throughout my period of study. I would like to further extent this dedication to all policy scholars, makers and implementers at large together with their consumers.

ACKNOWLEDGMENT

I acknowledge my supervisors; Dr. J.K Chelang'a and Ms. Esther Arusei for their guidance and their patience for reading through my work and offering positive criticism. I also extend my gratitude to the entire lecturers and all the non teaching staff in the school of Arts and Social Sciences for their constant support in our academic progress. To my colleagues in class. I further thank you for support, cooperation and team work you exhibited throughout learning process. I also wish to thank all the staff in Baringo County government drawn from different departments led by Hon. Benjamin Cheboi, Governor of Baringo County, and County Executive Commitee (CEC) for department of Health, Hon. Atuko Moses and Chief Officer (CO) for health services Dr. Gideon Toromo. Vote of thanks also goes to line staff management in Baringo County who helped me in one way or another. I appreciate the help I got from the public health professionals drawn from the six Sub Counties situated in different levels of health care facilities ranging from dispensaries, health centers, Sub County Hospitals and County referral hospitals in Baringo County. My gratitude goes to Nongovernmental Organization (NGOs) and Private Health providers, particularly, World Vision, Child Fund, and Bare Care Center among others for their crucial information they gave me for my study.

Thanks to the staff from private hospitals operating in Baringo. Thanks to Barnet Memorial hospital, Barnet Faith clinic, Mercy hospital and St Francis Mission Hospital, Salawa for their support and cooperation. My sincere gratitude further goes to the entire residents of Baringo drawn from Six Sub Counties for patiently giving me the

opportunity to solicit information from them. God Bless you so much for your kindness and courtesy you accorded me.

ABSTRACT

Implementation of Public health has been a concern to governments globally. Although, several public health policies have been formulated; implemented and evaluated, little progress has been made in addressing the public health challenges. For decades, public health policy makers have emphasized primary health care through implementation of promotive, preventive and rehabilitative public health policies espoused during the Alma Atta declaration of 1978. A few States are yet to implement this approach. Kenya, through recent health care reforms, is inclined to this strategy which forms the coronary of this research. The overall objective of this study was to assess the implementation of Public Health policies in Baringo County in Kenya by operationalizing the following objectives: to identify public health policies in Baringo County, the role of various stakeholders in the implementation process, the mode of financing of public health policies and finally the challenges that have undermined implementation. The study was guided by New Institutionalism theory propounded by March and Olsen, (1984) and Thomas Smith model (1973) of policy implementation. Cross-sectional survey was undertaken on sampled population. A purposive sampling was used to sample policy makers, NGOs officials and health professionals while stratified sampling was carried out on the community and local leaders based on their sub county population. Open and closed-ended questionnaires were administered to the sampled population of 400 respondents while interviews conducted on key policy makers, NGOs and health professionals. The data collected was analyzed quantitatively by use of SPSS (Statistical Package for Social Sciences) and qualitatively through categories of themes that emerged from the data. The studies found out that (72%) of respondents were aware of existence of public health policies in Baringo. This response confirms that most of the residents know existing programs being implemented within their locality despite majority of respondents attested having never been involved in any policy or programme implementation by the government. Resource scarcity and allocation appeared a great challenge in the implementation process. In addition, the results that emanated from the study noted that governances still remain a challenge in the implementation of public health policies. The study recommends health policy implementers to involve the community in the health care implementation for sustainability and ownership. In addition, community participation shall enhance good governance, foster transparency and accountability among the implementing actors. The study recommends increased funding to the sector and improvement of infrastructure such as establishment of dispensaries and health centers, equipments and drugs and health personnel especially in the rural and far flung areas. It further recommends the stakeholders to strengthen their relations for better and coordinated implementation.

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OPERATIONAL DEFINITION OF TERMS

Communities are individuals who share characteristics, regardless of their location or degree of interaction to do or perform common services.

Decentralization is taking decision making and services from national level to the lower levels of governments.

Equity is distribution of resources, rights and healthcare across the population in a fair manner.

Fiscal federalism is devolving financial autonomy to the local levels of administration.

Health care is the diagnosis, treatment, and prevention of disease, illness, injury and other physical and mental impairments in human health care.

Health it is the physical, social, psychological and economic wellbeing of an individual and not merely absence of disease.

Health system consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health.

Policies are purposive course of action followed by an actor or set of actors in dealing with a problem or a matter of concern.

Primary Health Care is health care provided at community level often controlled by the community.

LIST OF ABBREVIATIONS AND ACRONYMS

AIDS **-** Acquired Immuno-Deficiency Syndrome

ASAL -Arid and Semi Arid Lands

C.S.Os - Civil Society Organizations

CBOs Community Based Organizations

CDF **-** Constituency Development Fund

CEC -County Executive Committee

DHMB -District Health Management Boards

DHMT -District Health Management Teams

ESP - Economic Stimulus Package

FBOs **-**Faith Based Organizations

GIS **-**Geographical Information System

G.o.K - Government of Kenya

H.S.S.F –Health Sector Service Fund.

HIV - Human Immune Virus

I.M.F -International Monetary Fund.

JPWF **-** Joint Program of work and Funding

KEPH **-** Kenya Essential Package for Health

KHPF **-** Kenya Health Policy Framework

KNBS -Kenya National Bureau of Statistics

LATF **-**Local Authority Transfer Fund

M.D.Gs - Millennium Development Goals

M.o.H **-**Ministry of Health.

N.G.Os **-** Non Governmental Organizations

NHIF **-** National Hospital Insurance Fund

NHSSP - National Health Sector Strategic Plan

PHC **-**Primary Health Care

SNG - Sub-National Government.

SWAp **-** Sector Wide Approach

T.I -Transparency International

U.N **-** United Nations

USAID -United States Agency for International Development.

W.B - World Bank

W.H.O - World Health Organization

CHAPTER ONE

INTRODUCTION

1.1 Introduction

This chapter covers the background of the study, statement of the problem, the purpose of the study, the objectives and the questions that guide the study, the justification and finally scope and delimitation of the study.

1.2 The background to the study

Health policies have been of crucial concern to various institutions, scholars, policy makers and communities' worldwide. Critical to health systems in the world is arriving at a common understanding on what should constitute a health system of a given population. Are health systems to be concerned with fair or equal distribution of 'health', 'health care' or 'opportunity' for maximizing health status? Unfortunately, there is no agreement on 'what' should be distributed equally (Culyer, 2001).There is a fair consensus that a fair distribution of healthcare is a more realistic objective of health system than a fair distribution of health. This is based on the argument that equity in health suggests equality in health outcome, and there are numerous factors that affect health status that are outside the locus of health system (Whitehead, 1992).

For decades, health problems have had profound impact in the Africa's development. Perennial fight against these diseases has consumed much of Africa's resource as insurmountable amount of money annually is used to fight these diseases. As Cooke (2009) notes, nowhere are global public health's more acute than in Africa. The continents immense disease burden and frail health system are embedded in broader

context of poverty, underdevelopment, conflicts and weak or ill-managed government institutions.

The improvement and extension of healthcare delivery in Africa is also being constrained by gaps in financing. Africa makes up 11% of the world's population but accounts for 24% of the global disease burden, according to the International Finance Corporation. More worrisome still, the region commands less than 1% of global health expenditure (World Bank, 2011). More than half of healthcare costs on the continent are currently met by out of- pocket spending, a ratio that rises to as much as 90% in some countries (World Bank, 2011). Because of the inadequacy of government programs to address Africa's health emergencies, the continent has long been a big recipient of external aid in the healthcare sector. External donors are of two types: foreign governments and NGOs. While foreign governments have more funds at their disposal, the strings attached to their aid are sometimes onerous, and NGOs' relative independence (especially from large pharmaceutical corporations) can make them more effective (KPMG, 2012).

African countries have traditionally had fewer healthcare workers per head than anywhere else in the world. Low pay and poor living conditions contribute to a continuous brain-drain of health professionals to the developed world and this makes it difficult to recruit and retain skilled staff, particularly in more remote regions where the need is often greatest (W.H.O, 2011). Increased urbanization in many African countries, along with growing incomes and changing lifestyles, have led to a rise in the rate of chronic conditions such as diabetes, hypertension, obesity, cancer and respiratory diseases. These threaten to put considerable further strain on already overstretched healthcare systems. The WHO estimates that chronic diseases will overtake

communicable diseases as the most common cause of death in Africa by 2030 (W.H.O, 2011).

To improve healthcare in Africa, primary healthcare should be strengthened. PHC is defined by three features: level of care, philosophy and set of services it provides. In terms of level, PHC is the first point of contact between the health system and the population it serves. It could be health clinics, health centers or hospital ambulatory care (WHO, 1978). As a philosophy, PHC subscribes to equity, sustainability, efficiency, acceptability and the universal coverage of all citizens with some basic set of healthcare services-a comprehensive approach. The philosophy of PHC promotes the active participation of the community that it served; inter-sectoral collaboration (especially the social sector) and the use of effective technologies (WHO, 1978). The set of services provided by a health system based on PHC focuses on improvement of the overall health of the population rather than just treatment of disease (WHO, 1978).

Evidence suggests that health systems that are oriented towards the PHC approach are likely to deliver better outcome (Macinko et al, 2003). Specialized medical care is more expensive, and with limited resources and competing uses, it is more difficult to provide such services to entire population (Starfield, 1992). Also, specialized medical care is solely concerned with treating disease and so cannot maximize population health as disease rarely exist in isolation (Starfield, 1992). Other arguments for the PHC approach are that PHC is characterized by continuous care of the population such that PHC providers and the patients are usually known to each other, fostering social cohesion within communities. The organization of PHC is less hierarchical and primary healthcare physicians are closer to the patient's milieu (Maeseneer et al, 2007). The system is

therefore inherently more adaptable to the changing needs of the community and the physicians are in a better position to appreciate social and environmental impacts on illness (Maeseneer et al, 2007). The understanding of PHC as the point of contact with the community and population's gateway to the health system has been predominant in countries that have achieved adequate level of basic health services (Kekki, 2003).

World Bank (2011) notes that, by the end of the decade, many African countries will have overhauled their health facilities and treatment pathways to emphasize primary care services that educate people about healthy lifestyles keep them in good health and help them to manage chronic conditions. The changes will amount to a revolution in healthcare delivery (World Bank, 2011). Leading the charge will be a renewed focus on preventive care as a way of managing chronic conditions, promoting wellness and reducing expensive hospital stays (World Bank, 2011). As noted by KPMG, (2012), governments, multinational organizations and NGOs currently prefer to focus on primary healthcare simply because it is the most cost effective way of improving the health of a population and to deliver high impact interventions at low cost.

However, primary health care provision can only thrive in an environment where there is a greater representation through devolution. In recent years, decentralization has been promoted by advocates of health sector as a means of improving efficiency, quality of service; promoting democracy and accountability to the local population (Green, 1999). The argument is that decentralization facilitates the design of the most effective mechanism for coping with three crucial challenges to the health system. The first challenge is that it is common to find diversity in the epidemiological pattern of disease across regions and populations within a country. This is accounted for by characteristics

of the health sector, geographical, ecological, environmental, economic, social, behavioral, demographic and cultural factors that may differ from population to population in regions within a country. The second challenge is the increased complexity of heath care. The greater awareness of the important influences of non-medical factors on health status requires the mobilization of complementary inter-sectoral action from agriculture, education, sanitation, labor and industry. Third, the delivery of health care has to respond constantly to changes occurring in the health situation in local areas, especially as these changes do not occur uniformly nor at the same pace in all regions of the country (Adetokunbo, 1999). It brings decision making closer to the field-level providers of health care and it is also suggested that breaking down the large monolithic decision-making structures that are typical of centralized health system increase efficiency of service provision (Green, 1999). Fiscal decentralization brings expenditure and budgeting decision-making closer to the communities, and therefore has potential to increase the responsiveness of the public sector to differential needs of local jurisdiction (De Mello, 2000) and reduces information and transaction costs associated with provision of public goods and services (World Bank, 1997).

South Africa has set the processes of laying emphasis on primary health care through her 1996 constitution which led to fiscal federal system and implementation of health policies spread across three levels of government: national, provinces and local municipality levels (National treasury, government of South Africa, 1999). In practice, national governments role in the area of joint responsibility with the provinces is primarily to determine policy, while provincial government shape some policy and have considerable role in implementation (National treasury, government of South Africa, 1999).

Like South Africa, Kenya for decades has formulated and strived to implement primary health care policies and with the devolution of healthcare in the newly promulgated constitution, PHC is expected to yield better results in reducing disease burden. The Kenyan devolution is a revenue sharing model where the national government collects revenue and share it to the counties for various development agendas by which health is one of them. It is on that basis that Kenya through its constitution has embraced the role of primary health care. As noted by KPMG (2013) through Kenya Health Policy (2012-2030), devolution of healthcare to the counties provides an enabling environment for this approach as the county governments are responsible for the provision of primary care. Bringing primary care services closer to the people allows for ownership and participation (KPMG, 2013).

Baringo County is one of the rural counties in Kenya that has some of these characteristics that reveal low levels of health care. A review by ministry of health conducted in 2014 ranked Baringo County number 38 out of 47 counties in County sanitation benchmarking. The same study notes that through these indicators, Baringo loses Ksh. 538m each year due to poor sanitation. This includes losses due to access time, premature deaths, health care costs and productivity. Funding for Health in Baringo County is still marginal. According to MoH 2014/2015 National and County Health Budget Analysis Report published in 2015, Baringo allocates 22% of the total budget to health that gives majority for funding on recurrent expenditure at the expense of development expenditure which further compromises the provision of primary health care.

1.3 Statement of the Problem

There are several global policies that have been formulated globally, regionally or at the local level such as primary health care declared at the Alma-Atta, Millennium Development Goals among others. In 2010 report, the WHO noted that overall progress towards meeting these Millennium Development Goals (MDGs) in Africa had been less than impressive. A 2010 review of the health situation in Kenya performed by the Ministry of Medical Services and the Ministry of Public Health and Sanitation reveals that improvements in health status have been marginal in the past few decades and certain indicators have worsened (G.o.K, 2010). The persistence of these health care problems prompted the researcher to interrogate factors that would be responsible for their persistence by focusing on how public health and other related policies are implemented. The research assesses their implementation to bring the desired change at the national and local level. Under the current health care reforms, public health policies require among other things participation of the stakeholders in the implementation process for sustainability and ownership. This raises the question as to what extend are stakeholders in Baringo County get involved in the implementation processes? Success for public health policies also depends on the amount of funds available to operationalize policies. Therefore, to what extend is funding for health care policies responsible for success or failure in their implementation in Baringo County? In a bid to unravel the mystery of never ending challenges of public health through policy implementation, this study sought to identify the existence of public health policies in Baringo County, assess the role and level of stakeholder's participation, nature of funding for public health policies

and finally other challenges that hinder implementation.

1.4 Overall objective

To assess the implementation of public health policies in Baringo County, Kenya.

1.4.1 Specific objectives

i. To identify public health policies in Kenya.
ii. To establish the role of various stakeholders in the implementation of public health policies in Baringo County.
iii. To assess the financing of public health policies in Baringo County.
iv. To establish challenges that affects the implementation of public health policies in Baringo County.

1.5 Research questions

i. What public health policies exist in Kenya?
ii. What role do various stakeholders play in the implementation of public health policies in Baringo County?
iii. How are public health policies financed in Baringo County?
iv. What challenges face the implementation of public health policies in Baringo County?

1.6 Justification of the study

The study intended to provide new literature on the approaches to the implementation of public health policies across the globe, Africa and Kenya in particular especially at this current dispensation where health policies have been devolved to Kenya's forty seven county governments.

This study yielded data that is going to provide information on appropriate techniques of public health implementation to policymakers and planners for health since health is critical for development as notes by Schultz, (1993) human health has a major role to play in economic development. There is a direct link between the health of a population and its productivity, and this relationship has been demonstrated in industrial countries, which are now benefiting from years of investment in health services (Schultz, 1993). The findings from the study shall augment the role played by health professional, communities and other consumers of public policy thus improving the service health care. In addition, the findings and recommendations emanating from this research shall foster cooperation of various stakeholders in the fight of public health challenge.

Finally, the findings from the study are useful to scholars of policy and other academicians on issues of policy implementation, devolution and healthcare financing. The research reviewed comparative analysis of public health implementation that provides fodder for scholars in the field of policy.

1.7 Scope and delimitation of the study

The study was conducted in Baringo County in Kenya reviewing the implementation of public health policies formulated and implemented between the periods 2003 to 2015. This was the period when governments had come up with a lot of public health policies and other policies related to health care. Baringo County was chosen has an area of study based on poor health and sanitation indicators published by ministry of health in the year 2014 that ranked Baringo County number 38 out of 47. The survey revealed that Baringo loses Ksh. 538m each year due to poor sanitation. This includes losses due to access time, premature deaths, health care costs and productivity. In addition, the area has diverse population owing to its socio-economic, historical cultural and political diversity necessary for such a kind of study as discussed later in area of study and the nature of Baringo population in Chapter three. The diversity of the population and health needs was acknowledged by a GIS study conducted in Baringo County by B. M Mwasii, (2010), who concluded that health service needs and barriers to health service access vary widely within and across geographic areas. According to Mwasii (2010) area specific analysis of needs and barriers can produce useful data for informing policy on improving accessibility to health service.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter reviews literature on various policy approaches to the implementation of public health policies, the role of various stakeholders in the public health policies both locally and internationally. In addition, the financing of health care is paramount in understanding health issues of various populations especially the concepts of equity, decentralization and human rights that accompany health of the population. Finally the chapter reviews the challenges that bedevil the implementation of public health policies.

2.2 Global Public Health Policies

For a better understanding of policy implementation, it is important to shed light on how public health policies emanate and how they are broken down for implementation as programs and projects for effective implementation. Public health policies are expressed in policy documents that include laws, national and local policies and plans, operational policies, and resource allocation plans (Cross, *et al.,* 2001). International organizations such as UN agencies also produce policy documents that offer guidance to governments and NGOs on health issues. Some policies derive from statements of heads of state or ministers without being formally written down as formal government orders or regulations. In some countries, unwritten procedures and even traditional norms and practices are also considered policies (Hardee *et al*, 2004). Policies are often broad statements of intention and, as such, require supplemental implementation documents, including strategic plans, implementation plans, and operational policies to ensure that the policies are carried out (Walt and Gilson, 1994). Programs are put in place to

implement policies. This component of the Policy Circle includes the organizational structure (including the lead implementing agency or body), resources that support program implementation, and activities required to implement the policy through programs. It also includes monitoring and evaluation of performance to assess if goals of the policies and implementation plans have been met (Hardee *et al*, 2004). From this literature, it is evident that broad objectives and intentions of policies require proper interpretation for implementation as they can never be implemented in their broad form. The formulated polices are broad which make them prone to misinterpretations, delay in the implementation and poor coordination of public health policies.

This study further reviews literature on what constitute health and the reason why health is important for human existence and development. Health is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity (W.H.O, 1978). According to this definition, Health is characterized as a fundamental human right and attaining the highest possible level of health as an important world-wide social goal. Furthermore the Declaration recognizes that realizing this goal requires the action of many other social and economic sectors in addition to the health sector (W.H.O, 1978). Donald (1988) provided the most widely quoted definition of public health in a report to the United Kingdom government. He saw public health as the science and art of promoting health, preventing disease and prolonging life through the organized efforts of society. In his definition, he notes that, public health is about keeping people well, rather than treating their diseases, disorders and disabilities after they have emerged, he emphasized promoting health, preventing disease and prolonging life and finally public health that focuses on populations, not individuals (W.H.O, 1978).

Globally, the public health policy has evolved through several stages engendered by global institutions. However, milestone in global public health was the creation of Primary Health Care (PHC). World Health Organization (W.H.O, 2000) provides a description of what primary Health Care should mean for each health system. This is based on the definition proposed at the 1978 International Conference on PHC in Alma-Ata, where most countries subscribed to the PHC approach to the health service delivery (Okorafor, 2010:10). The PHC approach to health service was promoted at the time as a result of combination of factors experienced in many health systems, albeit to different degrees. In the late 1960s many health systems were experiencing high cost in providing health service (W.H.O, 2000). This was largely because the health systems were hospital based, and a large proportion of condition treated in hospitals could have been managed by ambulatory care (W.H.O, 2000). Also, the hospital-based model used in most countries at the time resulted in the location of health facilities in more urban centers, leaving the majority of the poor and rural dwellers without access to healthcare. These pressures necessitated a radical change in health system to make them more cost-effective, equitable and accessible to the population they serve (W.H.O, 2000). The PHC approach was to provide promotive, preventive, curative and rehabilitative health services (W.H.O, 1978). In the late 1970s, PHC was seen as the key strategy for achieving 'health for all' by the year 2000. While the PHC approach has had mixed results over the past three decades, recent international advocacy has been initiated for the revitalization of the PHC as a central feature of health system (Kekki, 2003). The importance of PHC as a health policy it has been given impetus by scholars of health policy for instance; Bengoa *et tal* (2003) state that PHC is critical for the promotion of good health in any country,

and that a well functioning and organized PHC system is important for the achievement of Millennium Development Goals (MDGs). Indeed it has been argued that the PHC approach is the appropriate approach to achieving the two fundamental goals of health system: the optimization of health of the population; and the minimization of health disparities across population groups (Starfield, 1992). Despite the promulgation of PHC policy, the literature is replete on challenges that plagued it implementation in developing countries. For effective implementation of public health, policy makers need to relook the role played by this approach in developing countries in realization of adequate health care for everybody.

Other policies have been formulated to augment the PHC in the recent past. The Ottawa Charter (1986) defines health promotion as the process of enabling people to increase control over and improve their health. To achieve this, the basic pre-requisites individuals and groups require are: peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity (The Ottawa Charter, 1986).The implementation of the Ottawa Charter suffered unprecedented failures that it prompted World Health Organization to call another conferences to strengthen the charter.

The most recent international landmark publication on action to improve public health is the 2008 report of the WHO Commission on Social Determinants of Health. The report is entitled "closing the gap in a generation: health equity through action on the social determinants of health." (W.H.O, 2008). The Commission found that social injustice is killing people on a grand scale. They concluded that the poor health of the poor, the social gradient of health within countries, and the marked health inequities between countries are caused by:

a) the unequal distribution of power, income, goods and services, globally and nationally
b) the consequent unfairness in their access to health care, schools and education, their conditions of work and leisure, their homes, communities, towns, or cities - that significantly diminish the chances of the poor and ill leading a flourishing life.

The Commission concluded that this unequal experience of health-damaging experiences is not in any sense a “natural “phenomenon, but the result of a toxic combination of poor social policies and program, unfair economic arrangements, and bad politics (W.H.O, 2008).The work of the Commission On Social Determinants of Health (2007) draws attention to the influence of broader societal conditions on health status, and how PHC can play a central in achieving a more equitable distribution of population health. In its interim statement, the commission states that ‘the condition in which people grow, live, work, and age have a powerful influence on health….inequalities in these conditions lead to inequalities in health.’ (W.H.O, 2008*).* These differences in conditions are usually defined along socioeconomic axes, and those of lower socioeconomic status generally suffer a greater burden of ill-health. According to this view, PHC can address the broader social determinants of health through universal access to healthcare, empowering the vulnerable groups and through social cohesion (Maeseneer *et al,* 2007).

It is imperative that global public health policies have hugely been formulated yet their implementation is marred with a lot of controversies, challenges and rhetoric. From the promulgation of PHC at the Alma Ata (1978) to the Commission On Social Determinants of Health (2008), a lot were expected in the improvement of global health system yet

indicators reveal stagnation in the improvement of global health and the growing disparities in the provision of health. It is therefore important to relook and re-evaluate the implementation of these policies for better improvement of global health.

2.3 Public Health Policies in Africa

Regional institutions have never been left behind in combating public health challenges through a legislative framework. In Africa, several policies have been formulated by both public and private agencies and other development partners in a bid to address challenges of deteriorating public health conditions in the continent. According to W.H.O (2010) the weakness of national health systems in the Region has been a matter of concern for decades. Despite ongoing efforts to improve health systems performance, some issues related to governance, health financing, human resources for health, health technologies, information systems and service delivery are yet to be addressed. However, several regional policies have been formulated by the continent but they are yet to address the challenge of disease burden in Africa. In 1987, the World Health Organization together with UNICEF embarked on a serious advocacy programs to address health challenges due to poor economic crisis resulting from Structural Adjustment Programes (SAPs) in Africa. The outcome of the conference was duped Bamako initiative (W.HO, 1987). Other several regional commitments towards health development, including the *Abuja Declaration* of 2001 related to allocation of 15% of the public budget to the health sector; the 2006 Abuja African Union Heads of State call for *Universal Access to HIV/AIDS, Tuberculosis and Malaria Services by 2010*; the call for *Malaria Elimination;* and the *Nairobi Call to Action on Closing the Implementation Gap in Health Promotion* (2009). Furthermore, in November 2006, at the International Conference on Community Health,

Member States made a commitment to ensure universal access to quality health care and a healthier future for the African people (W.H.O, 2010:7). The *Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving Better Health for Africa in the New Millennium*, which was endorsed by the Regional Committee for Africa in 2008, was another milestone. The *Algiers Declaration on Research for Health in the African Region: Narrowing the Knowledge Gap to Improve Africa's Health* and the *Libreville Declaration on Health and Environment*, as well as many Regional Committee resolutions in 2008, set the policy framework for action in all these areas (W.H.O, 2010).

There are a lot of policies formulated regionally to combat regional public health problems yet there is scanty literature on their implementation, and evaluation. Ideally, member state governments are expected to adopt these policies and incorporate to their national laws and policy frameworks for implementation thus making states to have a varied adoption and implementation of these policies. For instance, Primary Health Care was espoused in 1978 but it was not until 1986 that Kenya formally recognized in the national laws and policies. Scholars of policies have not done enough study to establish experiences and lessons learned to guide future implementation and reflection. Routine formulation of polices that do not translate in to action creates liturgy and reinforces persistence of these challenges in the societies.

2.4 Public Health Policies in Kenya

In Kenya, health has been noted as fundamental sector for development through the improvement of human life and reduction of ill health and consequences that accompany the condition. As noted by (Mwabu, *et al*, 2004), a sound healthcare delivery system, good nutritional status, food security and absence of epidemic diseases are the conditions that produce healthy people capable of participating in a country's economic, social and political development. For many years, Kenya's health policy has been based on the country's landmark post-colonial nation-building and socio-economic development blueprint, the Sessional Paper No. 10 on African Socialism and its Application to Kenya of 1965, which emphasized the elimination of disease, poverty, and illiteracy (Wamae, 2009). To oversee heath care delivery and health reform at the district level, District Health Management Teams (DHMTs) and District Health Management Boards (DHMBs) were created in 1992, through a legal notice No.162 of the Public Health Act (Cap.242). The notice reiterated government commitments towards the transfer of resource generation, allocation and management responsibility away from central command (Mwabu and Kibua, 2008:266). The aim was to empower was to empower the DHMBs to represent interests in the implementation of health sector activities (ibid).however, the establishment of DHMTs and DHMBs was never a panacea to the challenges that hindered the implementation of health care in Kenya. According to Mwabu and Kibua (2008) the capacity of DHMB/T has been adversely affected by the degree of autonomy accorded by MOH. Other factors inhibiting the service delivery capacity of DHMBs and DHMTs include lack of capacity in planning and supervision mechanism, selection of competent DHMB/Ts members, external influence, weak

incentive systems, inadequate budgetary support, rigid government regulations and lack of clarity of roles and responsibilities of the district institutions.

Since 1994, the health sector development agenda has been guided by the Kenya Health Policy Framework Paper (KHPFP-1994-2010) up to 2010 (G.O.K, 1999). KHPFP (1994-2010) explicitly states the underlying vision for health development and reform to provide *quality health care that is acceptable, affordable and accessible to all* (ibid).The policy was to be implemented through National Health Sector Strategic Plan I (1999-2004) and National Health Sector Strategic Plan II (2005-2010) and the Community Health Strategy (2006). According to Transparency International report of 2011, the health sector operates in the context of a number of policy frameworks and within a policy environment that is subject to both internal and external influences (T.I report, 2011). Kenya's Poverty Reduction on Strategy Paper (PRSP), the public reform program under the office of the President, the Economic Recovery Strategy (ERS), the Public Expenditure Review (PER), the Global Fund, the Millennium Development Goals (MDGs), Kenya Vision 2030 Sector Plan For Health and other global initiatives comprise the major external influences on the Kenyan health sector system (ibid). The Kenya Health Policy Framework of 1994, the NHSSP II 2005-2010 and the Community Health Strategy and factors within the institutional and organizational context shape the internal environment. Similarly, there are other strategies and interventions that are formulated at the sectoral level to effect the implementation of these policies (T.I report, 2011).

Currently, the formulation of The Kenya Health Policy, 2012 – 2030 marks a radical change in the public health policy arena. This Policy is designed to be comprehensive, balanced and coherent and focuses on the two key obligations of health: contribution to

economic development as envisioned in the Vision 2030; and realization of fundamental human rights as enshrined in the Constitution of Kenya 2010. It focuses on ensuring equity, people centeredness and participatory approach, efficiency, multisectoral approach and social accountability in delivery of health care services (K.H.P.F, 2012-2030).The policy is to be implemented through a medium term strategic plan National Health Sector Strategic Plan III (2012-2017) which its main objective is "to deliberately build progressive, responsive and sustainable technologically-driven, evidence-based and client-centered health system for accelerated attainment of highest standard of health to all Kenyans" (NHSSP III,2012-2017).

2.5 Health Sector Reforms in Kenya

Healthcare policy reforms have been adopted as a strategy of supplementing government budget to revitalize healthcare delivery systems. The most notable health reforms the government has adopted include cost sharing and decentralization (Mwabu, *et al*, 2004)

2.5.1 Cost Sharing

This was a health policy introduced as a measure to cushion health sector owing to the consequences of Structural Adjustment programs. Many governments have been forced to cut down on public expenditure, abolishing free and subsidized healthcare in favor of market-oriented health services backed by cost sharing and user fees (W.H.O, 2001). According to the Health Management Information System (G.oK, 2001), the guiding principles of the cost sharing program are:

i. All revenue collected is retained at the local level. Seventy five (75) percent of the revenue was to be allocated to the health facility which collects the funds and 25

percent for preventive/promotive activities (PHC) in the district in which the funds are collected.

ii. Local planning for the use of the funds.

iii. Revenue is additive and "not fixed year". Treasury will not reduce Ministry of Health allocation because of cost sharing revenue, and unspent funds can be carried forward to the next fiscal year.

iv. Inpatients and outpatient fees would be higher at hospitals, lower at health centers, and almost non-existent at dispensaries to encourage the first use of lower level facilities (some dispensaries, have, however, opted for locally arranged revenue generation alternative ex-user charges in order to cater for such services as night security, among others).

v. Vigorous pursuit of National Hospital Insurance Fund (NHIF) reimbursement for inpatients.

vi. Exemptions and waivers would be used to ensure access to the poor and to protect the medically vulnerable.

Several challenges plagued the policy of cost sharing. According to USAID (1995), user fees in sub-Saharan Africa have contributed a small percentage, less than 5 percent, of operating revenues for publicly-provided services. This could be attributed to:

i. Setting prices at low levels relative to service costs, especially in hospitals where government recurrent resources are concentrated.

ii. The poor quality of services and the low-incomes of most of the population, which limits the willingness to pay for government health services

iii. Many users who are able to pay but avoid paying because public user fee schemes are poorly administered and exemptions that exist for non indigent persons.

Although cost sharing was introduced in Kenya, the program has not solved the problem of accessing affordable, effective and convenient health care to Kenyan people. As noted by Mwabu, *et al* (2004), More than a decade after its implementation, the cost sharing program has not fully addressed the problems of the vulnerable and has not promoted access to modern healthcare. Implementation problems and institutional weaknesses mar the program and there has not been corresponding improvement in the quality of healthcare.

2.5.2 Decentralization

Decentralization refers to the transfer of authority in public planning management and decision making from higher levels of government to lower levels. (Mills, 1990). Four forms of decentralizations can be identified:

i. De-concentration: shift in administrative responsibility from the center to lower levels of the system that does not involve the shift of any political power.
ii. Devolution: substantial shift in political responsibilities, often including tax-raising authority.
iii. Delegation: relocation of a specific function to a quasi-autonomous organization.
iv. Privatization: shift of specific functions away from the government. Some authors do not consider this a form of decentralization (Jowett, 2000).

Fiscal federalism is the devolution of expenditure responsibilities to the sub-national levels of government (De Mello, 2000). In modern federal structures, different levels of

government have varied and wide interaction between them (Cameron, 1999; Openski, 1999). Such interactions are shaped by the functions allocated to the levels of government. However, the form of decentralization, the nature of intergovernmental relations and the context of responsibilities shifted to the lower levels of government by any country is a reflection of its particular context (Cameron, 1999; Openski, 1999). There is some consensus that there is no 'best practice' with regards to the structure of intergovernmental relations (Feld et al., 2007). Bahl and Linn (1999) argue that theory cannot lead to firm conclusion about the optimal division of fiscal responsibilities between national, state and local governments. With regard to developing countries, Bahl and Linn (1999) provide arguments for fiscal centralization and decentralization. According to them, fiscal centralization may be the better option for developing countries. The reasons for this view are listed below:

- Growth policy: investment capital is scarce and must be controlled by the central government in order to maximize profit.
- Income distribution: centralization allows the national government more discretion in dealing with regional differences, for example rural-urban disparities in income and wealth.
- National governments have superior abilities in administering taxes and the management of public service delivery. With characteristic weak administration at local government levels, less local autonomy means that there is less possibility for mismanagement of finances by local governments.

They add that arguments such as those listed below can also be made in favor of decentralization:

- Local governments can adjust budgets in response to local preference, resulting in a more efficient distribution of public resource.
- Local government may be able to tax some sectors of the urban economy more easily than the national government.
- Cities would levy higher taxes and could thereby charge residents the full marginal cost of urbanization. Based on this, a more efficient size distribution of cities could result.

Bahl and Linn (1999) however raise concerns about the applicability of argument in favor of decentralization in developing countries. Theories of fiscal decentralization were developed in industrialized countries, where voter preferences are translated into budget outcome, and local councils are elected, not appointed. Local preference in these countries drive local government fiscal operations and this is not necessarily the case in many developing countries.

Empirical work by Ugo panizza (1999) using data from more than 60 countries, revealed there is greater decentralization in geographical large countries, rich countries, countries with many ethnic groups, and countries with high level of democracy. Oates (1972) argues that decentralization is appropriate in cases where there is heterogeneity in taste for public service between sub-federal jurisdictions, and that in absence of economies of scale and inter-jurisdiction externalities, decentralization is preferable.

In an attempt to improve efficiency and effectiveness in the delivery of health care services in Kenya and against the limitation of a centralized health care system, the ministry of health (MOH) adopted decentralization as the key strategy, with the districts

being the focal point with regard to health care delivery. Various policy documents including the Kenya Health Policy Framework paper of 1994 and the National Health Sector Strategic Plan of 1994-2004, have highlighted the ministry of health commitment to the implementation of decentralized strategy (Mwabu and Kibua, 2008). The new constitution of Kenya, 2010 ushered in the “second Republic”, the manifestation of the people’s desire for change, government accountability, and democracy. At the heart of this change is the concept of devolution of political and economic power to 47 newly-created counties (KPMG, 2013). Article (174) of the constitution stipulates the objectives of devolution as : promoting democracy and accountable use of power, fostering unity amidst diversity, enabling self governance of the people towards interrogation of the state, recognizing the rights of communities to self management and development, protecting and promoting the rights of minorities and marginalized groups, promoting socio-economic development, ensuring equitable sharing of national and local resources, rationalizing further decentralization of state organs and finally enhancing checks and balances.

In the devolved system, healthcare governance occurs at two levels: national and county. At the national level, the Ministry of Health (MoH) is responsible for providing stewardship and guidance. At the county level, county departments of health are responsible for coordinating and managing the delivery of health services (Kenya Health Policy 2012 – 2030.). The counties are responsible for three levels of care: community health services, primary care services and county referral services. The national government has responsibility for national referral services (Constitution of Kenya, 2010). The two levels of government are distinct and interdependent and will conduct

business on the basis of “consultation and cooperation” (The Constitution of Kenya, 2010, Chapter 2, Article 6(2)). This shift is projected to improve governance in the public health sector in Kenya. Community participation has been a mainstay of Kenya’s healthcare system since the implementation of the Community Health Strategy (M.o.H, 2006). The strategy is defined as, “the mechanism through which households and communities take an active role in health and health-related issues” and its objectives are: community empowerment, to bring healthcare closer to the people, the establishment of community health units and the enhancement of community-health facility linkages. This aspect of community participation has been carried on to the devolved system (M.o.H, 2006).

In the devolved government, the Kenya Health Policy 2012 – 2030 provides guidance to the health sector in terms of identifying and outlining the requisite activities in achieving the government’s health goals (KPMG, 2013). According to the Kenya Health Policy Frame work (2012-2030), in the devolved system, healthcare is organized in a four-tiered system:

Community health services: This level is comprised of all community-based demand creation activities, that is, the identification of cases that need to be managed at higher levels of care, as defined by the health sector.

Primary care services: This level is comprised of all dispensaries, health centers and maternity homes for both public and private providers.

County referral services: These are hospitals operating in, and managed by a given county and are comprised of the former level four and district hospitals in the county and include public and private facilities.

National referral services: This level is comprised of facilities that provide highly specialized services and includes all tertiary referral facilities.

Decentralization of health services in Kenya has not been successful in the past. In most cases these decentralized polices are subject to abuse, neglect and sabotages by national government. Examples of such decentralized strategies are cost sharing strategy, establishment of DHMTs/DHMBs, the implementation of community health strategy among others. For Successful implementation of devolved health care, policy makers and the Kenyan citizens must learn from challenges that hindered these past strategies

2.6 The Role of Various Stakeholders in the Implementation of Public Health Policies

It is vital to understand the people or stakeholders who participate in the process of policymaking, the places inside and outside the government that they represent in policymaking, their views on the "problem," and the various roles they play in policymaking (Hardee *et al*, 2004). According to Brinkerhoff and Crosby (2002) a stakeholder is an individual or group that makes a difference or that can affect or be affected by the achievement of the organization's objectives. From this definition, emanate two types of stakeholders: people (individual stakeholder) and places (institutional stakeholders).

2.6.1 Individual Stakeholders

Public sector individual stakeholders can include: politicians (heads of state and legislators), government bureaucrats and technocrats from various sectors (health, education, finance, and local government) and public sector staff who implement programs. Stakeholders from the nongovernmental sector can include representatives from civil society organizations, support groups such as groups of people living with HIV/AIDS, women's health advocacy groups, or networks of these groups, or from faith-based organizations among others. They can be researchers and others such as media personalities. Individual beneficiaries of policy can also be involved in calling for policy change (Hardee *et al*, 2004).

2.6.2 Institutional Stakeholders

It is important to know the roles and responsibilities of the various institutions. Various parts of the government clearly play key roles in formal policymaking, including the executive branch (the head of state and the ministerial or departmental agencies of government), the legislative branch (the Parliament, congress or equivalent), and the judiciary branch. Local governments have their own policymaking structures, if they have decentralized authority to do so. The strength of institutions involved in policymaking can have a direct impact on the success of the policies and programs (Hardee, *et al* 2004).

Institutions outside the government play a role in policymaking by acting as advocates for policy change (civil society groups, grassroots organizations, NGOs, and advocacy groups), by providing data for decision making (academic and research organizations),

and by providing funding (donor organizations)for policy research, policy dialogue and formulation, and implementation. Finally, international organizations also play a role in supporting—and influencing—policymaking (Hardee *et al*, 2004). Previous implementers of health policies have also acknowledged the role this civil society play in combating public health challenge. Cooke (2009) supports their role that Africa is-and for foreseeable future remains and enduring target of a global public health policies and interventions. HIV/AIDS has generated new institutions-UNAIDS and Global Fund to fight AIDS, T.B and Malaria, for example mobilized new constituencies including, religious, private foundations and corporations; and elevated the profile of Africa and that of public health among foreign public health experts, development specialists, universities and students group and nongovernmental organizations.

In Kenya, several stakeholders operate in ensuring adequate provision of public health services. Kenya Health Policy (2012-2030) and its implementing National Health Sector Strategic Plan III, (2012-2017), provides roles and responsibilities of various stakeholders both at national and county level (NHSSP III,2012-2017).These include the following:

i. The clients/consumers

This category shall consist of the individuals, households and communities. These represent the core reason for the existence, and activities of the sector. For attainment of the health goals, the Individuals are expected to exercise the appropriate healthy and health care seeking behavior required to maintain their health. Households are expected to take responsibility for their own health and well being, and participate actively in the management of their local health services. Finally, the communities are expected to exhibit real ownership and commitment to maximizing their health. Communities should

define their priorities, with the rest of the health system seen as supportive (G.o.K, 2012). According to Amartya Sen, freedom of people to participate socially and politically in shaping their lives and what they value is central to human and economic development (Sen, 1999). Sen offers many examples of how people having ‘‘agency’’ (the ability to act and bring about change), coupled with access to basic education and health services, can lift themselves out of poverty and transform societies (Sen, 1999).

ii. State actors

State actors are varied, but connected in that they all draw their mandates from the State. They include: The National Ministry responsible for Health, The County department responsible for health, Semi Autonomous Government Agencies Legal and Regulatory bodies primarily relating to health (G.o.K, 2012).

a) National Ministry responsible for Health

Its roles as stipulated by the forth schedule of the constitution of Kenya and the NHSSP III include:

- Establishing a National Health Policy and Legislation, Standard Setting, National reporting, supervision, sector coordination and resource mobilization
- Offering technical support with emphasis on planning, development and monitoring of Health services and delivery standards throughout the country.

- Monitor quality and standards of performance of the County Governments and community organizations in the provision of Health services.
- Provide guidelines on tariffs chargeable for the provisions of Health services.
- Provide National health referral services.
- Conduct studies required for administrative or management purposes.

b) County departments responsible for health

The Constitution has assigned the larger portion of delivery of health services to the Counties with exception of National Referral Services. Its overall roles and responsibilities shall be:

- Delivering County Health services
- Licensing and accrediting Non State Health Service Providers (HSPs).
- Financing of County level Health services
- Maintain, enhance and regulate (Asset development) and HSPs (operations).
- Approve County Special Partnership Agreements (SPAs) for County HSPs.
- In collaboration with national Government, gazette regulations for community managed health supplies to be implemented at county level
- Planning, investment and asset ownership function of Public Health Facilities.

- Develop an investment plan to enable fulfillment of the highest attainable right to health and document annually progress on fulfillment as required by the Constitution.
- Asset financing and ownership.
- Channel public and other funds to develop health facilities.
- Collect and aggregate information at County level on implementation of projects in order to document value for money and progress of the rights.
- Provide a legal framework for on-lending arrangements to facilitate loan repayments and fees for use of assets by licensed HSPs.

c) Regulatory bodies (Boards and Councils) and professional bodies/associations

The regulatory bodies (for example the Pharmacy and Poison Board and the Medical Practitioners and Dentists Board) are semi-independent institutions that operate under an Act of Parliament. These bodies perform important service related regulatory functions on behalf of the Ministry of Health: the definition of professional standards; the establishment of codes of conduct; and the licensing of facilities, training institutions and professional workers.

Various professional associations represent the interests of specific professional groups, including doctors, dentists, nurses, physiotherapists and others. They are independent and are mainly involved in welfare related activities for their members.

iii. Non State Implementing partners

Implementing partners in health have played a significant role in social development in Kenya specifically making significant contribution in making available health services to the community. The implementing partners have also been a critical source of much needed human and monetary resources that will be needed to implement this strategy.

a) The Private Sector (for-Profit and Not-for-Profit)

In the past years, collaboration between MOH and the private sector has been irregular and not fully productive. The KHSSP 2012-2017 has recognized the need to improve collaboration in order to:

- Facilitate regular consultative meetings between MOH and private providers.
- Facilitate acquisition of GOK owned land by private providers to develop health facilities in under-served areas as a step to improve equity.
- Rent out under-utilized facilities to private providers, on the condition that they cushion vulnerable groups from the high cost of health care.
- Facilitate waivers of taxes/duty on drugs and medical supplies.

b) Traditional Practitioners and Traditional Medicine

The general health law and legislation will ensure quality assurance and standardization, capacity building, protection of intellectual property rights, and the halting of loss of biodiversity. It also recommended the development of a national policy on traditional medicine and the exploration of possibilities of initiating commercial production of traditional plants for medical use.

iv. External Actors

Development partners constitute a rather heterogeneous group with a variety of objectives, interventions, technical and reporting requirements, and funding modalities. Some intend to support the SWAp and participate in funding, whereas others prefer to continue their "off-budget" support for programs in specific areas or targeted to special population groups. In general, coordination between MoH and the development partners is improving because of the established health sector coordination framework. MoH intends to strengthen that framework and would like to harmonize the different modes of cooperation with its development partners International initiatives, including the March 2005 Paris Declaration14 by the Development Assistance Committee (DAC) of the Organization for Economic Cooperation and Development (OECD) provide an important foundation for doing. This role has been structured around principles of aid effectiveness, which places emphasis on government ownership, alignment, harmonization, mutual accountability and managing for results on programs in the health sector the implementation of this strategy will require the continued support of development health partners from an increasingly strategic and coherent perspective given the devolved government system. The greatest donor funders on health in the year 2011/2012 were USG and USAID (World Bank, 2012).

2.7 Healthcare Financing

Financing of health is important in the provision of health care. Costs always determine access of health care service as in many case limit those endowed with little resources do not seek health care for fear of escalating cost. According to W.H.O, (2010) health financing is a determinant in ensuring that individual secures a better health and that

millions of poor and marginalized people face ill health daily and live in fear of catastrophic healthcare costs, which push more than 100 million people into poverty every year Health funding includes expenditure related to**:** Health systems; Specific medical interventions, interventions outside the health system that is specifically focused on health outcomes e.g. disease prevention; mitigation of health impacts (W.H.O, 2010). However funding for health in Africa has not been adequate. According to Economic Intelligence unit report, 2011, the financing of healthcare in Africa remains a patchwork of meager public spending, heavy reliance on foreign donors and a large dependence on out-of-pocket contributions and user fees that place the greatest burden on the poorest members of society. Direct payment at point of use is the least-optimal way of financing healthcare, as in poor countries in particular, dramatic and expensive ailments can push the poor into bankruptcy, or else high costs can dissuade people from seeking desperately needed medical care (Intelligence unit report, 2011).

Paying at the point of service is ultimately expensive and the creation of health insurance has not been effective in developing countries where many citizens are not covered by health insurance. KPMG (2012) acknowledges that at the moment the governments which are successfully addressing their populations' medical needs are combining direct expenditure with other financing models. In some, government chooses to finance the administrative side of healthcare, leaving specific projects relating to the control of epidemic diseases to external donors, and more and more medical services to the private sector. Therefore, according to KPMG (2012) the future of healthcare in Africa lies in health insurance and private medical companies, although government and external funding will be important for the foreseeable future. For an unchanged level of

government and external funding, improving Africa's healthcare expenditure profile will thus mean shifting private expenditure from direct payment to prepaid and pooled expenditure.

In Kenya**,** Primary funding for healthcare comes from three sources: public, private (consumers) and donors. Consumers are the largest contributors, representing approximately 35.9 percent, followed by the government of Kenya and donors at 30 percent each (G.o.K, 2011). Over the past few years, government financing as a percentage of GDP has been consistent at slightly above four percent (KPMG, 2013). Not only is Kenya spending a relatively low amount as a percentage of GDP on healthcare, but the allocation of funds to public facilities has been uneven (ibid). According to a 2011 *Healthy Action* report, secondary and tertiary facilities has historically been allocated 70 percent of the health budget. The same report notes that allocation of funds to primary care facilities has been "poor" − this despite the significant role these facilities play as the first point of contact in the provision of healthcare services. The hope of generating more resources through the National Hospital Insurance Fund (NHIF) is limited and uncertain due to weak administrative systems, poor investment portfolio, and low claims settlement, which have characterized the Fund (Mwabu, *et al*, 2004). While the NHIF opened membership to informal workers in 1998 and to persons aged over 65 in 2006, expanding coverage to everyone and to outpatient services should be pursued. Plans to expand and transform the NHIF into a social health insurance system in 2004 were never realized due to political handicaps (Wamae, 2009).

The devolution of health care to county governments let to the decentralization of roles and funding to the lower levels of governments. The essence of this fiscal

decentralization was to ensure that the governance of health moves away from the failure of past approaches that decentralized functions but denied resources necessary for implementation thus curtailing the success of health policies at the lower levels. In the devolved system, healthcare governance occurs at two levels: national and county. A glance at the county governments funding indicates a form equity that is likely to impact positively to health sector. As per the constitution of Kenya 2010, funding for county level functions is primarily from the national government. The four financing sources (three national governments and one county government) are: Generation of own revenues by the counties from, e.g., property taxes, business licenses, entertainment taxes, Equitable share with the counties assured of receiving no less than 15 percent of national revenue, Equalization fund set aside for marginalized communities and represents an additional 0.5 percent of national revenue and Conditional and unconditional grants from the national government. As outlined in the Constitution of Kenya, recruitment and hiring of staff for devolved functions are the counties' responsibilities. Each county has a public service which is tasked with appointing its public servants within a framework of uniform national standards prescribed by an Act of Parliament (Constitution of Kenya, Article 235). In addition, the constitution of Kenya provides a clear bill of right especially to rights related to health. All these reforms are projected to enhance provision of primary health care.

According to the Kenya Health Sector Strategic Plan III (2012-2017), the overall goal for Health Financing efforts is to assure Universal access of the population to the defined KEPH. This is to be attained through a focus on objectives, relating to resource adequacy, efficiency, and equity. To achieve these objectives, the sector needs to put in place

adequate means to assure effectiveness in functions of resource generation, risk / resource pooling, and purchasing of services (G.o.K, 2012). The Health Financing overall goal is on assuring Universal access to the KEPH. This aims to attain through a focus on three areas: increasing population covered, increasing services covered, and reducing direct payments for health care (G.o.K, 2012).

2.8 Challenges in the Implementation of Public Health Policies

There are challenges that have hindered implementation of public health policies globally, regionally and nationally. Persistence of these challenges is what has made scholars of policy to investigate the factors that keep holding them despite immense attention focused to eliminate them. Inequalities in provision of health care remain a challenge to policy experts. Disparities exist between developed and developing, regions in the same continent and varied health provision among different geographic parts in the same country. According to KPMG (2012:8) global public health such inequalities prevail owing to different geographic, historic, cultural and socio-economic differences among states, communities and even individual Salient feature of inequalities in the global health system is the rules of World Trade Organization in implementing legislations related to health such as patent rights which tend to undermine developing countries Global funding of public health policies is a big challenge especially to the developing countries (KPMG, 2012:). Public-sector funding for healthcare remains uneven across the continent. According to W.H.O (2011), African countries have traditionally had fewer healthcare workers per head than anywhere else in the world. Low pay and poor living conditions contribute to a continuous brain-drain of health professionals to the developed world and make it difficult to recruit and retain skilled

staff, particularly in more remote regions where the need is often greatest. World Bank (2001) argues that Poor governance in the health sector largely hinders the implementation of public health program. World Bank (2001) further reiterates that with corruption as both a cause and effect, the result has been the deterioration of general health among individuals and degradation on of the health system in developing countries Corruption drastically reduces the resources available for health, and lowers the quality, equity and effectiveness of healthcare services. It also decreases the volume and increases the cost of provision of health services. It further discourages people from the use and payment for health services and ultimately has a corrosive impact on the population's level of health (World Bank, 2001). Corruption in the health sector also has a direct negative effect on the access to and quality of healthcare (Transparency International, 2011).

Governance issues have direct impact to the implementation of policies especially in the decentralized systems of governance as witnessed in the past decentralized strategies. It is therefore important for the planner, implementers and consumers of the public health policies and programs to check these vices that are likely to undermine devolution of health care.

2.9 Challenges of Devolving Public Health Care in Africa

Devolved health care is susceptible to challenges especially in countries where such initiatives are being experimented like Kenya. It is therefore important to understand how devolved systems of health operate and challenges that are likely to suffer. In most African countries, the transfer of power and authority to the lower levels of health sector

has been motivated by the potential for increased efficiency, better quality of care and accountability (Gilson and Mills, 1995). Although decentralization can have positive influence on healthcare if it encourages the preferential allocation to remote and usually rural areas, decentralization can also have a negative influence on health care provision (Okorafor, 2010). Factors such as: inappropriate organizational and institutional arrangements such as Ghana, poor capacity at lower levels as Cote d'Ivoire and inappropriate resource allocation for PHC activities as in the case of Uganda (Dugbatey, 1999) have rendered health system unable to effectively establish a more effective and equitable distribution of health service. The problem of inappropriate resource allocation To PHC is common for most countries in sub-Saharan Africa. In appropriate financing of PHC usually arises from: resource allocation for PHC being based on existing capacity rather than need; and continued centralized control of hospital funding, protecting this portion of the national health budget at the expense of PHC (Dugbatey, 1999).

Other arguments against decentralization of health system in Africa include the following: lack of skilled staff in areas such as financial management at local level, especially in developing countries has the potential to counteract any efficiency gains from decentralization (Green, 1999). Second, where the process of decentralization is not properly handled, it could result in enhancing the power of elite groups at local levels, negating the prospects of community participation in the process of healthcare delivery (Green, 1999). Third, decentralization has the potential to increase administrative costs if it removes the economies of scale associated with centralization, and could encourage service duplication (Gilson and Mills, 1995). Perhaps the most serious argument against decentralization (and fiscal federalism) is its possible impact on the equitable distribution

of healthcare resource between local jurisdictions (Green, 1999). This potential is even greater where local authorities have revenue generating responsibilities and autonomy in spending the revenue. Differential capacity to generate and utilize resources coupled with different local preference will most likely yield different level of financing and provision of healthcare service across local jurisdictions (Okorafor and Thomas *et al,* 2007).

2.10 Public Health Challenge in Kenya

In Kenya, there are several challenges that have largely hindered implementation of public health policies. The common challenges include lack of resources, poor coordination of policies, Bad governance, poor legislation of public health policies, lack of participation and high poverty levels. These challenges are discussed below.

2.10.1 Lack of Resources

Resources to implement public health policies are meager. Provision of health services countrywide is still grossly inadequate. In addition, the health system suffers from inequitable spatial distribution of health services; shortages of health personnel; poor management of health services; inadequate funding; lack of medical supplies; low level of hospital operational efficiency; and lack of proper public health information and education (G.o.K, 1994).

2.10.2 Poor Coordination of Policies

There is poor coordination of implementation of public health policies among various implementing agencies. This leads to duplication and scramble for the scarce resources. Another example of policy working in a discordant manner is partnership with international development partners especially in the area of HIV and AIDS

(Transparency International, 2011). The same sentiments was noted by Wamai, (2009) who observed that since the publication of the NHSSP in 2005, the JPWF in 2006, the Joint Assistance Strategy (for 2007–2012) in 2007, and preparation of a government bill for joint funding in 2008 and the realization of this effort is still hampered by politics and competing interests and priorities among donors.

2.10.3 Bad Governance

There are several problems related to governance in the discharge of health services. Issues of transparency and accountability, equity and effectiveness and responsiveness and health rights are but some critical pillars of governance (Transparency International, 2011). High levels of corruption at various levels in the sector especially in the procurement of drugs and medical supplies are hindering many donors from working with the government or MoH directly (Transparency International, 2011).

2.10.4 Poor Legislation of Public Health and Other Related Policies

The legal framework of the health sector is not under a single institution but spread within a number of ministries and departments of the government. Even within the Ministry of Health itself, there are divisions, departments and specialized agencies responsible for different aspects of health regulations. These agencies have not been well coordinated in the past, often resulting into inefficiencies, and duplicity of efforts and wastage of resources (Transparency International, 2011).

2.10.5 Poor Participation in the Implementation of Public Health Policies

Many public health policies do not involve all the stakeholders for effective implementation. Public health policies require multi-sectoral approach in implementation.

Surowiecki (2004) emphasized the importance of participation by demonstrating how the combined intelligence and input of groups of people can create optimum conclusion about whatever they want to do. He states that “often crowds, like markets-or other forms of collective thoughts –are “smarter” than individuals who participated in them. The community like markets is made up of diverse people with different levels of information and intelligence, and yet when you put all those people together, they come up with intelligent decisions” (Surowiecki, 2004).

2.10.6 High Poverty Level

Poverty is multi-dimensional in its causes as well as its cures. Poverty compounds powerlessness and increases ill health, as ill-health increases poverty (M.O.H., 2006). This concurs with WHO (2001), that there is a general agreement that poverty not only increases the risk of ill-health and vulnerability of people, it also has serious implications for delivery of effective healthcare such as reduced demand for services, lack of continuity or compliance in medical treatment, and increased transmission of infectious diseases.

Several reforms in Kenya were thought would address some of these challenges yet they still persist. Cost sharing and decentralization has never galvanized the improvement of health as thought by the planner of health despite the acknowledgement of their role in healthcare system. For instance, De Mello, (2000) emphasizes that globally, public health has evolved owing to the growing forces of globalization. However, the devolution and fiscal federalism of health care has become a global trend. Moreover, challenges that are unique to the consumers of the public health policies need to be explored so that the

realization of successes through implementation can be realized. Governments should move away from the paradigm of sole implementer of public health policies thus undermining challenges that are unique to the environments these policies are implemented. The users of public health policies have a role in the policy making and implementation that need to be clearly studied for success of public health policies.

2.11 Theoretical Framework

This research was guided by New Institutionalism Theory. This theory finds its origins in a paper published by two political scientists (March and Olsen, 1984). The theory criticizes the original Institutional theory. New institutionalism recognizes that institutions operate in an open environment consisting of other institutions, called the institutional environment. Every institution is influenced by the broader environment. New Institutionalism connotes a general approach to the study of political institutions, a set of theoretical ideas and hypotheses concerning the relations between institutional characteristics and political agency, performance and change. According to March and Olsen (1984), New Institutionalism emphasizes the endogenous nature and social construction of political institutions. Government organizations are collections of structures, rules and standard operating procedures that have a partly autonomous role in political life. They generate and implement prescriptions that define how the game is played. Public institutions being one of the players may experience a large degree of autonomy and follow logics of their own, independently of outside influences or environment. These institutions then to choose historical process that happen to select organizational forms that are not always efficient.

In order to understand how policy-making really is processed and handled, New Institutionalism provides an analytic grid. Empirical observation should consider three fundamental dimensions or aspects:

1) The goals the various actors pursue

2) The way information, opportunities and support are mobilized for action taking,

3) The choice of decisions processes at work. It should identify how far in a given action set four main mechanisms may exist:

- Conflict avoidance behaviors.
- Uncertainty reduction processes.
- Problem solving as solutions seeking and finding initiators.
- Organizational learning dynamics through former experience and rules of attention allocation (Monitoring and Evaluation).

It predicts and explains how and why in a specific action context individuals and organizations try to reach some degree of understanding of the context they face. It analyzes why each of them allocates attention, or not, to a particular subject at a given time, and studies how information is collected and exploited (March and Olsen, 1984).

This theory guided this research in the sense that, various institutions in Baringo County whether formal as government institutions, private entities and Nongovernmental Organizations are independent and autonomous players in the process of public health policy implementation. In the process of implementation of Public health policies in Baringo County, Government has not always consulted these actors in the process. The

mode of implementation has been the top –down approach making those policies lack sustainability and failure in the long run. According to New Institutionalism, environment of implementation plays a major role; cooperation and consensus among various stakeholders including those that the public health policy is intended to affect must be factored in the policy process for public health policies to realize their intended objectives. This reduces transaction costs of implementation and enhances efficiency, effectiveness and sustainability of those policies. In addition, policy formulators and implementors must be proactive in the policy process by establishing strong monitoring and evaluation mechanisms that are unique to different context given the fact that in health we may not have a single approach of implementation due to geographic, demographic, environmental, cultural and socio-economic variations among institutions and communities involved in the policy process. This theory is relevant given the diversity of people of Baringo County and their need to consolidate their preference for health services. According to Cassel and Javovsky (1989) the external environment, which the public service organizations operate, has a bearing over capacity of individual actors within the task network to deliver services. The relevant external factors include economic conditions, such as adverse economic conditions, low or negative economic growth and budget constraints that hinder efficient, effective and equitable service delivery and political factors such as stability, degree of openness, participation, political leadership and vision and support of political leaders that influence the capacity of actors within the task network to implement policies (Cassel and Javovsky, 1989).

2.12 Conceptual Framework

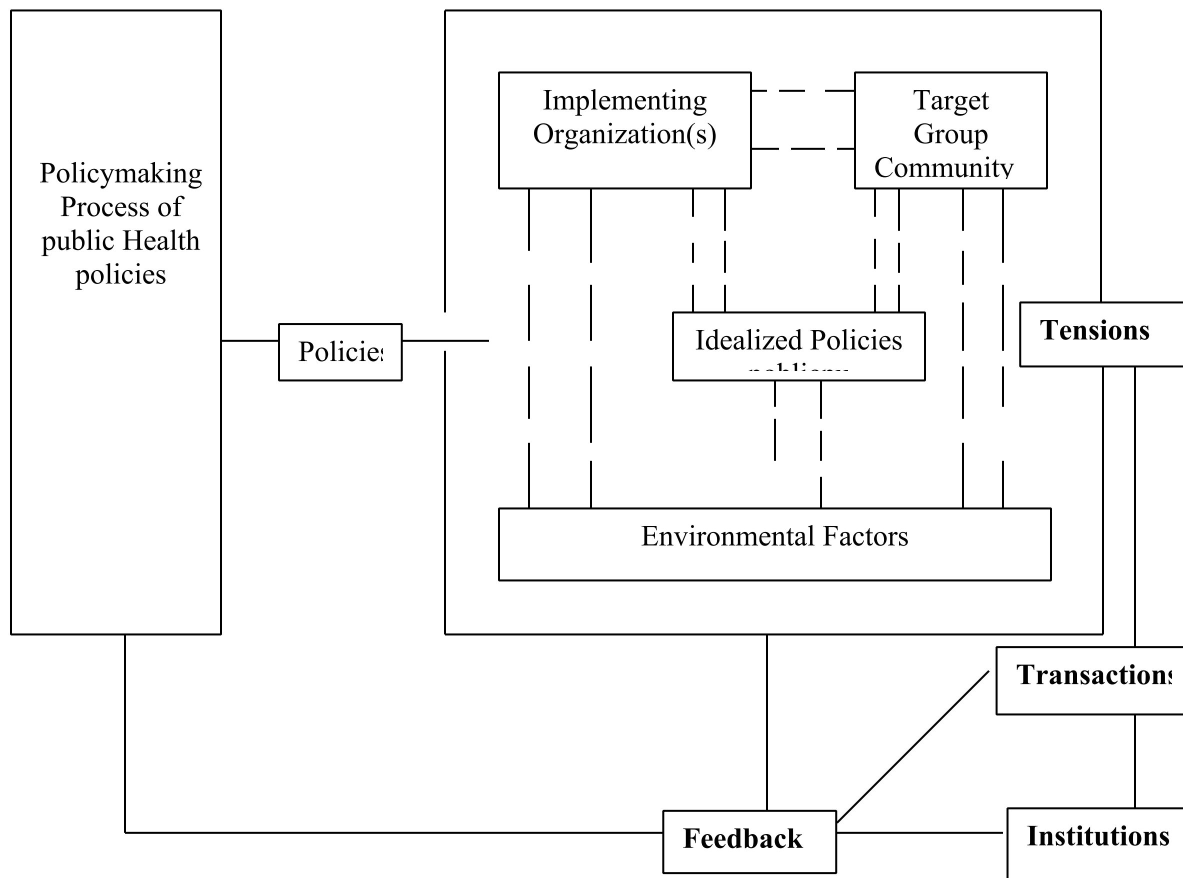

Figure 2.1: Thomas Smith's Model of Policy Implementation

Source: adopted from (Nachmias and Nachmias, 1996:45)

Thomas Smith's (1973) model of the policy implementation process provides an interesting example of modeling complex aspect of the real world that cannot be seen directly. Many people believe that once a public policy has been decided upon (for example, when congress passes a bill), implementation of the goals desired by the policy makers will follow naturally and even automatically. The technical problems of implementation are widespread and policies are never implemented in the manner

originally intended. In addition, public bureaucrats, interest groups, and affected individuals and organizations often attempt to force changes in the original policy during the implementation process. Smith's model abstracts certain aspect of the implementation process and focuses on four components:

1) The idealized policy, that is, the idealized patterns of interaction that the policymakers are attempting to induce.
2) The target group, defined as the people obliged to adopt new patterns of interaction by the policy. They are individuals most directly affected by the policy and who must change to meet its demands.
3) The implementing organization, usually a government agency, responsible for implementation of the policy.
4) The environmental factors influenced by implementation of the policy. The general public and various special interest groups are including here.

These four components and their postulated relations are diagrammed in the figure 2.1 above. The policymaking process produces public policies. These policies serve as a tension-generating force in the society: implementation cause strain and conflicts among implementors of the policy as well as the people affected by it. Tension leads to transactions, Smith's term for the response to these tension and conflict. The feedback initiated by transactions and institutions influence the four components of the implementation process as well as future policy making.

This research adopted this model to explain the processes that accompany implementation of public health policies in Baringo County. Ideally, policy makers formulate public health policies with the objective of solving a particular health problem.

In many cases, these officials my fail to consider other factors outside their bureaucratic square that largely influence the implementation process. Among these factors include: the implementing institutions, the target group, Non governmental institutions, private organizations and the larger target population. Therefore, during the process of implementation, these groups may resist, demand changes, or become indifferent and subsequently generating tension and conflict. In Baringo county this is manifest through several challenges has health workers strikes, poorly sustained community health programmes among other challenges. Practically, the policy makers and implementors should identify these contentious issues so that through the feedback loop they can redress. In public health policy implementation, these feedback loops do not exist thus policy implemetors push their policies as planned(top-down) making the policies lack sustainability while at the same time increasing the transaction costs that ought to be minimized through feedback loop(monitoring and evaluation). The transaction costs appear in terms of amount of resources committed for the same problem every year without realization of policy outcome, health workers strikes, loss of lives, lack of drugs, poorly designed public health programmes among others.

However, the theoretical framework and the conceptual framework had inherent limitations in explaining this study. Firstly, it can only be applied in highly democratic societies where institutions such as (courts legislators, executives, pressure groups, community members among other actors) function independently without interference by state or any other quota which may not the case in many developing countries, where such freedom and democratic space is limited for various actors to participate fully in the policy making and implementation process as in the case of authoritarian regimes.

Secondly, it can only explain a policy process where the participants are highly active. Therefore, it is requires a participant political culture. According to Anderson (1978), in participant political culture, individuals may organize in to groups or organizations and otherwise seek to influence government action to rectify their grievances. This constrains the research in areas of Baringo County where citizens and civil society organizations are not actively involved in governmental processes or lack knowledge on their role in public health policy making and implementation process. In addition, Actors may lack knowledge on other public health policy issues which can only be understood through technical sense. However, such a problem can be overcome by training those to provide within the community and equipping them with necessary resources to implement the health policies within their areas of residents.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter entails the methods, techniques and procedures by which the researcher collected, analyzed and presented data based on the objectives of the study. This chapter contains: research design, study area, target population, sampling design, sample size, source of data collection, data collection instruments, research validity and reliability. Others are data analysis presentation and ethical consideration.

3.2 Research Design

The study employed cross sectional survey. Cross sectional surveys are studies aimed at determining the frequency (the level) of particular attributes in a particular population at a particular point in time. Cross-sectional surveys are useful in assessing attitudes, practices, knowledge and belief of a particular population (Ross and Vaughan, 1986). The advantage of cross sectional research design is that it allows flexibility in different individuals and groups that the research intends to investigate (Serem, *et al,* 2013:13). Cross sectional survey can also be carried out in natural settings and permit researchers to employ random probability samples. This allows researchers to make statistical inference to broader population and permits them to generalize their findings to real-life situations thereby increasing the external validity of the study (Nachmias and Nachmias, 1996:131). Through cross sectional survey, the research used secondary and primary data from a

selected representative sample of respondents using both quantitative and qualitative data collection techniques that comprised interviews schedules and questionnaires.

3.3 Study Area

This research was conducted in Baringo County which is located in the Central Rift region of Kenya and divided into six Sub Counties that include; Tiaty, Baringo North, Baringo Central, Baringo South, Mogotio and Eldama Ravine as shown in table 3.1 and 3.2. The assessment was conducted across the six Sub Counties and findings were used to generalize the implementation of public health policies across the County. The area of study was chosen based on poor health and sanitation indicators published by ministry of health in the year 2014 that ranked Baringo County number 38 out of 47. The survey revealed that Baringo loses Ksh. 538m each year due to poor sanitation. This includes losses due to access time, premature deaths, health care costs and productivity. In addition, the area has diverse population owing to its socio-economic, historical cultural and political diversity necessary for such a kind of study. It is dawning to policy makers that non-medical factors within communities and other institutions have significant influence in the implementation of public health policies. For instance, the work of the Commission On Social Determinants of Health (2008) and its interim statement states that *'the condition in which people grow, live, work, and age have a powerful influence on health….inequalities in these conditions lead to inequalities in health.'* (W.H.O, 2008). In that vein, Baringo County was able to represent implementation of public health policies that can be replicated in the entire country. In addition, the area was familiar and affordable to the researcher.

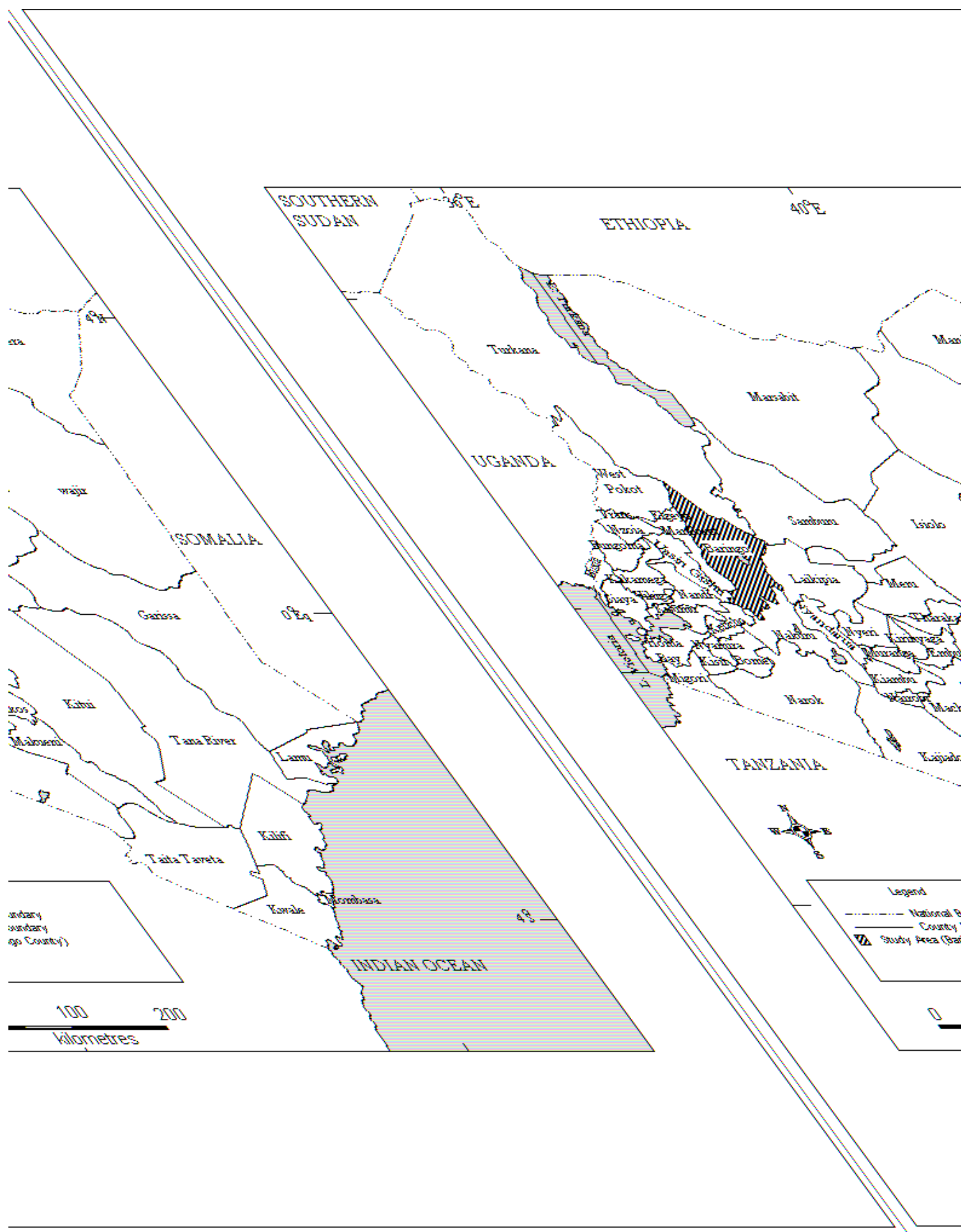
SOUTHERN SUDAN
ETHIOPIA
SOMALIA
UGANDA
TANZANIA
INDIAN OCEAN
Turkana
Marsabit
Samburu
Isiolo
Laikipia
Baringo
West Pokot
Narok
Kajiado
Garissa
Kitui
Tana River
Lamu
Kilifi
Taita Taveta
Kwale
Mombasa
Makueni
100
200
kilometres
Legend
Study Area (Barin

Figure: 3.1 Map of Kenya showing the location of Baringo County in Kenya

Source: Moi University GIS Lab.

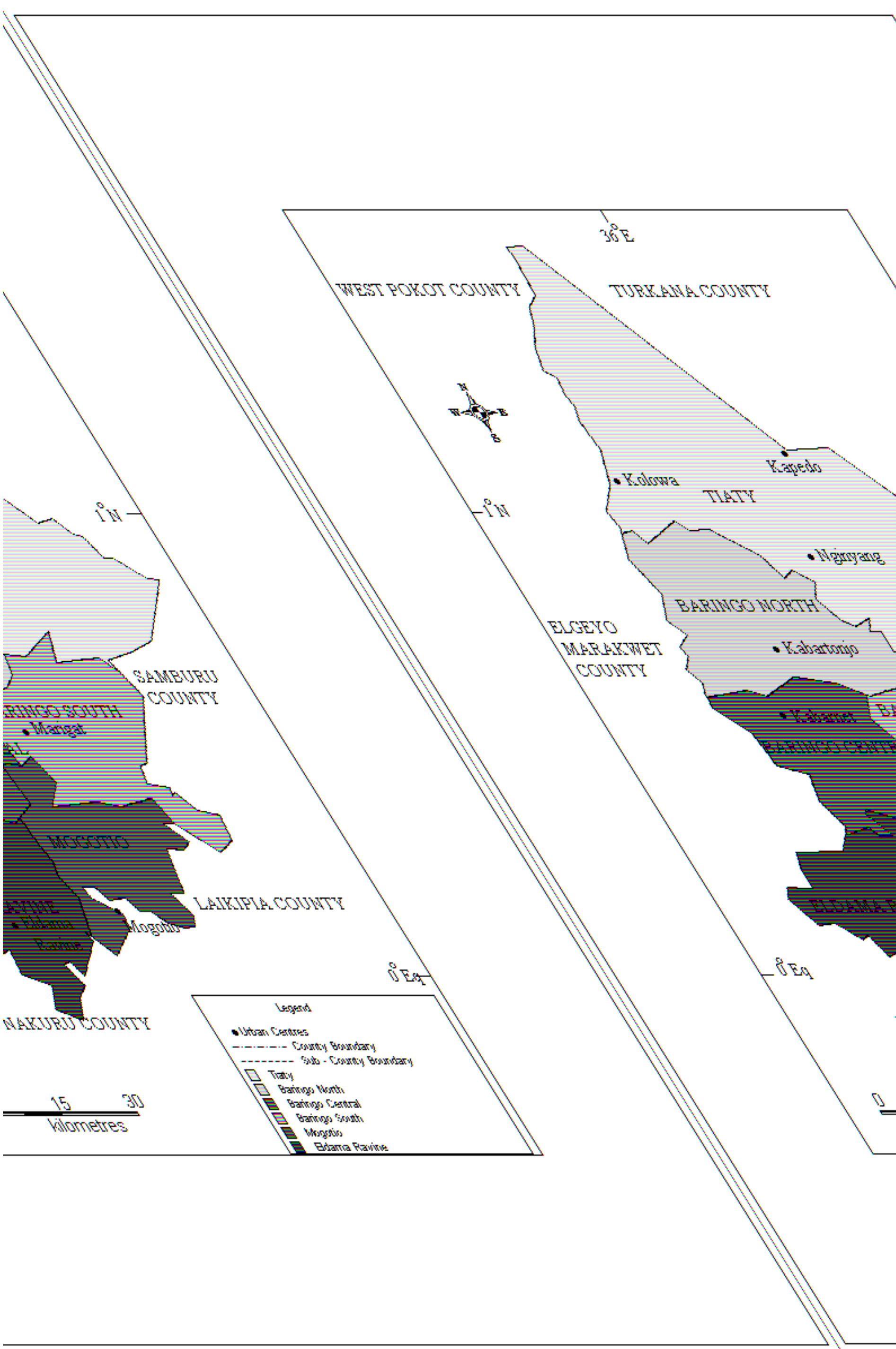

Figure 3.2: Map of Baringo County

Source: Moi University GIS Lab.

The Tugen Hills form a conspicuous topographic feature in the County. The altitude varies from 300m to 1,000m above the sea level. The trend of the hills is north-south and mainly consists of volcanic rocks. The hills have steep slopes with prominent gullies. On the eastern and western parts of the hills are escarpments. Rivers on the hills flow in very deep gorges. The Temperatures in the County range from a minimum of 10 °C in the highlands to a maximum of 35.0 °C in lowlands. Similarly, the rainfall varies from 1,000 to 1,500mm in the highlands to 600mm per annum in the lowlands. The county has five livelihood zones segregated in different proportions as Pastoral (33 percent), Agro Pastoral (nine percent), and Marginal mixed farming (39 percent), Mixed Farming (14 percent) and Irrigated Cropping (four percent) (Makanga and Munene, 2013).

Baringo County has poverty index that stand at 58 % (Baringo County development profile, 2013). This is exacerbated by frequent cases of insecurity, prolonged droughts, and frequent occurrence of landslides that predispose the population to health hazards like waterborne diseases and nutritional problems among others. According to Makanga, and Munene (2013) the top five diseases in the County, in order of prevalence, are upper respiratory tract infections, Malaria, Diarrhea, skin infection, and Pneumonia in both children less than five years and the general population. Rheumatic fever and Typhoid was reported in adults in some areas (ibid). The overall immunization coverage for all children aged less than five years is at 63.5 percent across the county but is lower in the pastoral livelihood zone of Baringo South, Baringo North and Tiaty due to insecurity

issues. Livestock is usually lost to the rustlers, lives threatened, institutions such as schools, health facilities and markets closed and families displaced leaving households vulnerable. These entire factors reinforce one another to breed ill-health and socio-economic disparities among the population. In Tiaty, cases of dysentery, typhoid, diarrhea, Hepatitis B and skin infections are common. The cases are attributed to low uptake of hygiene practices (Makanga, and Munene, 2013).

3.4 The people of Baringo

The dominant ethnic group in Baringo is Tugen which has the following ethnic groups; Samor, Lembus, Arror and Oldorois which practice mixed farming. Minority groups also inhabit the areas and they include; Pokot, Illjamus,and Turkana that practice pastoral farming. Nubians were also re-settled by the former colonial government in the suburbs of Kabarnet town, the Headquarter of Baringo County. According to Adetokunbo, (1999) understanding the diversity of the population is important in the sense that it is common to find diversity in the epidemiological pattern of disease across regions and populations within a country. This is accounted for by characteristics of the health sector, geographical, ecological, environmental, economic, social, behavioral, demographic and cultural factors that may differ from population to population in regions within a country (Adetokunbo, 1999).

3.5 The Target Population

The target population was the entire population of Baringo county which is 552,254 as per 2009 KNBS census (G.o.K, 2010). From this figure, the research chose individuals and organizations that are the largest players in the implementation and the consumption

of governments' health policies drawn from six Sub Counties in the county selected through simple random sampling. The respondents comprised clients drawn from the communities in the six sub counties, government officials (both national and county), health professionals (both public and private), and finally Non Governmental Organizations operating in the area.

Table 3.1 Target population

SUB COUNTY	POPULATION
Eldama-Ravine	105,273
Mogotio	60,959
Baringo Central	81,480
Baringo North	93,789
Baringo South	80,871
Tiaty	133,189
TOTAL	**552,254**

Source: GoK, 2010 (KNBS Census 2009)

3.6 Sampling Design

A sampling design is definite plan for obtaining a sample from a given population (Kothari, 2004). It refers to the technique or procedure the researcher would adopt in selecting items for the sample. The study employed stratified sampling method. This type of sample is usually used when the researcher wants to look at particular groups to represent the entire group of population (Serem, Boit and Wanyama, 2013). The method was appropriate because of the fact that the population investigated exhibited

heterogeneous characteristics varying in demographic, cultural, political and socio-economic backgrounds. Simple random sampling was used to select a sample from each stratum. Purposive sampling was appropriate for the specific individuals with crucial information that included key representatives of policy makers, and health professionals and Non Governmental Organizations. According to Oso and Onen (2005), purposive sampling allows the researcher to look for samples that will give him particular information to the research.

3.7 Sample Size

The sample size was determined using formula proposed by (Yamane 1967). The formula was deemed appropriate because it must take into account the variances of populations and strata before an estimate of the variability in the population as a whole can be made and also its practicality to sample large target population. The formula states that:

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

In this study,

n= Sample size

N=Target population at 552,254

e =Level of precision (assumed at 5% in the study)

$$n = \frac{552,254}{[1+552,254*(0.05)^2}$$

$$n=400$$

A sample size of 400 resulted from the use of Yamane's formula. This was the sample size utilized by the study. Formula proposed by Yamane cited by Glenn D. Israel (1992) was used for Proportional allocation to calculate sample from each stratum for the Sub-Counties as shown below.

$$n1 = \frac{N1}{1+Ne^2}$$

n1 = Sample size being selected in each strata

N1 = population in each strata

N = Total population

e = reliability 0.05

Through the Allocation formula, each Sub Counties' sample size is derived proportionately as follows; and summarized in table 3.2

$$\text{Eldama Ravine} \quad n\ 1= \frac{105{,}273}{1+552{,}254*0.05^2}$$

$$\text{Mogotio} \quad n\ 2= \frac{60{,}959}{1+552{,}254*0.05^2}$$

$$\text{Baringo Central} \quad n\ 3 = \frac{81{,}480}{1+552{,}254*0.05^2}$$

$$\text{Baringo North} \quad n\ 4 = \frac{93{,}789}{1+552{,}254*0.05^2}$$

80,871

The sample for residents and local leaders was chosen using stratified sampling based on the population of each Sub County through the use of formula proposed by Yamane cited by Glenn D. Israel (1992). The stratified sample did not only represent the overall population, but also key subgroups of the population.

Table 3.2 Sample Size

S/NO	SUB COUNTY	POPULATION (N)	SAMPLESIZE(n)
1	Eldama-Ravine	105,273	76
2	Mogotio	60,959	44
3	Baringo Central	81,480	59
4	Baringo North	93,789	68
5	Baringo South	80,871	58
6	Tiaty	133,189	95
	TOTAL	**552,254**	**400**

Source: GoK, 2010 (KNBS 2009) and Researchers' Computation, 2014

Top officials representing their organization that included policy makers, Non-Governmental Organizations and Health professionals were sampled purposively based on researchers' judgment and interviewed. They were able to provide critical information on pertinent issues that promote, hinder or influence implementation of public health policies in the area. Table 3.3 shows the sample size of those interviewed.

Table 3.3 Interview Sample

GROUP	SAMPLE SIZE
Policy makers	2
NGOs	3
Health professionals	3
TOTAL	**8**

Source: Researchers' computation, 2014

Once the sample had been determined the researcher embarked collecting primary data. The sources and instruments of collecting data are discussed in the ensuing section.

3.8 Source of Data Collection

The research used both primary and secondary data. The primary data formed the major data for the research and was obtained through the use of questionnaires and interview schedules. Secondary data was obtained from documentary materials such as the National Health Policy provisions, County Health Policy documents, conference papers, offices files, research journals, text books, incidents reports on health problems and health records information within the study area.

3.8.1 Primary Data

Primary data was collected from the respondents in the areas of study using data collection instruments which constituted: questionnaires and interview schedules where respondents were expected to provide crucial information for the study. The respondents

constituted public policy makers, health professional, on Nongovernmental Organizations and the community members.

3.8.2 Secondary Data

This was employed at the initial stages of the proposal development especially in the development of the background of the study, statement of the problem and the review of the literature to establish gaps concerning the issue of study. Some of the literature included: Books, journals, dissertations, thesis reports, government policy document and other relevant materials. These sources provided a source of knowledge on what others have done concerning health policy implementation and challenges of implementation. It also aided in revealing the gaps in the voyage of public health policy implementation in Kenya.

3.9 Data Collection Instruments

The following research collection techniques were employed by the research in collection of the data; Questionnaires, interview schedules, observation and secondary data drawn from health professionals.

3.9.1 Questionnaires

Questionnaires were administered to the residents of the county to fill. According to Nachmias and Nachmias (1992), the foundation of all questionnaires is the question. The questions must motivate the respondents to provide the information being investigated. The questions were standardized and structured issued and collected upon completion by the respondent. It was used to obtain information from the community members. One advantage of this technique is that the respondents were guided by the questions and it

gave a relevant information thus improved the reliability of the data to be generated. In addition, it saved cost and time as large population can be surveyed in a widely spread population. However, the technique was limited in the sense that it was not flexible enough to capture social expressions in social context such as attitudes, orientations, circumstances and experiences that can provide crucial data for health policy information from the respondents.

3.9.2 Interviews Schedules

The research collected data through interview. It was used for the government officials and health professionals and leaders of Non governmental institutions to obtain first hand information on policy issues and challenges in their implementation. According to Serem, Boit and Wanyama (2013) interview has several advantages in that the researcher can note the facial expressions, gestures, hesitations which help to authenticate the response. Interviews had a number of challenges. Firstly, it was time consuming interviewing interviewees. Secondly, interviewees purposely chosen for interviews were in most case not available at the right time due to their own commitments in their work places making the researcher to reschedule the time more often to accommodate their changes. Despite these challenges interviews were able to provide critical information necessary for this study.

3.10 Measures of Validity and Reliability

According to Serem, Boit and Wanyama (2013) precision and accuracy are important issues in research and validity and reliability are two key concepts that researchers use to assess the accuracy and rigor of the research process.

3.10.1 Validity

Mason (2002) defines validity as the extent to which the study actually investigates what it claims to investigate and report what actually occurred in the field. According to Serem, Boit and Wanyama (2013) validity aims at ascertaining the extent to which the research instruments collects the necessary information. This measure aims to assess whether or not the relationship is established or whether there is a gap between the information that was sought and the data collected. In this research, the validity of the instruments was guaranteed through pilot test conducted prior to the study. The pretest was conducted in Marigat town located in Baringo South Sub-County where ten questionnaires were distributed to the respondents. Marigat town was chosen because of its diverse socio economic, political and cultural orientation of the residents thus portrays variable characteristics of population in Baringo County. The feedback from the pre test was used to revise the tools to ensure the objectives of the study are realized. The instruments validity was acceptable because it produced consistent data that can be generalized on the entire population.

3.10.2 Reliability

Jwan and Ong'ondo, (2010:142), refer validity as the extent to which a researcher provides sufficient details and clarity of the research entire process in a way that would make it feasible for reader to visualize and appreciate and for a researcher to replicate the study which was necessary. Yin (2003:34) defines reliability as demonstrating that operations of study such as data collection procedures can be repeated with the same results. The Split Half technique was used to determine reliability of the research instruments. According to Nachmias and Nachmias (1996: 173), the Split-Half method estimates reliability by treating each of the two instruments as separate scales. The two are then correlated, and this is taken as an estimate of reliability (Nachmias and Nachmias, 1996). To adjust correlation coefficient obtained between the two halves, Spearman-Brown prophecy formula was applied.

3.11 Limitations of the Study

The study had some limitations which were noted and addressed to ensure validity and reliability of the study. These included the nature, vastness and the environment of the study area and the spread of the study sample to give the county outlook and relevance thus prolonging the study period. There was reluctance from residence to give information for fear of victimization and ethnic profiling which prompted the author to clearly explain the intention of the study to the respondents and their right to anonymity and confidentiality for giving out the information. There emerged questionnaires non response upon the return by the respondents thus compromising the much needed information for the study. However, the study noted that the non response was negligible

to compromise the study. Insecurity in some parts of South Baringo and North Baringo let to the missing of questionnaires as residents fled for fear of imminent attack from the neighboring community. However, the study was able to salvage some duly filled questionnaires from fleeing respondents that were incorporated to the findings. Finally, the applicability of this study can only be effective in Baringo County and may not reflect what happen in others counties in Kenya due to geographical, historical, political, socio-economic, demographic and cultural differences in other forty six counties of Kenya. Therefore this study recommended a similar study be replicated in other 46 counties in Kenya.

3.13 Ethical Considerations

Economic and Social Research Council (ESRC, 2005), defines research ethics as the moral principles that guides the research from its inception through to its completion and publication of results. According to Denzin and Lincoln (1994), it is impossible not to take ethical and value stance in the process of research since everything the researcher does involves making value laden decisions. Critical to this research are three ethical considerations: firstly, permission to carry out the study was sought from the National Commission for Science, Technology and Innovation (NACOSTI), Baringo County Government, Ministry of Education and from the respondents who participated in the study. Secondly, the respondents were informed on the consent, duration of participation and the expected benefits from the research to the society. Thirdly, privacy and confidentiality was guaranteed to the respondents especially on issues related to health status, and any other information that would pose harm to the respondents.

3.12 Data Analysis and Presentation

The study used quantitative and qualitative techniques in analyzing the data. The data collected was edited, coded and classified according to the specific class attributes and intervals for the case of quantitative information. It used descriptive statistics to analyze and describe the general trend and patterns in data sets. According to Serem, Boit and Wanyama (2013) descriptive analysis describes patterns and general trends in data sets and was used to explore one variable at a time. The quantitative data was analyzed using SPSS (Statistical Package for Social Sciences) and then was presented using frequencies and percentages with their specific tables. Qualitative data were collated thematically to answer the study's questions. Any emerging themes were incorporated in the analysis and presentation.

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND INTERPRETATION

4.1 Introduction

The chapter entails the presentation and analysis of data that was collected from the respondents and interviewees. This research study addresses the specific information that the researcher intended to investigate. The chapter entails, the return rate, analysis of the demographic information and the analysis of response of each variable that sought information to answer every objective.

4.2 Return Rate

The target population constituted all the residents of Baringo County government officials and Non-governmental Organization officials (NGOs) and private health care providers operating in the area. The research tools were administered to all the sampled 400 respondents and 8 interviews conducted. A total of 400 questionnaires were distributed but 304 were returned thus (76%) return rate. Mugenda and Mugenda (2004) argue that a response rate of over (50%) is sufficient for a study. Therefore a response rate of (76%) was considered adequate for this study. The main reason why the study was not able to obtain all distributed questionnaires was that respondents issued with questionnaires in some parts migrated due to volatile security situations in their areas especially in the parts of South Baringo and North Baringo adversely affected by banditry and therefore became difficult for the researcher to trace them from their original residents. Secondly, there were incidences where respondents misplaced the questionnaires issued by the researcher.

4.3. Demographic Data of the Respondents

This part of the chapter presents the demographic information of the respondents.

4.3.1 Age of the respondents

The researcher sought to establish age of the respondents because age is a demographic feature that affects behaviour or perception of respondents. This data is presented in table 4.1

Table 4.1 Age of the Respondents

Age	Frequency	Percentage
18-25 Years	77	25.3
25-35 Years	152	50.0
36-45 Years	36	11.8
45-65Years	39	12.8
Total	**304**	**100.0**

Source: Field data, 2015

From the data collected it was noted that (25.3%) of the respondents were between 18-25 years while (50%) were between 25-35 years, from the data (11.8%) were between 36-45 years and (12.8%) were between 45-65 years. This implied that a majority of the respondents lie between 25 and 35 years. This meant that at least they were old enough to understand existing policies and benefits of health policies on residents well being. The youngest respondent had 18 years while the oldest respondent was 64 years of age.

The specific variables used to investigate on the gender of the respondents were male and female. The researcher saw it important to seek information from both male and female. The specific findings are presented in figure 4.1

Figure 4.1 Gender of the Respondents

Source: Field data, 2015

From the data collected it was evident that (48.7%) of the respondents were male while (51.3%) were female. This implied that gender disparity is less than (4%). From these figures, it emerged that majority were female. In many societies, women have had the burden of ill-health and many other issues that revolves around health decision making. Despite imbalance, both the male and the female respondents understood the importance of health policies in managing individual health.

4.3.3 Marital Status

The researcher found it imperative to establish the marital status of the respondents since correlation exist between marital status and healthcare. Data collected is presented in table 4.2

Table 4.2 Marital Status

Marital Status	**Frequency**	**Percentage**
Single	131	43.1
Married	167	54.9
Widow/Widower	6	2.0
Total	**304**	**100.0**

Source: Field data, 2015

From the data collected and presented it was noted that (43.1%) of the respondents were single while (54.9%) were married and (2%) were widowed. This implied that most of the respondents were married and thus considers family health paramount. The study found out that the majority of the single were the youth. Both groups cited health care has one of the contributing factors for high cost of living.

4.3.4 Size of Family

Family size is associated with demand in terms of needs upon which health is one of them. The bigger the family the more the needs and the smaller the family the lower the demands thus financial constraint are low. This data has been presented in figure 4.2

Figure 4.2 Family Size

Source: Field data, 2015

From the field data, it was evident that (26.3%) of the respondents had family members below 3, data collected revealed that (33.6%) had family size between 3-5 members, while (35.9%) are between 5-10 members and (4.3%) are above 10 members. The study notes that most of the members are above 3 hence the families are big. Lack of knowledge and unawareness of family planning methods makes one raise a big family. From the study, it is evident that people still value large families yet the size of the family has implication in the provision of healthcare and other factors that promote health such as food, shelter and education. Growing population also increases the demand for public health service thus straining the available public health facilities in a given area.

4.3.5 Level of Education

The study sought to find out the level of education of respondents using variables, never went to school, Primary School, Secondary School, Tertiary Level/College and University. The research sought to establish the level of education of the respondents so

as to verify on residents understanding on the importance of health policies. The specific findings is tabulated in table 4.3

Table 4.3 Level of Education

Level of education	**Frequency**	**Percentage**
Never went to school	8	2.6
Primary School	69	22.7
Secondary School	91	29.9
Tertiary Level/College	104	34.2
University	32	10.5
Total	**304**	**100.0**

Source: Field data, 2015

From the data collected, it was evident that (2.6%) of the respondents never went to school, (22.7%) attended primary School, (29.9%) attended secondary School, and (34.2%) have tertiary Level/College and (10.5%) reached the level of University. This implied that most of the respondents are educated hence they do understand the importance of health policies on citizens well being. The high literacy level in Baringo indicates that residents can be able to seek public health information on their own and fully participate in the public health implementation processes within their locality. From the same statistics, the findings also confirmed that this highest group of literate individuals also influenced decisions made in their communities thus provides an

opportunity for public health policy implementers to engage them for sustainable public health programmes.

4.3.6 Respondents Current Occupation

The researcher found it imperative to establish on the occupation of the respondents. Some of the variables used were; Pastoralists, Mixed Farmer, Business man/woman, Student, Government staff and Non-governmental staff. The data collected is presented in figure 4.3

Figure 4.3 Respondents Occupation

Source: Field data, 2015

From the findings it was evident that Pastoralists were (17.8%), Mixed Farmers were (29.9%), Business men/women were (16.8%), Students were (14.1%), Government staffs were (11.2%) and Non-governmental staffs were (10.2%). This implied that mixed farmers were the majority then followed by pastoralists, business men and women respectively. The occupation that one does is facilitated by the environment and locality of an individual. Baringo County has communities with diverse historical, socio-economic, cultural and political orientation has indicated by the figures above. Mixed farmers are the majority because vast areas of Baringo in semi arid land (ASAL) thus farmers diversify their economic activities to caution themselves against changing climatic conditions. On the other hand, some communities still value livestock as the only economic mainstay especially in the Sub-Counties of Tiaty and Baringo South. From the

collected data (16.8%) who engage in business commonly reside within urban centers that are sporadically growing.

4.3.7 Type of Fuel used at Home

Energy is crucial as it is used to cook and to light and impacts directly on health of individuals. Hence the study found it important to establish on the fuel used by the residents. This data is presented in table 4.4

Table 4.4 Type of Fuel used at Home

Type of fuel	**Frequency**	**Percentage**
Firewood	174	57.2
Charcoal	123	40.5
L.P.G(Gas)	7	2.3
Total	**304**	**100.0**

Source: Field data, 2015

From the data obtained (57.2%) use firewood, (40.5%) use charcoal and (2.3%) use L.P.G (Gas). This implied the usage of gas is not common among the residents. Most of them use firewood because it is readily and cheaply available. Those who use charcoal are majorly drawn from urban areas that cannot access firewood while at the same time cannot afford to purchase Liquid Packaged Gas (LPG). The mode of fuel used by the residents is not friendly to environment and also predisposes them to health problems. That may explain why respiratory tract infections leads other disease prevalence in the region as noted by earlier studies that, the top five diseases in the Baringo County, in order of prevalence, are upper respiratory tract infections, Malaria, Diarrhea, skin infection, and Pneumonia in both children less than five years and the general population (Makanga and Munene, 2013).

4.4. Public Health Policies Existence in Baringo County

Knowledge on existing public health policies among the communities and other implementing stakeholders is crucial for smooth implementation, success and sustainability of public health policies. This research therefore sought to establish level of awareness among the respondents, agencies that implement public health policies, mode used to obtain public health information and their level of involvement in the implementation process.

4.4.1 Awareness of any Public Health Programs Implemented

The researcher attempted to establish whether the residents were aware of public health policies and programs. Data collected is presented in table 4.5

Table 4.5 Respondents Awareness of Public Health Programs

Awareness	Frequency	Percentage
Yes	219	72.0
No	85	28.0
Total	**304**	**100.0**

Source: Field data, 2015

From the findings it was evident that (72%) of the residents are aware of the public health programs in the area while (28%) are not aware. This indicate that majority of the residents are aware of existences of public health policies within their locality. The public health policies identified by the respondents were the Primary Health Care, maternal health care, ambulatory care, HIV/AIDs prevention programs, immunization programs,

Ante natal and prenatal services among others. It also became evident that respondents were aware implementation of health care provision is a devolved function in the new constitutional dispensation. The implementing partners should therefore capitalize on the residents knowledge to implement health care polices by cooperating with the communities by involving them in the process to improve sustainability and success of such policies.

4.4.2 Agencies that Implement public Health Policies

The researcher found it important to establish on the agencies involved in health policy implementation. This data is presented in table 4.6

Table 4.6 Agencies that implements Public Health Policies

Agency	**Frequency**	**Percentage**
National government	125	41.1
County Government	79	26.0
Joint governments	22	7.2
N.G.O	64	21.1
Local Community	4	1.3
None response	10	3.3
Total	**304**	**100**

Source: Field data, 2015

From the field data collected, (41.1 %) of the respondents attributed programs implemented in the area to the national government, while (26%) of them attributed programs implemented to the county government, (7.2%) of respondents attributed implementation to Joint governments, (21.1%) of respondents attributed public health implementation to N.G.Os and finally (1.3 %) acknowledged local Community as having a role in implementation. This implied that the national government is the main agency that implements public health policies. It further reveals that County governments' role in implementation is minimal despite devolution of implementation of health care policy in the new constitutional dispensation. With the promulgation of the new constitution, county governments have been given mandate to implement public health policies while policy formulation; stewardship and guidelines left with the central government. This finding therefore disagrees with the distribution of function between national and county governments which gives impetus to counties in the implementation. According to Kenya Health Policy 2012-2030, in the devolved system, healthcare governance occurs at two levels: national and county. At the national level, the Ministry of Health (MOH) is responsible for providing stewardship and guidance. At the county level, county departments of health are responsible for coordinating and managing the delivery of health services (Kenya Health Policy 2012 – 2030). From data obtained, this transfer of responsibilities from national government to counties has not been felt in the grassroots level as many of the respondents attribute gains made to national government. Moreover, the new constitution calls for collaboration between the central government and county government to ensure the health policy is fully implemented. However, the field response

indicates hiccups between the national government and the county government in the provision of health care to the people as noted by county policy makers interviewed:

> *"The national government has been implementing some public health policies without involving county governments such as the recent purchase of state-of-art health equipments to be used in 47 Counties. Moreover, the funding to counties is meager compromising critical sectors such as health which is a highly devolved function."*

Local communities' inclusion in implementation is almost negligible at 1.3%. This is a setback in the realization of primary health care under a devolved system has it neglects the role residents play in taking charge of their own health through promotive, preventive and rehabilitative programmes. This contradicts with the literature available that there is increasing awareness among service providers that households and communities not only take the majority of preventive and promotive health actions but also provide clinical care of the critically and Chronically ill (G.o.K, 2006).

4.4.3 Source of Information on Policies Related to Health Policies

Information is knowledge as it impacts the community positively. The source of information varies based on the personnel involved and the medium used. In this case, some of the variables operationalized were; Health Facility, Public Barazas, churches, schools and Media. The data is presented in table 4.7

Table 4.7` Source of Information on Policies Related To Health

Source of information	**Frequency**	**Percentage**
Health Facility	166	54.6
Public Barazas	62	20.4
Media	76	25.0
Total	**304**	**100.0**

Source: Field data, 2015

From the data presented, it was evident that (54.6%) said that the main source of health information is health facility, (20.4%) said it is from the Barazas and (25%) was through the media. It implies that most of the information given to the residents is at the health facility once they succumb to an illness or reporting a disease incident that has already occurred in their locality. The study can logically deduce that most people do not embark on self seeking information concerning their health till they succumb to illness. It is therefore important to underscore the fact that Constitution of Kenya 2010, chapter four 35(1) (a) (b) provides all citizens the right to information from a public institution. Therefore for better understanding of implementation of public health policies, citizens must be provided with effective and prompt information concerning available health programmes, mode financing and implementation of the same policies. According to (World Bank, 1997) providing information to the users of government goods reduces

transaction costs associated with seeking information concerning the service. Literature reviewed revealed that inaccessibility of information can compromise transparency and accountability in the implementation of health policies. According to Owino *et tal,* (2001) access to some of the documents by DHMBs was constrained by government Secrecy Act that restricted access to vital governments information. According to him DHMBs operated without information to guide their operations leading to financing of expenditure plans approved by DHMBs that do not conform to the district health priorities (Owino *et tal,* 2001).

The citizens must be furnished with appropriate and accurate information related to health so that they can make the right decision concerning their health and health care within their areas. With rise of information communication technology, the dissemination of information has been simplified as citizens can easily access information online or though widespread communication networks across the globe. According to Economic Intelligence Unit, (2011) technology will be the dominant means of extending access to healthcare across the continent, enabling every citizen to access both basic and more specialist healthcare by 2022 even in the most rural parts of Africa.

4.4.4 Residents Involvement in Public Health Program or Projects

The researcher found it important to establish on whether the residents are involved in public health programs. This is because their opinion is crucial and it may help improve areas that the government or other institution may not see in the process of implementation. Paul (1995), alluding to the emphasis given to community participation within health care strategies, stressed the importance of ensuring health care users are

group within a task network which is involved in every aspect of health care planning and management. This information is presented in table 4.8

Table 4.8 Residents Involvement in Public Health Program or Project

Residents involvement in public health	Frequency	Percentage
Yes	86	28.3
No	218	71.7
Total	**304**	**100.0**

Source: Field data, 2015

From the data collected it was evident that (28.3%) of the respondents have witnessed residents' involvement in public health program. The remaining (71.7%) have never had such an experience. This implied that most of the residents are not involved or rather they do not volunteer in implementation of public health policies or programs. Through an interview, to one of government official, he admitted that communities have never been involved in promotive, rehabilitative and preventive health care despite the importance of such programmes in preventing the emerging and rising cases of disease prevalence. This is what county government official had to say in an interview:

> *"County governments' budgets can only cater for curative and administrative costs leaving very little finance for preventive and promotive health care within the communities despite the importance of those services in managing health and preventing diseases from getting to the health facilities for treatment."*

This implies that implementation of Primary Health Care under the devolved health care is grossly undermined by meager budgets. The continued funding on curative is not cost effective in the long run compared to PHC. Starfield (1992) argues that specialized and

curative medical care is more expensive, and with limited resources and competing uses, it is more difficult to provide such services to the entire population. Advocates of decentralization therefore preferred primary healthcare as opined by Kekki, (2003) that understanding PHC strategy as a point of contact with the community's and populations' gateway to the health system has been predominant in countries that have achieved adequate levels of basic health services.

It is therefore imperative for health systems to recognize other non- medical factors within the communities that influence health conditions and that can be done through working together with communities. Such initiative can never bear fruit if our systems continue to implement vertical programs that ignore communities through use of centralized strategies. The Government of Kenya in the introduction of the policy of Kenya Community health Strategy in the year 2006 acknowledged that the culture of dominance among service providers against that of silence among households and communities makes it difficult for the ideas of the communities to be heard. Service providers never really get to know what their clients understand. Thus they often assume that what they have said, advised or given has been accepted and will be done, only to be surprised later that no change has taken place in terms of behavior or practice and therefore health outcomes (G.o.K, 2006).

4.5 Role of Stakeholders in the Public Health Policies Implementation

It is pertinent to understand the role various stakeholders play in public health implementation process. Their role is indispensable in this era of democracy and popular participation in policy making and implementation. Emphasizing the importance of

stakeholders in policy implementation, Thomas Smith (1973) argues that public bureaucrats, interest groups and affected individuals and organizations often attempt to force changes in the original policy during the implementation process. The research therefore, sought to establish the role and relationships among the stakeholders. These stakeholders included: Governments (Both National and County), Communities, NGOs & FBOs, private health professionals.

4.5.1 Communities Role in the Implementation of Public Health Policies

Communities' role in development of policies has always been effective in implementation process as they help develop the right strategies for implementation and sustainability of such policies. Hence their presence and activity is mandatory in the implementation process. This information is presented in table 4.9

Table 4.9 Communities Role in the Implementation of Public Health Policies

Communities' role	**Frequency**	**Percentage**
Yes	262	86.2
No	42	13.8
Total	**304**	**100.0**

Source: Field data, 2015

From the data collected it was evident that (86.2%) of the respondents said yes they have a role to play and the remaining (13.8%) said no. From the findings it can be deduced that the success of the implementation of a health policy will depend on the people realizing

its benefits and impact through their own initiatives. This further means it is important to involve the people in the implementation process by considering their views. According to Amartya Sen, (1999) freedom of people to participate socially and politically in shaping their lives and what they value is central to human and economic development. Sen offers many examples of how people having ‘‘agency’’ (the ability to act and bring about change), coupled with access to basic education and health services can lift themselves out of poverty and transform societies (ibid). The data collected further agrees with (World Bank, 1997) that government programs work better when they seek participation of the users, and when they tap the community's reservoirs of social capital and the benefit shows up in smoother implementation, enhanced project performance, greater sustainability and better feedback to government agencies.

Health professionals interviewed acknowledged the role communities play in the implementation of public health programs but questioned the level of their participation. According to them community members are not trained to handle technical issues such as curative as they may not posses medical knowledge thus compromising quality and standards. One health professional pointed out that:

> "*Involving the community members in the implementation process requires them to posses some degree of technical skills and knowledge concerning health issues which may not be the case in many areas of Baringo thereby compromising national and global quality that require sets of standards for health service delivery that should diligently be observed.*"

According to March and Olsen, (1984) lack of information and skills limits communities' involvement in the implementation especially in societies where trained medical personnel and literacy levels are low. However, such a problem can be overcome by

training community and equipping them with necessary resources to implement the health policies within their areas of residence. According to Economic Intelligence Unit 2011, non-professional people can be trained to provide education, support treatment for HIV, deliver prescribed medicines, and use a weighing scale or glucose-testing device thus freeing up specialized medical staff to perform more complicated procedures and reducing the pressure on overstretched public-sector hospitals.

4.5.2. Role of NGOs and Private Health Providers in the Implementation of Public Health Programs

NGOs and private health providers have played a critical role in implementing health policies in Kenya and they have positively influenced the people especially in arid and semi arid areas (ASAL) where the government is not effective in provision of health care. Due to this, the researcher found it important to establish their role in the implementation of the health policy. This data is presented and tabulated in table 4.10

Table 4.10 Role of NGOs and Private Health Providers in the Implementation of Public Health Programs

NGOs	Frequency	Percentage
Yes	274	90.1
No	21	6.9
Non response	9	3.0
Total	**304**	**100**

Source: Field data, 2015

From the data collected it was evident that (90.1%) agreed that NGO have a great role to play while (6.9%) disagreed and the non response was (3.0%). From the findings it can be deduced that the NGOs and private health providers have a role to play. This includes construction of a hospital or development of a mobile clinic which offer immunization in far flung areas, provision of ambulatory services and health education and awareness. NGOs funded health facilities provide quality services at affordable costs in areas where government facilities are few or non-existent. One of the NGOs officials interviewed had the following to say on their role in health care provision:

> *"NGOs play a key role in areas where government health facilities are inadequate or understaffed and in most cases partner with government in implementing some community health programs and other programs such as immunization, reproductive health, nutrition and maternal health and other programs related to health such as eradication of poverty, provision of clean water and education."*

This response is consistent with Hardee *et al*, (2004) that institutions outside the government play a role in policymaking by acting as advocates for policy change (civil society groups, grassroots organizations, NGOs, and advocacy groups) by providing data for decision making (academic and research organizations) and by providing funding (donor organizations) for policy research, policy dialogue and formulation, and implementation. Finally, international organizations also play a role in supporting—and influencing—policymaking. Literature reviewed indicate that the importance of these actors in the implementation of public health policies have never been taken with seriousness they deserve by the government health system as observed by Mwabu and Kibua (2008) that health planners have never streamlined the role of donor funding for purposes of good health care delivery. According to Mwabu and Kibua (2008) District

Health Systems failed to recognize the role of private sector and NGOs in the delivery of health care services in the districts despite the important role played by private sector and NGOs especially the mission facilities located in under-served areas (Mwabu and Kibua, 2008).

4.5.3 Relationship of Stakeholders

In public health implementation, individual and institutional relationships are important as it allows proper coordination in the areas of cooperation. The researcher sought to know how the government, NGOs, private healthcare givers and the community relate in their day to day business of providing health services. Data tabulated on relationship is presented in table 4.11

Table 4.11 Relationship of Stakeholders

Relationship	Frequency	Percentage
Good	130	42.8
Very Good	6	2.0
Average	154	50.7
Poor	4	1.3
Non response	10	3.3
Total	**304**	**100**

Source: Field data, 2015

From the data collected response showed that (42.8%) termed relationship has good, (2.0%) has very good, (50.7%) has average and (1.3%) has poor. From these data

obtained it can be deduced that the relationship is fairly good. These stakeholders should strengthen their partnership in areas they co-operate especially the areas of health education and awareness, maternal health, ambulatory care, referrals and immunizations as these were the major areas respondents cited has the major ‘areas of cooperation’. However, county government officials mentioned some hiccups in its relations with the national government in implementations of health programs. County official interviewed had this to point out:

> *“The relationship between the national and county government sometimes is constrained. The national government is not committed in increasing the funds for policy implementation, usurps the roles for county governments in the implementation thereby creating ‘bad blood’ between these two levels.”*

The same challenge is supported by the literature reviewed. According to Transparency International (2011) there is poor coordination and implementation of public health policies among various implementing agencies which leads to duplication and scramble for the scarce resources. Despite these hiccups, cooperation among implementing stakeholders is critical for successes. World Bank, (2011) underpinning importance of cooperation among actors argues that while the role of the private sector in African healthcare continues to be “contentious”, better collaboration between both the public and private sectors will be crucial to improving healthcare provision in Africa. In many cases, governments and multilateral donors are likely to look to public-private partnerships (PPPs) as the most efficient way of extending high-quality healthcare across the continent (World Bank, 2011). The same sentiments are echoed by Economic Intelligence Unit (2011) that large-scale collaborations have already been critical to developing medical treatment such as the Medicines for Malaria Venture and the International AIDS Vaccine

Initiative and other initiatives have aimed to strengthen health services by developing a comprehensive approach to prevention, care, treatment and support.

4.6. Financing of Public Health Policies in Baringo County

Funding for public health policies is important for those policies to realize their intended objectives. Finance is a constraint that determines the success or failure of policies as meager budgets hinders implementation. Consumers of public health policies can also be constrained by the health care finances that often limited their choices of maximizing health care services provided within their locality. In an attempt to find out the level of funding for public health policies, this research operationalized the following variables: the health facility attended by respondents, charges in those visits, the mode used by the respondents and their perception about the cost vis a vis the quality of services offered.

4.6.1 Health Facilities Attended in the Last One Year

The choice of a health facility is motivated by individual needs, proximity, costs and quality of services offered. Some of the operationalized variables are; Government, Private, N.G.O Funded facility and Traditional Doctor. Data on facility attended is presented in table 4.12

Table 4.12 Health Facilities Attended

Health facilities	Frequency	Percentage
Government	190	62.5
Private	101	33.2
N.G.O Funded facility	7	2.3
Traditional Doctor	6	2.0
Total	**304**	**100.0**

Source: Field data, 2015

From the findings it was evident that; (62.5%) visited Government facility, (33.2%) visited Private facility, (2.3%) visited N.G.O Funded facility and (2.0%) visited Traditional Doctor. From the findings it was deduced that government facility has the most visits and thus plays a key role in health management. It also indicates that residents have faith in the government managed health facilities although others prefer private health facilities because of the convenience and quality of services they offer. The data obtained seems to validate the KPMG report (2012) on the future of health care financing that at the moment the governments which are successfully addressing their populations' medical needs are combining direct expenditure with other financing models. In some, government chooses to finance the administrative side of healthcare, leaving specific projects relating to the control of epidemic diseases to external donors, and more and more medical services to the private sector (KPMG, 2012: 9). The data calls for planners

to put more resources and attention to governments health facilities has they remain preferred health care facility by the residents.

4.6.2 Charges per Visit in Health Facility

The researcher found it important to establish on the charges per visit. Charges are usually calculated based on amount spent or rather the total cost incurred. This data is presented in table 4.13.

Table 4.13 Charges per visit in health facility

Charges	Frequency	Percentage
Expensive	93	30.6
Moderate	180	59.2
Cheap	26	8.6
Very Expensive	5	1.6
Total	**304**	**100.0**

Source: Field data, 2015

From the data gathered it was evident that (30.6%) of the respondents cited charges being expensive, while (59.2%) cited charges being moderately, (8.6%) cited charges being cheap and (1.6%) cited charges being very expensive. From the findings it can be deduced that most respondents go for affordable health services. It is evident that majority of the residents prefer government managed health facilities due to their moderate costs. In the provision of health care, costs are critical because it can discourage users from utilizing the facility especially when other providers are available for choice.

Government officials interviewed cited the costs that are passed to the residents as a cost sharing costs. This is what one of them had to say:

> *"These costs are meant to boost the management of the health facility thus there is no free health care in public health facilities for older citizen unless for children under the age of five and maternity services for women. This money recovered is used to finance operations within the health facility for better service delivery."*

According to the literature reviewed, the rationale for cost sharing was to charge those who make most use of the curative care and those who are most able to pay and channel the subsidies to those least able to pay (Owino *et al*, 1997). However, previous studies reveal that in many public health systems the scheme turned out to be an avenue to siphon public funds from the users and was marred with a lot of challenges in the process of implementation. According to Mwabu *et tal* (2004) more than a decade after its implementation, the cost sharing program has not fully addressed the problems of the vulnerable and has not promoted access to modern healthcare. Implementation problems and institutional weaknesses mar the program and there has not been corresponding improvement in the quality of healthcare (Mwabu *et tal*, 2004). Nevertheless, literature reviewed has lauded this policy in other parts of Africa. For instance, World Bank (1994) lauded experiences from the initiative where community were involved in cost sharing mechanisms in support of primary healthcare suggested that cost sharing in local health centers paid significant dividends. In countries like Benin, Guinea and Nigeria where experiences have been closely monitored, local operating costs (including salaries) are being covered by user fees in facilities participating in the Bamako Initiative (World Bank, 1994). It is therefore important for government to relook in to the implementation

of this noble policy and make a comparison with those countries that were able to achieve their objective for a better and affordable health care provision.

4.6.3 Mode of Payment in Every Healthcare Visit

The researcher found it important to establish on the mode adopted by the respondents in settling their hospital bill. The modes adopted are based on convenience and affordability. This information is presented in table 4.14

Table 4.14 Mode of Payment in Every Health Care Visits

Mode of payment	Frequency	Percentage
Out of pocket	260	85.5
NHIF	44	14.5
Total	**304**	**100.0**

Source: Field data, 2015

From the data collected it was evident that (85.5%) do use out of pocket and the remaining (14.5%) do use NHIF. From the findings it can be deduced that out of pocket and NHIF are the common modes used in Baringo County. The use of out of pocket in settling medical bills in health is not cost effective. Moreover, many of those who were beneficiaries of NHIF insurance scheme still opted for out of pocket spending because the scheme was only valid for hospital bed occupancy and not for outpatient service. In

addition, many health facilities in Baringo were not NHIF approved facilities thus constrained the residents from benefiting from the insurance scheme. According to Economic Intelligence Unit report 2011, direct payment at point of use is the least-optimal way of financing healthcare, as in poor countries in particular, dramatic and expensive ailments can push the poor into bankruptcy, or else high costs can dissuade people from seeking desperately needed medical care. From the data collected, proper education and awareness should be enhanced in the communities for residents to register and pay for health care insurance to reduce the burden of health care financing. The same observation was supported by literature reviewed that for an unchanged level of government and external funding, improving Africa's healthcare expenditure profile will thus mean shifting private expenditure from direct payment to prepaid or pooled expenditure (KPMG, 2012).

4.6.4 Quality of Services Rendered in the Public Health Facility

The researcher was keen to establish the quality of service on residents well being. This was to verify whether the respondents are comfortable with the health policies in the local health facilities. This data is presented in table 4.15

Table 4.15 Quality of Services Rendered in the Public Health Facility

Quality of services	Frequency	Percentage
Good	68	22.4
Poor	51	16.8
Fair	185	60.9

Total	304	100.0

Source: Field data, 2015

From the data collected it was evident that (22.4%) of the respondents termed services offered within health facilities to be good, while (16.8%) termed services to be poor, and (60.9%) rated services to be fair. This implied that the services are averagely good and thus meet residents need. However, the county government officials interviewed during the study pointed several challenges that have hindered the provision of quality services to the residents of Baringo:

> *"The finances that are allocated to the health sector are not enough to effectively implement the public health programs within Baringo County. For instance in the last financial year, KSH.1.3 Billion was allocated to health ministry and 1Billion were used on salary for medics and support and administrative staff leaving 300million to implement other health programs within the entire Baringo."*

According to the County government officials, national government revenue allocation to Baringo is meager because the County has never been considered a marginalized region to attract the equalization fund which in his view would help to fund health programs. The finding concurs with Mwabu *et tal,* (2004) that Kenya has invested heavily in healthcare in terms of infrastructure and health personnel training but the quality is still low due to various reasons including inadequate financing, inadequate medical supplies, lack of transport, and imbalances in staffing.

It was also established from the study that services were still centrally allocated across different regions of the County despite the decentralization of health care provision as the best way of providing public health care. This is contrary to World Bank report(1993)

that decentralization is a key component of heath sector reform of decentralizing fiscal, administrative, ownership and political authority in the health sector from the ministry of health(MoH) to lower levels which has been advocated as one of the ways through which efficiency in delivery of healthcare services could be improved. According to a senior technical County Public Health official interviewed, there is uneven resource allocation on health within the County budgets and priority spending within the department of health. This is what he pointed out:

> *"Resource allocations for various community projects are neither informed by community concerns and priorities nor indicators from the grassroots but from competing political interests. Such a kind of allocation is likely to compromise sustainability and equity within and across different regions of the county."*

This data is consistent with the literature reviewed that not only is Kenya spending a relatively low amount as a percentage of GDP on healthcare, but the allocation of funds to public facilities has been uneven (KPMG 2013). According to the public health official interviewed centralized resource allocation for health compromises technical efficiency (cost-consciousness at the periphery) and allocative efficiency (allowing the mix of services and expenditures to be decided and shaped by the local users' choice) necessary for effective and efficient service delivery. Proponents of devolution have always feared the role power elite can do to undermine devolved initiatives. For instance, Sott-Herridge (2002) while assessing devolution in Uganda observed that mechanism of participation should be in place in determining service priorities yet this is not fully effective as local elites still seek to determine priorities and local people are not always consulted.

4.7 Challenges Facing Public Health Policy Implementation in Baringo County

Health sector has a number of challenges and some of the challenges include; expensive drugs, services being far, Services not fast, Health officials are absent and Lack of Drugs. This information is presented in table 4.16

Table 4.16 Challenges Facing Public Health Implementation

Challenges	Frequency	Percent
Drugs are expensive	123	40.5
Very far	23	7.6
Services not fast	102	33.6
Health officials are absent	52	17.1
Lack of Drugs	4	1.3
Total	**304**	**100.0**

Source: Field data, 2015

From the data gathered it was evident that (40.5%) of the respondents intimated that the main challenge is expensive drugs, (7.6%) rated services being far as a challenge while (33.6%) attributed slow service delivery to be the major challenge, (17.1%) of the respondents blamed absenteeism by health officials and (1.3%) of respondents rated lack of drugs to be the challenge. This implied that there are several challenges facing the management of health in Baringo County. Most of the respondents expressed displeasure on the provision of drugs in public health facilities citing cases where doctors prescribe them drugs and refer them to private chemists to purchase them yet the government has the responsibility to provide drugs. Literature reviewed concurs with the fact that availability of drugs has been a challenge in the Kenya's health system. According to Mwabu *et tal,* (2004) majority of Kenyans have limited access to essential drugs or pay

high prices for the available drugs. Non-availability or unsteady drug supplies in government health facilities has led many patients to rely on private. The attempt to sell low-cost drugs through community pharmacies (the Bamako Initiative) to the poor has been unsuccessful due to inability to sustain the drug funds (Mwabu *et tal,* 2004). In addition, many respondents attributed lack of drugs to wide spread corruption where health personnel steal drugs from public health facilities and sell them to private chemists operating within the area .

According to policy makers interviewed, it became evident that corruption hinders the provision of health service delivery through the hiring of personnel where favors` are given and procurement of drugs where kick-backs are solicited. W.H.O, (2001) warned that with corruption as a cause and effect, the result has been the deterioration of general health among individuals and degradation on of the health system in developing countries. According to W.H.O (2001) corruption drastically reduces the resources available for health, and lowers the quality, equity and effectiveness of healthcare services. It also decreases the volume and increases the cost of provision of health services and discourages people from the use and payment for health services and ultimately has a corrosive impact on the population's level of health (W.H.O, 2001). The same sentiments were echoed by Transparency International (2011) that corruption in the health sector also has a direct negative effect on the access to and quality of healthcare.

Again, the residents drawn from pastoralist communities were constrained by the distances travelled to seek medical care. The distances in times of emergencies constrain treatment and often results to loss of lives in the process as noted by a resident from Tiaty Sub County:

> *"During times of emergencies as pregnant women giving birth or casualties during conflicts, victims take long times to get medical attention which often leads to deaths or serious fatalities. The problem is further sustained by rocky terrains, poorly maintained roads and lack of effective communication for ambulatory assistance in those affected areas"*

The response obtained agrees with Mwabu *et al* (2004) that transport is also grossly inadequate in public hospitals and in many district hospitals, there is only one vehicle available for patients and staff and this affects transportation of medical supplies and causes delays in transferring patients to referral hospitals. There is also tendencies that medical personnel are absent in public health system. The information obtained linked their absence to private practice or hiring by private clinics which consumes much of their time needed to serve the public in the government health facilities. This concurs with Kimuyu *et al*, (2000) that many experienced health personnel employed in the public sector are also operating own clinics and hospitals, or are employed in the private sector, a situation which limits hours the staff can work in public health facilities.

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter presents summary of the findings of the study, conclusion, recommendation and suggestion for further research. Recommendation and implication for further research are deemed necessary so as to enhance greater implication of health issues on individual well being. The chapter begins with the summary of background information of the respondents followed by the objectives of the study.

5.2 Summary of Findings

This study sought to answer the following objectives: to identify various public health policies in Kenya, to establish the role of various stakeholders in the implementation of public health policies in Baringo County, to assess the financing of public health policies in Baringo County and finally to establish challenges that affects the implementation of public health policies in Baringo County. The study drew the following findings.

5.2.1 Demographic Information

This part of the chapter presents the summary of the background information of the respondents. The demographic features of the respondents provide a base for further analysis of the specific research objectives and their findings using descriptive statistics, tables, frequency and percentages.

The researcher sought to establish age of the respondents because age is a demographic feature that affects behaviors or perception of respondents. From the findings it was evident that (70%) of the respondents lie between 25 and 35 years. The specific variables used to investigate on the gender of the respondents were male and female. From the findings it was evident that irrespective of the imbalance both the male and the female respondents do understand the importance of health policies in managing individual health. Family size is associated with demand in terms of need and wants. From the findings it was evident that most of the members are above 3 hence the families are big. The level of education of the respondents was done using Never went to school, Primary School, Secondary School, Tertiary Level/College and University. From the findings it was evident that over (92%) of the respondents went to school thus boosting the literacy level hence they do understand the importance of health policies on citizens well being and can participate in the process of implementation. From the findings it was evident that mixed farmers were the majority and business men and women followed and pastoralists followed respectively. Energy is crucial as it is used to cook and to light. From the findings it was evident that the usage of gas is not common among the residents. Moreover, (97.7%) of respondents use firewood and charcoal because it is readily available and affordable.

5.2.2 Public Health Policies Existence in Baringo County

The study found it important to establish on whether some health policies exist in Baringo County. According to Mwabu and Kibua, (2008) awareness is important for stakeholders in the implementation process. It is captured by the number of local media adverts, distribution of posters, and public announcements of impending stakeholders

meetings and whether the local authorities have conducted civic education especially as relate to the role of the community on the preparation and implementation of public health policies (ibid). Awareness is prerequisite for participation. From the data collected it was evident that over (72 %) of the respondents were aware of health policy existence. This means that majority of the residents are aware of existence of public health policies and programmes being implemented by government and other partners in their locality. It is therefore evident that the government has made a huge stride in coming up with public health policies awareness programs and ensuring that their implementation is carried out at grassroots level. However, residents that indicated were not aware of public health policies were largely drawn from pastoralist communities that keep on moving from one area to another in search for water and pasture for their livestock. The researcher found it important to identify the agents involved in health policy implementation. From the findings it was evident that the national government is the main agency of implementing health policies at (46%) followed by county at (26%) and community at (3%). This indicates that residents have not felt the presence of county governments in implementation despite devolution of health care implementation in the new dispensation. Moreover, the role of the community in implementation has been downplayed by policy makers and planners yet community is important for the implementation of primary health care. The findings negates the spirit of devolution that gives impetus the role of local levels in the implementation of health care as acknowledged globally as the ‘best practice’ of health care provision as noted in the literature that for provision of Primary Health Care, there is an even stronger argument for decentralization. This is based on PHCs underlying values that advocates for

community participation and greater responsiveness to the needs of community (W.H.O, 1978). In the recent years, decentralization has been promoted by advocates of health sector reform as a means of improving efficiency, quality of services, promoting democracy and accountability to the local population (Bossert, 1998). Therefore, the continued centralized implementation of public health policies need to gradually pave way for county government to fulfill the spirit and the later of constitutions that guarantees citizen to take charge of their own health care through county governments. Information is knowledge as it impacts the community positively. The role of information in the implementation of public health policies has been captured in the literature by Olsen and March (1984) that reiterated the importance of how information is collected and exploited for the purposes of proper policy implementation by various stakeholders. The source of information varies based on the personnel involved and the medium used. From the findings it was evident that residents obtained information from the health facility and the media. For effective implementation of decentralized health care strategy other modes of passing information such as civic education, use of lay health workers, and use of posters to relevant stakeholders especially the communities need to be explored for proper decision making and implementation.

5.2.3 Role of Stakeholders in the Implementation of Public Health Policies

The researcher found it important to establish on whether the residents are involved in public health program. From the findings it was evident that (71.7 %) of the residents are not involved or rather they do not volunteer in initiating health initiatives or policies despite (86.2%) of residents indicate that community has a major role in the implementation of public health policies. Despite findings revealing that stakeholders

have a significant role in public health implementation, literature reviewed contradicts the results. According to Mwabu and Kibua (2008) past government effort to involve the stakeholders in countries development effort have been constrained by poor administrative capacity, limited financial resources and inability to link policy, planning and budgeting by involving the stakeholders. According to Mwabu and Kibua, policy making, planning, and budgeting in Kenya take place independently of each other, translating in to resource being allocated thinly across numerous projects that do not emanate from stakeholders. Communities' involvement in development of policies has always been effective in implementation process as they help develop the right strategies for the job to be done. From the data collected it was evident that the success of the implementation of a health policy will depend on the people realizing its benefits and impact through participation. According to UNDP (2004), the concept of participation which embraces transparency, openness and making demands in both public and private setting can be widened to include: engagement of people without taking part in decision making, sensitizing the of people to increase their receptivity and respond to development; active processes where people take initiative and assert their autonomy ; fostering dialogue with local people during project planning, implementation and management; voluntary involvement of people in self-determined change and self-development. This further means it is important to involve the people in the implementation process and consider their views. It is imperative to strengthen the relationship of all these stakeholders and multi-sectoral collaboration for the effective implementation of health care if PHC is to be realized under a decentralized system of governance.

5.2.4 Financing of Health Care Policies in Baringo County

The choice of a health facility is motivated by individual needs and capability. From the findings it was deduced that government facility has the most visits at (62.5%) and thus plays a key role in health provision. This implies that majority prefer the public because of the moderate costs and convenience. The response is consistent with (Mwabu *et tal,* 2004) that private and mission health facilities and public hospitals are important sources of health services for the non-poor in Kenya while health centers in rural areas and urban slums are the mainstay healthcare providers for poor patients (ibid). Therefore, improvement in rural and basic urban health facilities would be more beneficial to the poor. Policy makers interviewed cited poor funding or lack of it that constraints implementation of health care within the county. This response seems to confirm the Economic Intelligence unit report (2011) that financing of healthcare in Africa remains a patchwork of meager public spending, heavy reliance on foreign donors and a large dependence on out-of-pocket contributions and user fees that place the greatest burden on the poorest members of society. In Kenya, Health care is still underfunded and meager resources are shared among different health programs that that are devolved. According to the Kenya Human Development Report (1999), government financing of health expenditure is about 60 percent of what is required to provide minimum health services, therefore implying that healthcare delivery in Kenya is under-funded. As noted by KPMG, (2012) the annual health budgetary allocation is approximately 4% of the total GDP which is a way far from the Abuja declaration of 15% of the annual total GDP. The

Abuja Declaration requires countries to allocate at least 15 percent of their total national budget to the health sector. The revised methodology should involve aggregation of health budgets of the 47 county governments and the MOH. According to national and county Budget review report of FY 2014/2015, the combined (national and county) allocations to health by Kenya is estimated to have increased from 5 percent in FY 2013/14 to 7.5 percent in FY 2014/15. However, both the FYs 2013/14 and 2014/15 estimates are lower than the 7.8 percent reported in FY 2012/13, before devolution was implemented. With the new estimates, Kenya is far from achieving the Abuja target (G.o.K, 2015).

The research also established that Primary Health Care funding attract little funding despite the importance of PHC in prevention and promotion of disease control within the communities as provided in the various policy documents. For instance, the Kenya Health Policy Framework (G.o.K, 1994) advocates a shift towards increasing financial resources to community programs and preventive measures, which are more cost effective in reducing disease incidence and burden. The reality on the ground is the opposite of the policy recommendations where PHC is underfunded despite existence of their recognition in the policy frame works.

The researcher found it important to establish on the charges per visit. From the findings it was found that most residents go for affordable health services offered by the government which were moderate and affordable and among those who attended medical care. From the findings, (85.5 %) settled their bills through out of pocket spending while the remaining (13.5%) had registered in public insurance scheme (NHIF). It can be deduced that out of pocket and NHIF are the common methods used in Baringo County.

There are several barriers that hinder the public from properly benefiting from the insurance scheme. The respondents interviewed cited cases of distances in getting registered, few available NHIF approved facilities within the region and failure to cater for outpatient service. Mwabu, *et al, (2*002) concur with such challenges that the fund is characterized by problems of weak administrative system, poor investment portfolio and low claim settlement. Most of the registered health facilities with NHIF are rarely used by the poor. The poor use local clinics and dispensaries, which are not registered by the Fund, and therefore do not get reimbursed for the medical expenses they incur even though they are members of the Fund (Mwabu, *et al, 2*002). The pattern of healthcare financing implies that the poor are subsidizing the rich as the poor rarely claim for reimbursement from the Fund (Mwabu, *et al, 2*002). However, during times of chronic illnesses, individuals using out of pocket payment shall incur the escalating costs pushing them to financial problems as paying at the point of illness is expensive compared to prepaid or pooled payment . The study further established that cost sharing policy is still operational despite other scholars citing its failure in theory and practice. For instance, according to Mwabu *et al,* (2004) more than a decade after its implementation, the cost sharing program has not fully addressed the problems of the vulnerable and has not promoted access to modern healthcare. Implementation problems and institutional weaknesses mar the program and there has not been corresponding improvement in the quality of healthcare (Mwabu *et al,* 2004). March and Olsen, (1984) gives a good recommendation on such policies as cost sharing that policy programs should routinely be scrutinized to establish relevance to bring desired change. Therefore, relevance of

government policies such as cost sharing introduced in the late 1980s as a cost recovery strategy needs to be evaluated to establish their viability in healthcare funding.

5.2.5 Challenges Facing Public Health Care in Baringo County

Challenges are inevitable and thus the health sector has a number of challenges. From the findings it was evident that there are several challenges facing the management of health in Baringo County. According the findings, government officials blamed lack of financial resources has a major obstacle to the implementation of the public health policies especially the implementation primary health care within the communities. Poor governance further emerged as hindrance to health service delivery in the area as public official engaged in blatant corruption through illegal selling of drugs meant for the poor and corrupt recruitment of personnel that undermine quality offered. According to Transparency International (2011) there are several problems related to governance in the discharge of health services in Kenya. Issues of transparency and accountability, equity and effectiveness and responsiveness and health rights are but some critical pillars of governance and high levels of corruption at various levels in the sector especially in the procurement of drugs and medical supplies are hindering many donors from working with the government or MoH directly (Transparency International, 2011). On the other hand lack of appropriate skills by the health professionals, policy planners and their support staff drastically compromises quality of service delivery offered in public health facilities. Mwabu and Kibua, (2008) reiterate that availability and quality of human

resource within an organization are critical factors that influence the capacity of an organization to deliver services. Residents further indicated that the public health personnel and drugs were not enough in their locality. This concurs with Government of Kenya, (1994) that health system suffers from inequitable spatial distribution of health services; shortages of health personnel; poor management of health services; inadequate funding; lack of medical supplies; low level of hospital operational efficiency; and lack of proper public health information and education. These challenges can only be managed if the governments both at national and county level take proactive measures to address them for better health care to the residents of Baringo County.

5.3. Conclusion

The study set out to assess the challenges in the implementation of public health policies using available literature and primary data obtained from questionnaires issued to residents and interviews with policy makers both at national and county level, NGOs operating in the area and senior health professionals.

5.3.1 Public Health Policies Existence in Baringo County

From the findings the study concludes that indeed residences do know the existence of health policies and their role in the implementation and impact of implementation has been felt in almost every part of the county. This reveals that the government is disseminating information to the residents on health care policies to be implemented within their locality. Residents obtained information from the health facility and the media. This is important for individual screening and appropriate measures before a disease arise. Therefore, frequent checks are encouraged among the residents. The

success of the implementation of a health policy will depend on the people realizing its benefits and impact of such initiatives. This further means it is important to involve the people in the implementation process and consider their views.

5.3.2 Role of Stakeholders in the Implementation of Public Health Policies

The findings conclude that the national government is the main agency of implementing health policies despite health being a devolved function. Private sector and NGOs were acknowledged by residents as having a role to play in the provision of health care especially in areas where the government services are inefficient, ineffective and nonexistent. The study calls for collaboration between these stakeholders especially central government and county government to ensure the health policy is fully implemented.

5.3.3 Financing of Health Care Policies in Baringo County

The findings highlighted ineffective funding of public health policies greatly hindering provision of health care under decentralized system where more responsibilities have been devolved. Resource allocation is not informed by priority needs from the communities but politicians make decision s based on their political interests. This is likely to hinder equity and sustainability in the county. Again, the common mode of payment for health services by the residents is ‘out of pocket’ where they pay at health facility and NHIF commonly used by those working class residents living in the area. The use of out of pocket in paying for health greatly disadvantages the poor members of the society since it is expensive mode of payment. The use of cost recovery measure

popularly called cost sharing at its present form lack relevance under the new dispensation. The government should re-evaluate the policy for effective and affordable health care funding.

5.3.4 Challenges Facing Public Health Care in Baringo County

The study concludes that poor governance hinder the provision of health service within the health systems. The illegal selling of government drugs to private chemist, poor management of financial resources that emanate from the cost sharing program, kick-backs from procurement of drugs and policy implementation and soliciting favors for employment within the health systems weaken the capacity and proper functioning of health care system in Baringo.

Finally, the study concludes that the services are averagely good and thus meet residents need. In addition there are several challenges that adversely affect the provision of health care in Baringo County. These include: poor financing of public health policies, lack of participation among various stakeholders in the implementation process especially the community and NGOs that plays a crucial role in the realization of Primary Health Care, policies, lack of proper regulation and clarity of roles between the national and county government, lack of provision of necessary equipments, drugs and personnel.

5.4 Recommendations

5.4.1 Public Health Policies Existence in Baringo County

From the findings of the study the researcher recommends that government and other implementing partners should recognize the importance of involving residents in implementation of public health programs for a sustainable and cost effective management of health problems. The policy implementation should be informed by community priorities and not political patronage that negates the spirit of participation provided in the new constitution. The continued neglect of the users of health care simply mean health care provision still remains centralized as it alienates the residents in taking charge of their own health. Community members can be incorporated in implementation of non-specialized areas of public health such as creating awareness; management of health facilities, home based health care, maternal health care and monitoring of health situations in their area of jurisdiction.

Government and Nongovernmental organizations to disseminate information to the residents on health policies so as to enable them participate in every step of the policy processes. The use of media, posters, civic education strategies that train the residence on the importance of health and how to manage community health in their locality must be emphasized by government institutions. This can be done through hiring more Community Extension Workers and Community Owned Resource Persons (CORPS) who shall educate community on basic health care services. This is consistent with Smokes' (2003) submission that information, education and incentive for behavioral change are critical. The government should emulate other countries where such initiative has succeeded in revolutionizing their health care system such as Ethiopia and India.

5.4.2 Role of Stakeholders in the Implementation of Public Health Policies

The integration of stakeholders' interests and strategies incorporating activities of donors, private sector and NGOs within the county will go a long way towards enhancing the provision of quality health care. This calls for restructuring of health system to allow for joint planning, budgeting, implementation, monitoring and evaluation of all health projects in the county. The Swap (Sector Wide approach) created by government should be implemented fully so that it can create necessary policy framework to ensure private sector, NGOs and donors are brought together for joint planning and management processes at the county level.

5.4.3 Financing of Health Care Policies in Baringo County

The study recommends increased budgetary allocation to the health sector. The biggest challenge to the provision of health care is lack of enough resource which has hindered the provision of essentials services offered at secondary and primary level of health care. The current equitable share allocated to Baringo county government is meager for implementation of critical services such as health care. Furthermore, the county government should apportion more funds to health department in the budgetary allocation and ensure that the allocation is informed by priority health needs from the community other than political patronage. Cost sharing strategy should be re evaluated to establish its viability as a cost recovery strategy in the new dispensation. Sensitization of residents to enroll for prepaid or pooled payment for health care other than relying on out of pocket spending which is expensive in the long run need to be emphasized especially in the rural areas. The government should restructure the public health care insurance popularly called NHIF, to accommodate outpatient services and to cater for the less privileged members of the society. The scheme should be made available in all public health

facilities located in the rural areas. The government can borrow a leave from African governments that have excelled in improving health insurance cover for majority of their citizen such as South Africa, Tunisia and Ghana.

5.4.4 Challenges Facing Public Health Care in Baringo County

The study recommends the government to establish health facilities and equip them with personnel, drugs and health equipments especially in far flung areas of Baringo.

The study recommends improvement of governance within the health sector. Corruption must be checked especially in the procurement of drugs, employment and implementation of programs. Health management system must prudently use health care resources for successful implementation of policies. Governance can also be enhanced through creation of active Communities Based Organization (CBOs), NGOs and strong civil Society Organizations (CSOs) to provide checks and balances at both national and county level and more importantly is the decentralizing services of Ethics and Anti Corruption Commission (EACC) to all the counties to tame corruption. With the devolution of health care, governance should be a pillar for its success. Therefore transparency and accountability must be exercised by individual, communities and institutions involved in implementation.

5.5 Suggestions for Further Study

The study recommends four areas for further research:

a) The findings reflect implementation of public health in Baringo and may not effectively explain what happens in other Counties in Kenya. The researcher therefore suggests a similar study be done in other forty six counties.

b) The researcher noted that Baringo county government is two years old in implementing health policies under the devolved arrangement and it is experiencing some teething problems. The study suggests a study be done to fully ascertain effectiveness of other county governments in implementing primary health care policies five years after their promulgation.

c) The study suggests an inquiry whether there is equity in the distribution of health care provision among 47 counties in Kenya and regions with a county and establishes criteria used by policy makers in sharing health care resources.

d) The study finally suggests that a comparative study to be done on the governance of health care between the old system of healthcare and the current health system. A comparative study on public health policy implementation should also be done between or among various counties to establish varied experiences in the devolved system for lessons to be learned and experiences shared.

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APPENDIX I: QUESTIONNAIRE FOR THE COMMUNITY AND LOCAL LEADERS

Dear respondent

My name is **ROTICH WILFRED,** Moi university student pursuing Masters of Arts in Public Administration and Policy. You have been selected as one of the respondent in

this study. The research is entitled "implementation of public health policies in Baringo County, Kenya". Health sector is critical for development in this county and your response is valuable for this study.

I request you to participate in my study by answering the questions in this form. Any information collected will be treated with utmost confidentiality and anonymity. Your cooperation, effort and time for this research is highly appreciated.

SECTION A: DEMOGRAPHIC INFORMATION

1. Indicate your age

a) 18-25 years ( ) b) 25-35 years ( ) c) 36- 45 years ( ) d) 45- 65 years ( )

2. Gender

a) Male ( ) b) Female ( )

3. What is your marital status?

a) Single ( )

b) Married ( )

c) Widow/widower ( )

d) Specify others ( )

4. What is the size of your family?

a) Below 3 members ( ) b) 3-5 members ( ) c) 5-10 ( ) d) above 10 ( )

5. State your level of education?

a) Never went to school ( )

b) Primary school ( )

c) Secondary school ( )

d) Tertiary level/College ( )

e) University ( )

6. What is your current occupation?

a) Crop Farmer ( )

b). Pastoralist ( )

c) Mixed farmer ( )

d) Business man/woman ( )

e) Student ( )

f) Government staff ( )

g). Non- governmental staff ( )

h) Others (Specify) ……………………………………………………………….

7. Which type of cooking fuel do you use at home?

a) Firewood ( )

b) Charcoal ( )

c) L.P.G (Gas) ( )

d) Specify other……………………………………………………………….

SECTION B: PUBLIC HEALTH POLICY

1. Are you aware of any public health programs implemented in your area?

a) Yes ( ) b) No. ( )

2. Do the following policies exist?

a) Primary health care ( ) b) maternal health care policies ( ) c) policies implemented by CDF ( ) d) policies implemented by the County government( )

b) Which agency implements?

a) National Government ( ) b) County government ( ) c) Joint governments ( ) d) N.G.O ( ) e) Local community. ( ) f) Specify any other …………………………………………………………………………………

c) Do you think those programs have improved health conditions in your area?

1. Yes ( ) 2. No. ( )

d) If No, in the Q.4 above, specify the reason?

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Where do you get information on policies related to health?

a) Health facilities ( ) b) Public Barazas. ( ) c) Churches. d) School ( )

e) Media ( ) f) specify other……………………………………

e) How often do you get this information?

a) Daily ( ) b) Weekly ( ) c) Monthly ( ) d) Yearly ( )

f) Do you take this public health information seriously?

a) Yes. ( ) b) No. ( )

g) If yes, in Question 9 above, specify how?

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h) If No, in Question 9 above, specify why?

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SECTION C: ROLE OF STAKEHOLDERS IN PUBLIC HEALTH POLICIES

1. As a resident in Baringo County, have you been involved in any public health program or project in your area?

   a) Yes ( ) b) No ( )

2. If No. in question 1 above, what is the reason?

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3. If yes in question 1 above, what role did you or are you playing in the program?

   a) Management ( ) b) Membership ( ) c) representative ( ) d) participant ( )

4. Did (do) you encounter any challenge in the implementation process?

   a) Yes ( ) b) No. ( )

5. If yes in Question 4 above, which problems?

…………………………………………………………………………………………

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6. Do you have public health committees in your area?

a) Yes ( ) b) No. ( )

7. If yes, specify their role.

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8. Do you think communities have a role in the implementation of public health policies?

a) Yes. ( ) b) No ( )

9. If No in question 8 above, what is the reason?

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10. If Yes in question 8 above, specify their role.

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i) Do you think Non-governmental organizations and private health providers have a role in the implementation of public health programs?

a) Yes ( ) b) No ( )

12. If No in question 11 above, what is the reason?

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13. If yes in the question 11 above, specify their role.

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14 How do you rate the relations of these stakeholders?

a) Good ( ) b) Very Good ( ) c) Average ( ) d) Poor ( )

Briefly explain your choice.

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SECTION D: PUBLIC HEALTH FINANCING

1. How many times did you visit health facility in the last one year?

a) Once ( ) b) twice ( ) c) thrice ( ) d) Four time ( )

e) More than five times ( )

2. Which among the following health facilities did you attend?

a) Government ( ) b) Private ( ) c) N.G.O funded facility

d) Traditional doctor ( ) e) Specify other……………………………………….

3. Why did you choose health facility in question 2 above?

a) Quality service ( ) b) Cheap [ ] c) Near my home [ ]

d) Specify other reason ………………………………………………

4. How do you rate their charges per visit in that health facility?

a) Expensive ( ) b) Moderate ( ) c) Cheap ( ) d) Very expensive

5. How do you settle your medical bills in any visit you make?

a) Out of pocket ( ) b) NHIF ( ) c) private insurance ( )

d) Community initiatives ( ) e) Specify any other………………………………

6. Why do you prefer the choice in question 5 above?

a) Employed ( ) b) Can afford ( ) c) Cheap ( ) d) Convenient ( )

e) Don't know other modes of payment ( ) f) any other reason……………………

7. How do characterize charges in public health facilities?

a) Cheap ( ) b) Expensive ( ) c) Moderate ( ) d) Very expensive ( )

8. In relation to question 7 above, rate the quality of service rendered in the public health facilities.

a) Good ( ) b) Poor ( ) c) Fair( ) d) Very Good ( )

9. Justify your choice in question 8 above by briefly describing the state of service delivery.

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SECTION E: CHALLENGES TO PUBLIC HEALTH IMPLEMENTATION

1. What are some of the challenges you face in seeking public health care in your area?

   a) Drugs are expensive ( ) b) Very far ( ) c) Services not fast ( ) d) Health officials are absent ( )e) Specify other…………………………………………………………

2. In response to question 1 above, what alternative solutions do you prefer?

   a) Opt for another facility ( ) b) Abscond medication ( ) c) do nothing ( ) d) specify other…………………………………………………………………

3. Do you think health professionals are enough in health facilities situated in your area?

   a) Yes ( ) b) No. ( )

4. If No, in question 3 above, what should be done?

   a) Train community members ( ) b) hire more professionals ( ) c) refer patient to Higher facility ( ) d) Specify any other……………………………

6. What are other challenges that affect implementation of public health programs in your area?

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8. Briefly elaborate solution to these problems.

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THANK YOU AND GOD BLESS YOU

APPENDIX 11: INTERVIEW SCHEDULE FOR SELECTED GOVERNMENT OFFICIALS

Dear respondent

My name is **ROTICH WILFRED,** Moi university student pursuing Masters of Arts in Public Administration and Policy. You have been selected as one of the respondent in this study. The research is entitled "implementation of public health policies in Baringo County, Kenya". Health sector is critical for development in this county and your response is valuable for this study. The information gathered will be for research purposes only.

I request you to participate in my study by answering the questions in this form. Any information collected will be treated with utmost confidentiality and anonymity. Your cooperation, effort and time for this research is highly appreciated.

SECTION A: BACKROUND INFORMATION

1) Your gender Male ( ) Female ( )

2) Your age bracket 18-25 ( ) 19-35 ( ) 36-55 ( ) 56 – 60 years ( ) 61 years and above ( )

3) Your education level Primary ( ) Secondary ( ) College ( ) Degree ( )

   Masters ( ) any other (specify) ______________________

4) Your work experience up to 1 year ( ) 5 years ( ) 6 – 10 years ( ) 11 – 15 years ( ) More than 15 years ( )

5) Which level of the government are you working?

   a) National government ( ) b) county government ( )

6) You work in which sub County? Tiaty ( ) Baringo Central ( )
   Baringo North ( ) Baringo South ( ) Mogotio ( ) Eldama Ravine ( )

7) How long have you worked in this county?

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SECTION B: PUBLIC HEALTH POLICIES

1. a) What are some of the policies put in place to address public health problems in the county?

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b) Do you think these policies are effective in addressing public health problems?

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SECTION C: THE ROLE OF VARIOUS STAKEHOLDERS

2. Are there other actors in the implementation? If they are there, name them.

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3. a) What nature of relations exists among these implementing actors?

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b) Do you think these relations affect implementation of public health policies?

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SECTION C: FINANCING OF PUBLIC HEALTH POLICIES

4. How is public health policies financed in this county?

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5. a) Are these funds enough to implement public health policies?

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c) If not, how is the deficit financed for smooth implementation?

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d) How is the allocation of fund for implementation done?

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e) Justify the criteria for allocation.

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6. How do you account for the funds used for public health policies?

SECTION D: CHALLENGES OF PUBLIC HEALTH POLIC IMPLEMENTATION

7. a) How many health personnel are staffed in the county?

   …………………………………………………………………………………

   …………………………………………………………………………………

   b) Do you think they are sufficient to implement public health policies in the county?

   …………………………………………………………………………………

   …………………………………………………………………………………

8. a) What mechanisms have been put in place to evaluate implementation of public health Policies?

   …………………………………………………………………………………

   …………………………………………………………………………………

b) Are these mechanisms effective in revealing the success or failure of a public health policy?

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c) Describe the relationship between national and county governments in the implementation of public health policies.

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b) Do you think this relation has implication on the implementation of public health policies?

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9. What other challenges that affect the implementation of public health policies in this county?

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THANK YOU AND GOD BLESS YOU

APPENDIX III: NGOs, FBOs, private and health public health professionals

Dear respondent

My name is **ROTICH WILFRED,** Moi university student pursuing Masters of Arts in Public Administration and Policy. You have been selected as one of the respondent in this study. The research is entitled “implementation of public health policies in Baringo County, Kenya”. Health sector is critical for development in this county and your response is valuable for this study.

I request you to participate in my study by answering the questions in this form. Any information collected will be treated with utmost confidentiality and anonymity. Your cooperation, effort and time for this research is highly appreciated.

SECTION A: PERSONAL BACKGROUND

Organization name ……………………………………………………

Job designation …………………………………………………….

Gender

1. Male ( ) 2. Female ( )

What is your level of education?

1. Below ‘O’ level ( )
2. ‘O’ level ( )
3. ‘A’ level ( )

4. Certificate ( )

5. Diploma ( )

6. Graduate ( )

7. Masters ( )

8. Doctorate ( )

9. Others (Specify)…………………………………………….

B: PUBLIC HEALTH POLICIES

1. What is your area of specialization within the organization?

…………………………………………………………………………………………

…………………………………………………………………………………………

2. How has your organization prepared you to handle public health policies in your area?

a) Training ( ) b) improved equipment ( ) c) good remuneration ( ) d) specify other….

3. What are common public health problems in your area?

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3. What are some of the public health policies are you implementing in your area?

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4. In relation to question 3 above, do you think those policies achieved their objectives?

a) Yes ( ) No ( )

5. If Yes in question 4 above, explain how?

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………………………………………………………………………………………………

6. If No. in question 4 above, explain why?

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7. What do you think should be done to improve the implementation of those policies?

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SECTION C: ROLE OF THE STAKEHOLDERS

1. Do you know other agencies implementing the same public health policies in your area?

a) Yes ( ) b) No. ( )

2. If Yes in question 1.above, names some of them.

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3. What are some of your area of cooperation in the implementation process?

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3. What are the challenges you face working with other agencies in the implementation process?

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4. Characterize the relation you have with these agencies in the implementation process.

a) Good ( ) b) Very Good ( ) c) Average ( ) d) Poor ( )

SECTION D: HEALTH CARE FINANCING

1. Who finance these public health policies in your organization?

a) Government ( ) b) Donor ( ) c) community ( ) d) private ( ) e) specify other…….

2. Are these funds enough to implement policies in your organization?

a) Yes ( ) b) No ( )

3. How do you fill the financing deficit in your organization?

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SECTION E: CHALLENGES OF PUBLIC HEALTH POLICY IMPLEMENTATION

1. What challenges do you face in the implementation of public health problems in your area?

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2. How can these challenges be addressed for better implementation of public health policies?

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THANK YOU AND GOD BLESS YOU

APPENDIX 1V: Yamane Table

Size of population	**Sample size (n) for precision (e) of:**			
	±3	**±5%**	**±7%**	**±10%**
500	A	222	145	83
600	A	240	152	86
700	A	255	158	88
800	A	267	163	89
900	A	277	166	90
1,000	714	286	169	91
2,000	811	333	185	95
3,000	870	353	191	97
4,000	909	364	194	98
5,000	938	370	196	98
6,000	959	375	197	98
7,000	976	378	198	99
8,000	989	381	199	99
9,000	1000	383	200	99
10,000	1,034	385	200	99
15,000	1,053	390	201	99
20,000	1,064	392	204	100
25,000	1,064	394	204	100
50,000	1,089	397	204	100
100,000	1,099	398	204	100

>100,000	1,111	400	204	100

Source: Yamane Toro, 1967

APPENDIX V: Letter of authorization

NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

Telephone: +254-20-2213471,
2241349, 310571, 2219420
Fax: +254-20-318245, 318249
Email: secretary@nacosti.go.ke
Website: www.nacosti.go.ke
When replying please quote

9th Floor, Utalii House
Uhuru Highway
P.O. Box 30623-00100
NAIROBI-KENYA

Ref: No.

NACOSTI/P/14/6750/4230

Date:
11th December, 2014

Wilfred Chacha Rotich
Moi University
P.O. Box 3900-30100
ELDORET.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ***"Implementation of public health policies in Baringo County,"*** I am pleased to inform you that you have been authorized to undertake research in the **Baringo County** for a period ending **30th September, 2015.**

You are advised to report to **the County Commissioner, the County Director of Education and the County Coordinator of Health, Baringo County** before embarking on the research project.

On completion of the research, you are expected to submit **two hard copies and one soft copy in pdf** of the research report/thesis to our office.

SAID HUSSEIN
FOR: SECRETARY/CEO

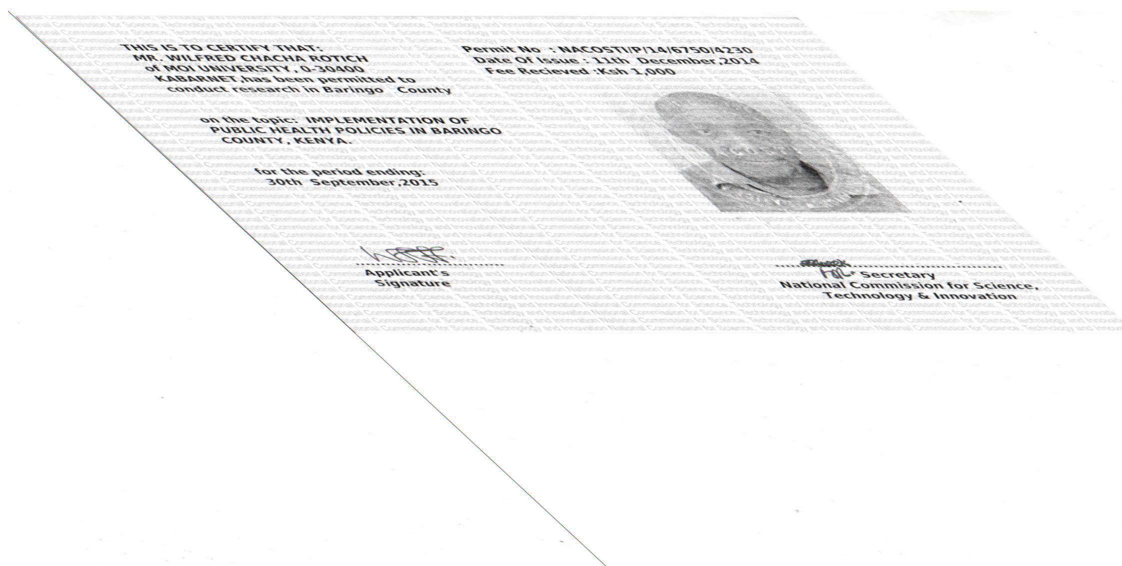
Copy to:

The County Commissioner
Baringo County.

The County Director of Education
Baringo County.

The County Coordinator of Health
Baringo County.

APPENDIX VI: Research permit



THIS IS TO CERTIFY THAT:
MR. WILFRED CHACHA ROTICH
of MOI UNIVERSITY, 0-30400
KABARNET,has been permitted to
conduct research in Baringo County

on the topic: IMPLEMENTATION OF
PUBLIC HEALTH POLICIES IN BARINGO
COUNTY, KENYA.

for the period ending:
30th September,2015

Permit No : NACOSTI/P/14/6750/4230
Date Of Issue : 11th December,2014
Fee Recieved :Ksh 1,000

Applicant's
Signature

Secretary
National Commission for Science,
Technology & Innovation