Political Devolution for Transformation of Health Service Delivery in Ugunja Sub County, Siaya County, Kenya

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ABSTRACT

The study was based on health is a political responsibility. Devolution brings the government close to the people so they can engage and challenge the elected and nominated together with the executive on accountability and transparency over the government services. A people centered health services require integration of the people in the planning, resource mobilization, and implementation for an Integrated People Centered Health Service Delivery (IPCHSD). Theories applied in the study are decentralization, public choice, and health belief model. The study aimed to explore the experiences of Ugunja Sub County dwellers on healthcare service delivery in post devolution period to describe political devolution impact on health service delivery phenomenon. The study used mixed methods approach, combining quantitative and qualitative data to understand political devolution impact on health service delivery. Data were collected through interviews and focus group discussions focusing on impacts of political devolution on health service delivery; organization of health service structure; and transformative approach to improve health service delivery.

Keywords: Political devolution, health service, people centered health service, phenomenology, Integrated People Centered Health Service Delivery (IPCHSD).

INTRODUCTION

Health is a political responsibility to ensure healthy lives and well-being of the people, animals and their environment under the UN Sustainable Development Goal 3. Devolution in Kenya is covered under Kenya Constitution 2010 (KC 2010), implemented from 2013. Health services is among the decentralized functions under KC 2010) and, this study examined post devolution period political impact on health services delivery in Ugunja Sub County, Siaya County, Kenya.

Devolution is a form of decentralization with concepts, principles and values founded on the principle of subsidiarity (Busnich, 2010; Murkomen, 2012). It brings services closer to the people and allow for the elected and government to be transparent and accountable for the wellbeing of the people governed. Discussion in this study is about people's lived experience and perception from the devolved public health facilities delivery of health service. Public services decisions in the devolved structures are made at the county level by both the executive and the legislature with minimal participation of the people who create demand for such services.

Healthcare in Kenya, as in other parts of the world, is co-produced by the state and the people. It is a collaborative effort between the national and county governments, led by the political executive (civil servants) and legislature (elected officials). This scenario often excludes the people and their real community health care needs that would include animals and environment. The health system structure leads people to depend on government provided health care services. This study seeks to understand how political devolution impacts delivery of health service. This can only be discovered by asking how people perceive delivery of their health service, and it is a phenomenon that can only be described by individuals.

The structure keeps people away from participation in policy decisions against Article 196(1)(6) of the constitution. In studying political impact on health service delivery, the following questions guided the process: i) What are the people's experiences and perceptions on their health service delivery? ii) How is

Kenya's health service structure organized? iii) What is the transformative way forward for improving health service delivery? The research was carried out in Ugunja Sub County within Siaya County, involving 163 individuals who participated in interviews and focus group discussions.

The conscious experience or how people perceive devolution impacts on health service delivery demands familiarity with politics, democracy, governance and welfare (servicing needs of an ordinary people). Politics is about who gets what, why, when and how (Lesswell, 1936). On the other hand, democracy is getting the who shares what, when and how; it may be considered a rule by the people. In the African context, democracy is when people meet to discuss, discuss, explain until they reach an agreeable conclusion. Governance on the other hand, means people participating to hold those in elected office of power accountable, and transparent, so that they may take responsibility for actions and observe human rights. *Welfare and wellbeing* are seen as one, but why devolution if we are not meeting the wellbeing of people? The answer to this question lies in the Sustainable Development Goals (SDGs) 1 to 17 that target people's wellbeing, e.g. 1 is about poverty; 2 Hunger; 3 Health and wellbeing; 4 Education; 5 Gender equality; 8 Equal employment opportunities; 10 Inequalities; 16 Social justices and 17 Partnerships to meet all goals. This study focuses on SDG 3 health and wellbeing, 16 social justices and 17 partnerships because they are all mutually inclusive in the rights to health service.

Since 2007, researcher has engaged with the government and the people on changing the quality of life and livelihood through commonality. The engagement meant being an intermediary between the people and the government as a change agent. Researcher facilitated improvement of local schools' physical facilities and performance; organic agricultural practices for food security; community health service delivery; provision of clean and safe water; environment conservation through tree planting; and infrastructure development. Through these initiatives researcher observed the relationships between the people, legislature and the executive in the governance of service delivery and related strains. It is therefore deemed necessary for changes to make government services more effective and positive in people's perceptions as opposed to the general assumptions below:

1. Government social sector services are state centered for self-interest, with most medical procurements centralized and this entrenches dependency
2. People at times require to influence government service for expediency, and this leads to corruption
3. Political interest is self-preservation through control and denial of participation maintains power position.
4. There is need for transformative way forward for effective and people centered health service delivery.

Politics And Its Influence On Health Service Delivery

In this study, we argue that health services delivery is a political choice with global linkage through World Health Organization (WHO) with the following parameters for healthcare sector activities:

1. Commitment to health equity (held self-accountable)
2. Data and management to understand populations' health
3. Comprehensive needs assessment to identify, anticipate and respond to critical societal needs
4. Collaborative partnership within sectors to deliver care
5. Care continuity through planned care and transitions to prepare for patients changing needs
6. Engaging patients in care by designing individualized care, a clinical focus
7. Community informed and patient centered care, a people centered approach

This background sets the ground for understanding the problem of lack of commonality and consistency in the healthcare delivery. Consequently, health service delivery is a phenomenon that appears to an individual in their conscious experience (Moran, 2000). The service is devolved under the Kenya 2010 Constitution that transferred or devolved functional authority that are fiscal, administrative and legislative responsibility for social sector services, among them health service. Irlbacher-Fox, & Mills, (2007) describe devolution as a transfer of functional authorities to sub national governments from the national government. The devolution brings services closer to the people in order to serve their needs.

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This study focuses on SDG 3 health and wellbeing, 16 social justices and 17 partnerships because they are all mutually inclusive in the rights to health service. SDG 3, explains health as a common good which every person should enjoy as part of human development agenda. This particular function is overseen by the World Health Organization (WHO), a United Nations (UN) agency that operates with the aim of achieving three main objectives: enhancing the overall health of the population, meeting the reasonable expectations of the served population, and generating funds to improve health in an equitable manner.

These objectives are coordinated at both the global and country levels, as they are considered to be political responsibilities (Jones & Potvin, 2017). The WHO and World Bank utilize various indicators to assess the delivery of health services, including quality, cost effectiveness, acceptability to citizens, good governance, public choice, managed competition, quasi-commercial provider, efficiency, and market-based approaches. However, it is important to note that despite the critical role played by the WHO in directing and leading health funding, there is a significant reliance on external sources of funding (Sales et al., 2012; Labonte et al., 2008). These arguments suggest that the WHO operates on a market-oriented approach in order to provide funders with a return on their investment in serving the population.

The concept of a health system, as defined by the World Health Organization (WHO), encompasses a collection of entities, individuals, and activities that are primarily focused on advancing, recovering, or preserving health (Jones, Clavier & Potvin, 2017). The system aims to enhance health equity through responsive, fair, and efficient resource allocation; however, the organization is confronted with two obstacles. It is skewed towards curative care, which makes it not holistic and, is therefore dependent on government revenue that is determined by political and power interests.

Healthcare systems require well-coordinated frameworks, networks, resources, information, and skilled individuals with strong ethical principles. However, the management of healthcare services is hindered by sectoral perspectives and a failure to prioritize understanding the actual needs of the community for efficient resource allocation, coordination, and ethical decision-making. The concept of devolution highlighted in this research emphasizes the importance of comprehending the contextual factors and relationships among political entities (elected officials and executives), the general population, non-governmental actors, and various processes (Carrin, 2009). Because the actors in health are diverse with different decision centers, a *circular* coordination is indispensable

Political And Health Governance In Kenya

Devolution in Kenya means the sovereign power of the people is exercised at two levels of government with values and principles recognized in Article 10 of the 2010 Kenya Constitution. Article 6 (2) provides that "The governments at the national and county levels are distinct and inter-dependent and shall conduct their mutual relations on the basis of consultation and cooperation."

Article 43 of KC 2010 makes delivery of health service one of the most important right for every human condition and a way for fighting poverty

Health is a devolved mandate as outlined in the 2010 Constitution of Kenya, however, it still involves collaboration between the national and county governments (Constitution Articles 20, 21, 26, 32, 46, 53-57, 174-175, 189-191, and Fourth Schedule). The Fourth Schedule of the 2010 Constitution assigns significant accountability to the counties for healthcare service provision in order to achieve the devolution goals of ensuring access to healthcare services as a right. To achieve devolution objectives, the county governments have all the instruments of power necessary in discharging their functions to: enter into contracts; acquire, purchase or lease any land; delegate any of its functions to its officers, decentralized units or other entities within the county; enter into public private partnerships (PPP); and to establish agencies. Nonetheless, with all the powers and constitutional framework, the right of communities to manage their own affairs and to further their development and participation is not practiced. This argument is supported by Article 196(1)(6) of the Constitution of Kenya, 2010 provide that "A County Assembly shall facilitate Public Participation and involvement in the legislative and other businesses of the Assembly and its Committees". This point to the elected leaders' unwillingness to facilitate constitutional mandate to the sovereign power of the people. The discussion drives for a circular or polycentric coordination because there are different actors and different decision centers.

Our personal experience on healthcare inadequacy and empirical literature affirms the need to improve on delivery of healthcare in Kenya as well as Africa in general. The 2017 Kenya Comprehensive Public Expenditure Review (CPER) highlights governance challenges related to the division of responsibilities for health, with 62.56% allocated to county governments, 20.72% to the national government, and 16.72% shared between the two. This indicates a necessary collaborative effort between the national and county governments to access 37.44% of revenue for managing health services. The county government, consisting of elected officials and appointed executives, has predominantly followed a centralized planning approach, utilizing public participation to validate policy decisions and budget allocations. This approach is seen as state-centric, with county leadership operating within linear structures. Consequently, it is suggested that elected and appointed leaders may struggle to embrace self-governing ideals that promote collective action, as outlined in the 2010 Kenya Constitution.

Despite devolution, the politics of health policy denies people participation to sustain *dependency* of the individuals and community on the government and politicians. Devolution, in view of the above, may not be effective on healthcare without appropriate political goodwill at the two government levels to allow full decentralization to the village level. This can be attested by the fact that only eight (8) counties out of 47 have legislated and implemented village administration provided in the constitution, as at the time of this report. The Kenya Household Survey Model (HMS), currently referred to as the Kenya Integrated Household Budget Survey (KIHBS), serves as a benchmark for other nations. Its main aim is to gather data on healthcare utilization and expenses within households in Kenya. The key objectives include:

1. Document healthcare-seeking behavior and assess how behavior varies with demographic characteristics.

2. Collect detailed information on healthcare service utilization;

3. Gain insight into the health expenditures made by the household members when they consult healthcare providers and analyze how expenditures vary with socioeconomic and demographic characteristics and type of health care sought; and

4. Investigate household use of outpatient and inpatient healthcare services by provider type.

Kenya health policy intervention affirms co-function, coordination challenges and dependency biases that strengthen the clinical services rather than being comprehensive (Kenya Health Policy, 2014). In order to prioritize the needs of individuals, the practice of devolved health governance should embrace the active involvement of people as co-producers throughout the entire spectrum of healthcare services. People participation is deemed would help address challenges of unavailability, staffing, equipment and services. Researcher's interpretation of the gaps here is that there is need for political will in the implementation of the constitution guidelines to the letter in order to meet the real needs of healthcare.

The Kenya Constitution of 2010, specifically Article 6, provides a comprehensive framework for ensuring the quality of health services for both individuals and the community. This framework consists of eight key features, namely social and economic development, democracy, accountability, accessible health services, and seamless service delivery. One important aspect of this framework is the empowerment of communities to govern their own health services, which promotes self-governance and recognizes the rights of communities to manage their own healthcare.

In order to achieve health equity, both national and local county resources are targeted towards improving health outcomes. Collaboration and partnerships between state and non-state actors, such as public-private partnerships (PPP), are also encouraged to enhance service delivery. This requires circular or polycentric coordination between the two levels of government.

The Constitution facilitates the decentralization of state organs responsible for health functions, ensuring checks and balances in the separation of powers between the national and local governments. However, the implementation of these provisions is often hindered by political and power interests, as well as market forces. To achieve equality and quality in healthcare service delivery, inclusivity, participation, democracy, justice, and solidarity are essential. Additionally, establishing network linkages through circular or polycentric coordination among actors involved in healthcare can help sustain health services and prevent disruptions.

Kenya is actively engaged in global health networks and linkages, including those established by the United Nations and its agencies such as the World Health Organization (WHO) and the World Bank. However, the country's ability to make independent decisions regarding the quality of health services is often constrained by these global linkages. The stewardship of health services lies with the elected officials and the executive in positions of power, but political and power interests often hinder the goodwill necessary for effective governance. It is important to note that local interventions in health services have been in place since 1963, building upon the pre-colonial communitarian approach to healthcare.

Service Delivery And Healthcare In The Kenya Health System

Kenya health system was inherited and centralized from the colonial and missionary owned and operated medical infrastructure in the districts, now counties. The facilities maintained their colonial operation under skeleton staffing with basic equipment. Sessional Paper No. 1 of 1963 marked the beginning of key policy interventions in addressing the challenges faced by the country, namely illiteracy, diseases, and hunger. These challenges continue to persist and have now become part of the country's 4 Big Agenda. This study specifically focuses on diseases and their impact on health services. Several significant interventions have been implemented over the years to address health-related issues, including the Ndegwa Commission in 1975, the Executive Order in the same year, the District Focus for Rural Development in 1984, the Constituency Development Fund in 2003, and the Universal Health initiative in 2017.

In 1971, the Ndegwa Commission Report recommended that doctors should have the freedom to engage in private practice. This decision led to many doctors leaving government facilities. Additionally, in 1975, an executive order was issued to amend the independence federal constitution, granting centralized control and stewardship of government resources to the state. The centrality of the state in this regard has remained unchallenged and unparalleled to this day. The District Focus for Rural Development (DFRD) of 1984 aimed to make districts the focal points for rural development. However, it failed shortly after its implementation due

to its top-down approach, with little input from legislators and limited local participation. In contrast, the Constituency Development Fund Act (CDF Act) of 2003 allocated funds to constituencies, leading to the rapid growth of government health facilities. Unfortunately, this growth lacked coordination between different sectors, resulting in delayed integration, inadequate staffing, and operational challenges due to insufficient infrastructure. The Health Act of 2017 introduced a market-driven e-care system for Universal Healthcare, which was put into operation in 2018 through an executive order. However, its uptake has been slow, as many ordinary individuals lack the financial means to pay for insurance. Overall, these interventions maintained a vertical sectorial approach that primarily served the interests of the state.

Vilka (2004) highlights the existence of communities with sovereign power prior to the establishment of the state, emphasizing their capacity to address their own needs. This supports and reinforces the objectives of devolution. However, sociopolitical power dynamics and market forces continue to influence the provision of healthcare services, with minimal involvement of the people as co-producers. This suggests that the governance of healthcare follows a structural and functional approach. The Ndegwa Commission Report (1970-71) may provide evidence of the political influence and market-oriented approach that weakened the delivery of health services (Aluoch, 2018). The present study argues that the understanding of devolution and decentralization of healthcare can only be achieved through the interactions and experiences of individuals at service delivery points (Bovaird and Löffler, 2003). Therefore, a phenomenological inquiry is necessary to describe these relationships accurately.

The development and expansion of healthcare infrastructure, including facilities, staffing, financing, medicines, technology, and environment, appear to have not been adequately incorporated into the medium-term expenditure frameworks (MTEF), as indicated by the Budget Analysis reports of 2014/15 and 2016/17. This deficiency could be attributed to the absence of mechanisms to effectively implement the recruitment of personnel and establishment of equipment. The allocation of funds for healthcare is a political decision that constrains the availability of resources, staffing, and maintenance of health services. Against this backdrop, the current research aims to explore the impact of devolution on healthcare delivery by examining the decentralized health services in Kenya. Although devolution and decentralization are enshrined in the Kenyan Constitution of 2010 and the County Government Act of 2012, the policies and resources remain largely controlled by the national government. This situation marginalizes the counties in the implementation of healthcare policies in an impartial and fair manner, as decision-making authority rests with elected officials and executives. Consequently, citizens become reliant on the government for assistance, leading to a healthcare system in Kenya that falls short of the ideals outlined in the constitution.

Healthcare Delivery In Siaya County, Kenya

The health policy of Siaya County is derived from the Kenya 2010 Constitution and the County Government Act 2012, aiming to enhance the well-being and health of both individuals and the community. The objectives of devolution encompass the rights of communities, the interests and rights of minorities, accessible services, equitable distribution of resources, decentralization, and the establishment of checks and balances. On the other hand, the county health objectives focus on improving access, affordability, and the expansion of diagnostic and curative services to reduce the occurrence of preventable diseases and promote a healthy lifestyle. These objectives are implemented through a vertical approach, where policy decisions are made by the Legislative Assembly and Executive, with the public receiving directives.

The county health policy also emphasizes the importance of improved environmental hygiene and sanitation, as well as the provision of universal health care. However, the actual progress in achieving these goals may be limited due to the fact that the county only receives 3.9% of the national health budget and allocates only 30% of its budget to health (CIDP 2018-2023). Additionally, delays in the release of funds from the national government and the legislative process of the County Assembly further hinder the implementation of the policy.

Health services in Ugunja Sub County, similar to the rest of the county and the entire nation, continue to be centralized and state-centered at the county headquarters. The Sub County Health Medical Officer of Health (MOH) plays a crucial role in providing guidance, leadership, and supervision of health services. The MOH

office is responsible for coordinating, reporting and monitoring the various healthcare facilities. On the other hand, the County is responsible for directing the planning process at these facilities and managing the budgetary procedures, which are then presented to the Board of Management (BOM) for approval at each respective facility.

This research considers the centralization of services to be primarily driven by the desire for economies of scale, but it also recognizes that power dynamics and dependency play significant roles. According to the constitution, the decentralization of political, fiscal, and administrative functions necessitates the active participation of the people in policy decisions. However, the current framework tends to merely endorse executive decisions without genuine public involvement (Faguet, 2014). This argument highlights the fact that health governance is inherently political, and power interests often shape the competing needs within the system.

This study targeted four main categories of residents in Ugunja Sub County of Siaya County: general population; political leaders (elected, nominated, opinion); health managers and health service providers; and both local national and county administrators. Another target was volunteer group of doctors under Ugunja Health Pillar whose viewpoints on the governance of health service is very valuable as they advocate for people centered health services. Health Pillar experts' position is that people centered health service requires a coordinated participatory citizen, inter-sectors and institutions' collaboration at national and county to cascade quality of health services.

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

The goal of theoretical literature is to seek improvement of health service delivery through change approach. Three theories are used in phenomenological approach. Decentralization theory (Jean Paul Fagued and James Manor) offers insights into the structural and governance aspects of political devolution. Public Choice theory (James M. Buchanan and Gordon Tullock) focuses on democratic decision making process within the political realm. On the other hand, Health Belief Model theory (HBM) (M. Rosenstock, Godfrey Hochbaum, S. Stephen Kegeles, and Howard Leventhal in the 1950s) explains and predicts how people think about their health and is used in designing health promotions and disease prevention programs. Combining these theories gives a comprehensive framework for the study using phenomenology approach.

Decentralization Theory

The argument on decentralization theory is that it makes the government accountable and responsive to the governed. Improving governance is central to decentralization. However, literature has focused on policy relevant outcomes such education and health services, investments and fiscal deficits. This theory evolved from the 1960s and became a broad movement in the 1970s for governance policy issues in development (Faguet 2004a and Manor 1999). World Bank Study indicate that over 80% of the world developing countries are implementing decentralization.

Decentralization brings government close to the people to make them be able to challenge and interrogate the executive and the legislature on policy and service delivery in areas that affect their lives.

Public Choice Theory

Public Choice theory is a democratic process of what public goods are provided, how they are provided and distributed, and the rules that govern the process. The theory focus on how elected officials, bureaucrats, and other government officials perceived self-interests can influence their decisions (James M. Buchanan and Gordon Tullock, 1962). These two scholars formulated framework for constitutional decision making and structures that divides decisions into two categories: constitutional decisions and political decisions. Health decisions is political operated within the constitutional structures. Therefore, the realm of this study is anchored in public choice theory under political decisions.

Heath Belief Model (HBM) Theory

Health Belief Model Theory focus on individual beliefs about health conditions that can predict the individual health related behaviors. The model provides key factors that influence individual to health behaviors as individual's perceived threats to sickness or disease (perceived susceptibility), belief of consequences (perceived severity), potential benefits of action (perceived benefits), potential barriers to action (perceived barriers), exposure to factors that prompt action (cues to action), and confidence in ability to succeed (self-efficacy) (M. Rosenstock, Godfrey Hochbaum, S. Stephen Kegeles, and Howard Leventhal in the 1950s). This theory imbeds well with people's lived experiences when they seek public health service delivery and complements the decentralization and public choice theories. It provides a holistic understanding of how political devolution impacts health service delivery in Ugunja Sub County.

Phenomenology Theory

Phenomenology is a philosophy of experience, and can be viewed as a personality theory that focuses on examining an individual's present experiences of themselves and their surroundings for individual functioning and development. In the realm of social science research, phenomenology is a commonly utilized methodology to investigate and elucidate the lived experiences of individuals (Welch and Barr, 2017). Combined with theories of decentralization, public choice and health belief model (HBM) the experience of dwellers of Ugunja Sub County explains the impact of devolution on health service delivery.

On the other hand, governments use phenomenology for policy setting and reviews as a scientific method that has three variations (realist, constitutive, existential) drawn from the tradition of Edmund Husserl. Literature discussing the nature of phenomenology in this study was used to illuminate the core fundamental principles of Husserlian interpretive phenomenology.

Healthcare is dependent on a political action and, Bedorf and Steffen (2019) identified three types of political phenomenology, reinforcing its object in terms of political experience, political ontology, or political epistemology. Political experience operates via eidetic analysis to identify a series of phenomena such as freedom, power, or conflict as basic conditions of political action.

Political figures often restrict the ability of individuals to engage in policy-making processes that have a direct influence on their well-being, such as healthcare. On the other hand, political ontology uses existential analysis to uncover the structural conditions and normative foundations of the political sphere. Health as a political action is government centric with clear structures. For people's experience, political episteme uses genetic analysis to understand the broader space of experience itself as the result of an institutional event. Taken together, the phenomenology of experience, ontology and episteme uncover a genuine phenomenological account to the realm of the politics. This argument grounds health service delivery in the political phenomenology.

In recent years' phenomenology has become a tool for reflecting on political questions (Bedorf and Herrmann, 2020). Political theory phenomenology is considered the right theory to connect political devolution with health service delivery following normative principles in political philosophy. The normative approach focuses on the values that underpin community building, operating on the belief that individuals inherently seek belonging, purpose, and success. In contrast, phenomenology is a philosophical perspective centered on lived experiences, encompassing both descriptive and interpretive methodologies. The descriptive phenomenology, pioneered by Edmund Husserl, and the interpretive phenomenology, developed by Martin Heidegger, are the two main approaches within this philosophical framework (Connelly, 2010).

Edmund Husserl, a prominent philosopher, is credited with founding the field of phenomenology, particularly the descriptive branch, which involves describing participants' experiences in the world without any preconceived notions.

Experience is recognized to encompass perception, thought, memory, imagination and emotion, each involving 'intentionality', as the individual focuses their gaze on a specific 'thing' or event. The examination of political

devolution and health service delivery through a phenomenological lens is considered to be the fundamental basis for understanding the significance and impact of political factors on healthcare provision. Political phenomenology represents a recent development in Western philosophical thought, emerging in the aftermath of classical, Machiavellian, and behavioral paradigms (Jung and Embree, 2016). This approach leverages historical insights to inform future investigations into political matters, and is recognized for illuminating the intersection of ethics and politics. Within the realm of phenomenology, three main categories exist: realist, transcendental, and existential (Gabriela, 2019).

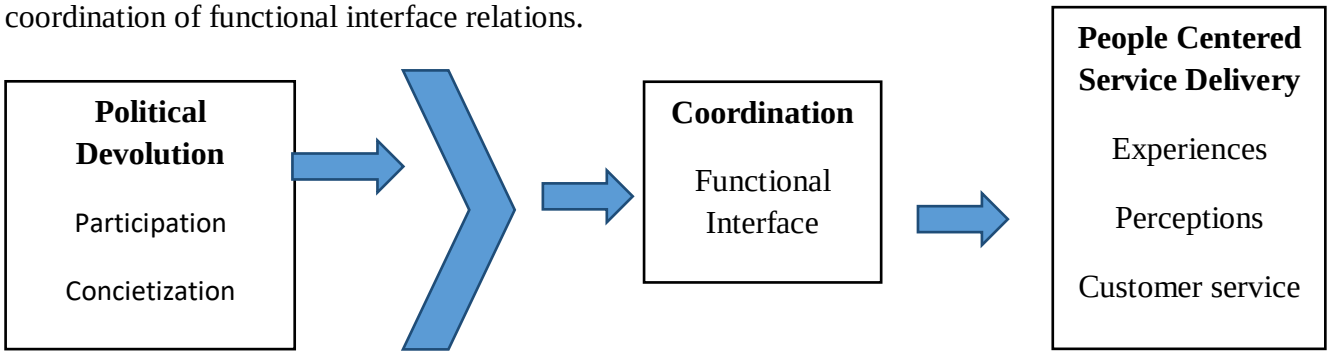
The Research Gap

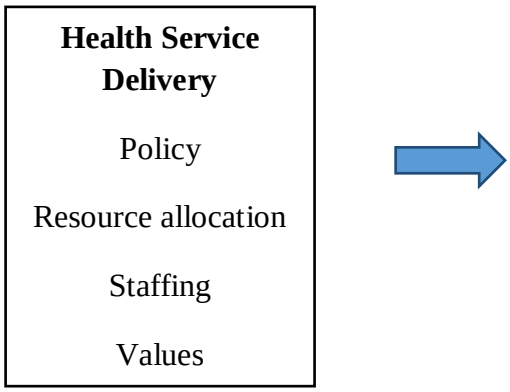
Gap analysis seeks to determine constraints that when addressed the desired state is actualized. For this study, literature show health service delivery is state centered and its planning and implementation is directed from the center, and this a political shortcoming. This supports and aligns to collaborative and communality gap. A combination of decentralization, public choice, and health belief theories with phenomenology strengthen the collective and communality gap.

The current devolved health service a co-function of national and county governments and, is state centered, operated by medical experts as part of the executive. This may not meet the total health needs of the people. The aim of this research is to elucidate the relationship between political devolution and the delivery of health services based on individuals' real-life experiences, thereby exploring a particular phenomenon.

Theoretical Framework: Integrated People Centered Health Service Delivery (IPCHSD)

Thesis conceptual framework had the independent variables (IV) political devolution and health service delivery. Dependent variable (DV) had people centered health service delivery. Moderating variable (MV) had coordination of functional interface relations.

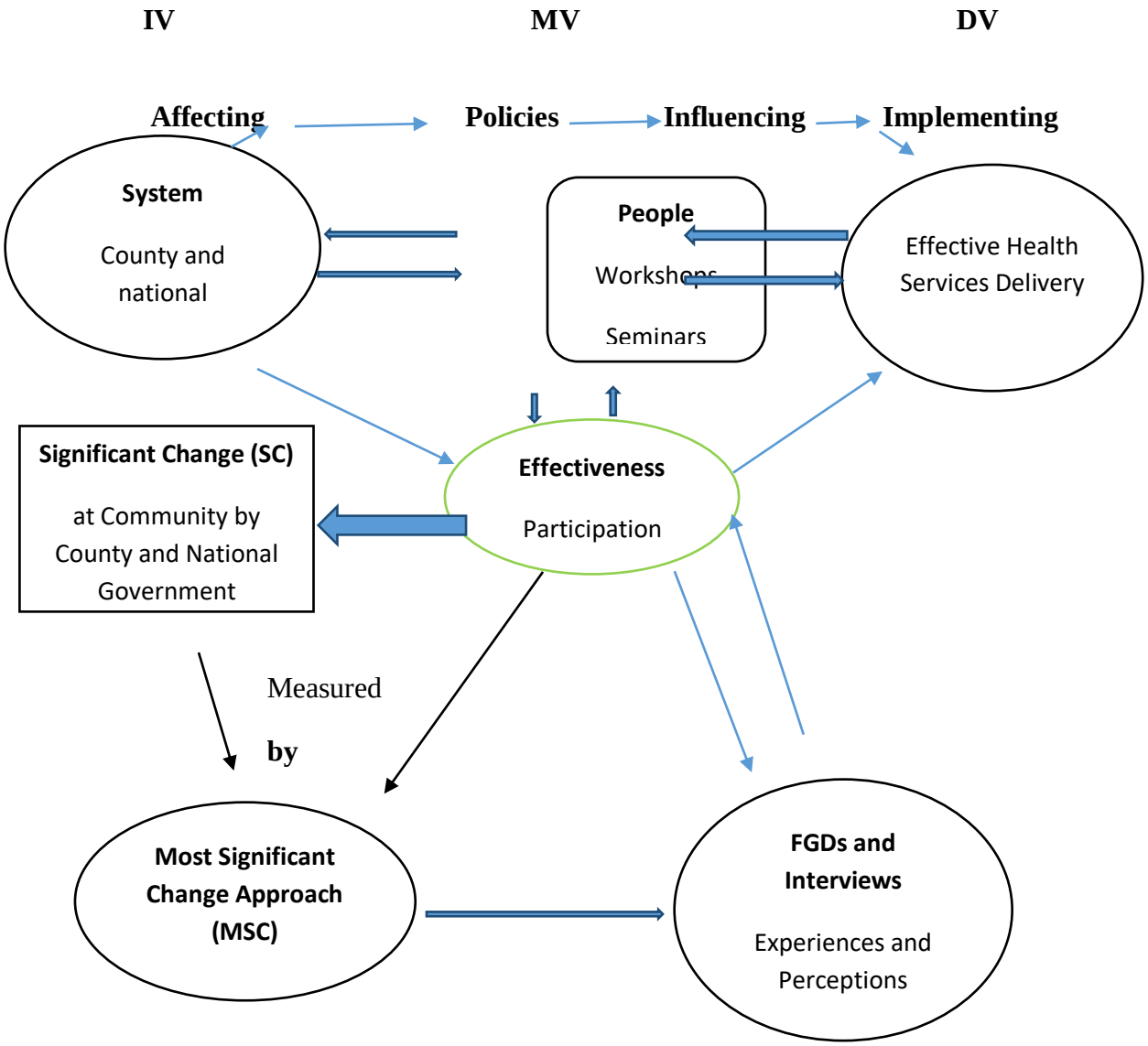




In integrating people and all stakeholders in health service delivery, we seek improving the services. This means making some changes that require going for significant changes, calling for Most Significant Change (MSC) Approach modeled by Rick Davis (1996). The MSC method is essentially a qualitative and participatory approach to monitoring and evaluation, focused on reporting changes resulting from the implemented activities. Within this updated structure, the independent variable (IV) is the system (comprising county and national governments), the dependent variable (DV) is the effective delivery of health services

(integrated people-centered health services delivery - IPCHSD), and the moderating variable (MV) is the people's health belief model driving the change.

Effective Health Service Delivery: Integrated people centered health services (IPCHSD)



RESEARCH METHODOLOGY

Research Design

For the study on "Political Devolution for Transforming Health Service Delivery in Ugunja Sub County", a convergent parallel mixed methods design is the most appropriate.

1. **Quantitative Component**: Surveys with structured questions to collect data on the impact of political devolution on health services.
2. **Qualitative Component**: Semi structured interviews and focus group discussions to gather detailed personal experiences on healthcare services delivery in the post-devolution era.
3. **Data Integration**: Merging findings during the analysis phase to draw comprehensive conclusions that seek to determine the best transformative approach for effective health service delivery.

The research design was tailored to the cultural environment of the Luo people. The study went through the history of decentralization of health service delivery with participants. Research quantitative aspects engaged people selected among the elected/nominated and opinion leaders, the appointed executives and the people. Considerations took account of the emotional aspects such as feelings, experiences, hopes and consequent decisions. The qualitative phenomenological research design helped discover ways to transform health service

delivery to be people centered and responsive to the people and community needs, in accordance with Kenya 2030 Vision. The design forms the structure for the data collection, measurement and analysis. The design framework, may be defined as a scheme, outline or plan as the basis to generate answers to research problems (Cresswell, 2014; Orodho, 2003 and Kothari, 2012).

During the fiscal period of 2013/14 to 2016/17, Siaya County experienced the highest infant mortality rates and the lowest life expectancy in Kenya, as highlighted in the Comprehensive Public Expenditure Review (CPER, 2017). This study aims to explore the impact of political devolution on delivery of health services by examining individuals' personal narratives and their subjective experiences and emotions related to the healthcare system. By delving into the descriptions of the healthcare phenomenon, this research seeks to shed light on the intricate relationship between political devolution and the provision of healthcare services. That effect is people's perceptions of political devolution on delivery health services and the organization for the provision of the services. The study further sought transformative ways to make the delivery of health services value chain people centered and effective in responding to the needs of the people and community. Creswell, (2007), argues that qualitative research gives us the ability to understand details of a complex issue.

Qualitative phenomenological research design was chosen because it is attentive to data and sensitive to people's natural habitation. It also pays attention to how people perceive the contexts of their health service delivery. The study data collection and analysis keenly listened to how the people perceive their health service delivery and their common position or different understanding of the functional interface relationships and the actors (Creswell 2007).

Location of the Study Area

The study was carried out in Ugunja Sub County of Siaya County within the Republic of Kenya. Ugunja is one of the six Sub Counties that make Siaya County whose inhabitants are predominantly the Luo people. It is located astride Kisumu-Busia highway, which links Kenya and Uganda. The Sub County area is approximately 213 square kilometers with a population of 130,435 (KBS, 2017). It neighbors Gem Sub County to the South East, Ugenya Sub County to the North and West, and Alego to the South.

Selection of the sub county for research is based on its creation at the inception of devolution with election in 2013. This fits well with the review of first five-year term of devolution (CPER, 2017). Health services are a shared responsibility between national and county levels, where counties rely on the national government for financial support, subject to legislative processes and budget constraints. Siaya County in Kenya has been reported to have the highest infant mortality rates and the lowest life expectancy (CPER, 2017). The current infant mortality rate stands at 24 per 1000 and life expectancy stands at 56.6 years (County Director of Medical Services, 4th November 2024). The health policy in Kenya primarily focuses on curative services, lacking a holistic approach. Utilizing smaller decentralized units like sub-counties can facilitate efficient data collection within a constrained timeframe.

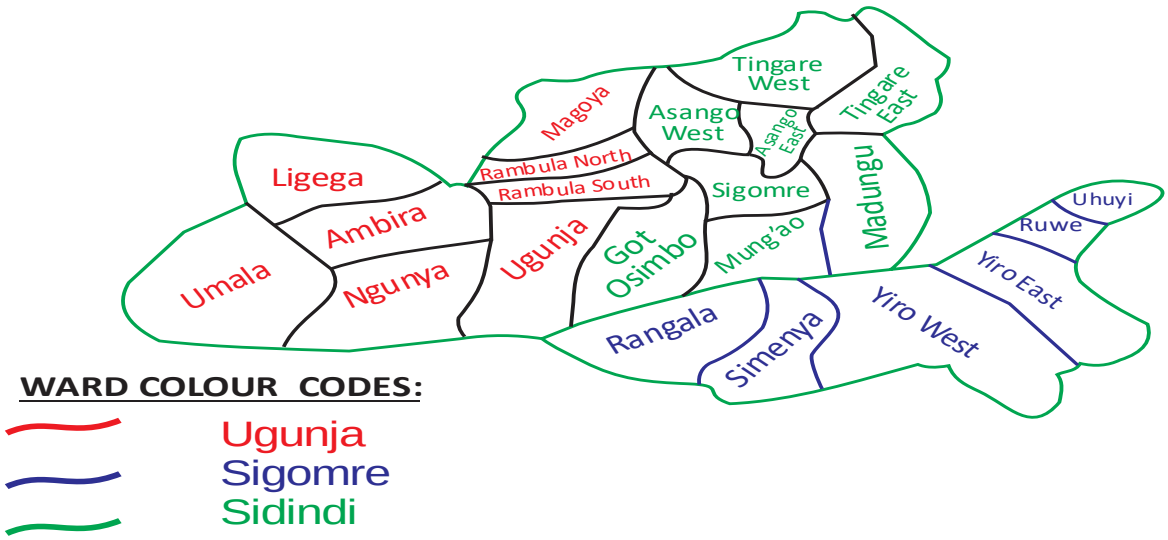


Figure 1: Map of Ugunja

Target Population

Ugunja Sub County has three Wards with 22 sub locations has a population of 130,452 (KBS, 2017). According to Siaya County Integrated Development Plan for 2018-2023, Ugunja Sub County has 12 public health facilities (Ugunja Health Pillar, 2021). Selection criteria of the target population are inclusivity, accessibility and prior interactions with health service delivery. The participants in the study come from sub frames of elected and nominated leadership, appointed public administrators, people as co-producers of health services, and the health staff as managers and care givers. The participants include persons with disabilities (PWD), women, youth, men, community and faith institution leaders. The populace holds constitutional authority of sovereignty, but delivery of health services is a shared responsibility of both the national and county governments. Therefore, this study deems focus of health service delivery does not revolve around the individuals and their community.

Sampling Design

Probability for quantitative and Non-probability for qualitative sampling design were applied for this study because samples were drawn from predetermined categories of the population aligned to the Luo social system. Individuals participants were chosen based on specific criteria, like convenience or researcher judgement, giving not everyone a chance of being included in the sample.

Sampling Size Determination

Individuals are chosen based on specific criteria, like convenience or researcher judgment, giving not everyone a chance of being included in the sample. Sample size is determined for quantitative data collection and qualitative for good representation at the grassroots.

1. **Quantitative:** We need a Sampling Frame that lists all units from we draw the sample. We need Formula such as Krejcie Morgan to calculate sample size. We need a Table to show how the sample size is drawn and distributed across all the units, preferably proportionate to the population. Based on 130,452 population of the sub county a 95% confidence interval and an approximate error of 5% the sample size is around 384. There is possibility of adding 10% attrition to that which will make around 422 respondents for quantitative data collection.
2. **Qualitative**: We need a good representation from the grassroots (~50%) and some voices from leaders, especially those who are involved in healthcare service management and delivery. For qualitative approach, 45 respondents were proposed on the principle of saturation. We have FGD based on 118 that form 13 groups.

Sampling Techniques

This research employed two sampling techniques: Quantitative (Probability) – Stratified proportionate sampling technique and Qualitative (Non-probability) – Purposive criterion sampling technique (only people who receive or manage health services are selected for this study).

The sample population was divided into five subgroups of population strata made of health service providers; elected and nominated representatives; public administration, the general population, and faith-based organizations drawn from the 130,452 residents of Ugunja Sub County (Stephanie, 2015) to reflect percentages of the strata. Quota sample of 163 participants is greater than 50, the limit of typical case. The five strata provide for diversity, experience and perceptions on health care. Quota sampling is a non-probability sampling technique that relies on the researcher's discretion (Yang & Banamah, 2014). The selection of participants in quota sampling is based on specific characteristics or quotas set by the researcher.

Category	**Nature of Participants**		**Sample Size**
	Male	**Female**	
Elected/Nominated	2	0	2

Public County Admin	15	5	20
Opinion Leaders	4	4	8
Health Service Managers	6	10	16
Faith and Special Interests	4	5	9
Adult men/women	18	24	42
Youth	10	26	36
PLWD	4	8	12
Health service Providers	8	10	18
TOTAL N =	**71**	**92**	**163**

The table above gives demographics total of the population samples were selected by meeting the criteria from the total N = 163 sample size using online calculator from a total population of 130,452 residents of Ugunja Sub County. The online calculator gave a sample size of 383 which the researcher considered too large and moderated the sample down to 163, considered useful in examining the opinions of the constituents of Ugunja Sub County due to time and resources constraints.

Sample size of 163 above was deemed large enough to represent the population and allowed in-depth understanding how people perceive political devolution and health service delivery. All the three objectives utilized the information that came from document analysis. From the sample of 163, KII took 45 and FGDs took 118 participants, all drawn from Ugunja Sub County's 3 Wards. These demographics represent the population and responded to how people perceive political devolution in the delivery of health services.

Understanding how people perceive political devolution impact in their health service delivery required engaging key informants (the elected and nominated representatives, opinion leaders, public and health administrators). The general population samples were made of adults, health care service providers, youth, PLWD, and the faith leaders for balanced reflection. Triangulation was used to test validity through the convergence of information from KIIs and FGDs.

Table 2 KII Sample size of human participants

Category	**Nature of Participants**		**Sample Size**
	Male	**Female**	
Elected/Nominated	2	0	2
Public/County Admin	8	2	10
Opinion Leaders	4	4	8
Health Service Managers	6	10	16
Faith and Special Interests	4	5	9
TOTAL N =	**24**	**21**	**45**

In creating the KII interviews the criteria used was the roles played in the community. The individuals who play crucial roles in advancing the community health agenda include those who are elected or nominated, the executive branch of public administration, opinion leaders, health service managers, and representatives of faith and special interests. The categorization of these roles can be observed in Table 2.

The community gatekeepers, the Chiefs, were directed by the Sub County Commissioner to contact the FGD participants based on criteria set in the research proposal. The chiefs worked with the Assistant Chiefs who are in direct contact with the community to reach the identified FGD participants. The KII were contacted directly by the researcher. Some of the data were collected from participants on opportunity as they happened to be where either interviews or FGDs were being held.

FGD sample of participant categories are described in Table 3 below.

Table 3 FGD Sample size of human participants

Category	Nature of Participants		Sample Size
	Male	**Female**	
Assistant Chiefs	7	3	10
Adult men/women	18	24	42
Youth	10	26	36
PLWD	4	8	12
Health service Providers	8	10	18
TOTAL N =	**47**	**71**	**118**

Data Collection Techniques and Analysis

The objective of this study is to understand political impacts on health service delivery. This was achieved by engaging people through interviews and focus group discussions on how they perceive the delivery of health services The main objective was to record the individual opinions regarding political devolution and delivery of health service, as perceived by the public. The primary methods employed for data collection included group discussions (FGD) and interviews. To optimize efficiency, FGD sessions were conducted with a diverse range of participants, including the general population (men, women, youth, and people with disabilities), health service providers, and faith leaders. This approach aimed to streamline the process and save valuable time. Interviews were used for the elected representatives, public administrators, opinion and faith leaders, and health services administrators. Unit of analysis was individual participants in FGDs and interview in the discussions and responded to questions that generated recurring common themes. Each objective, question, and discussions for data collection are summarized below.

Table 4: Summary of Objective Data Collection Points

Objective 1

The Impact of Political Devolution on delivery of health services

1.What are the political power interests and market forces?

2. What cultural and values influence health services?

3. How dependent are we on government healthcare?

4. Do you experience corruption?

5. Does the community participate in health decision?

6. Are resources allocated adequate?

Objective 2

Organization of Kenya's health structure towards health service delivery

1. What's the structure for healthcare?

2.Are the facilities and staffing adequate?

3.How good is the customer service in health facilities?

4. How is the staff attitude?

5.Who participates?

6. How accessible and affordable is the healthcare?

8.Does work schedule allow 24 services?

Objective 3

Transformative approach for effective health service delivery

1. How do we make healthcare people centered and Inclusive?

2.How do we make health services holistic?

3.How can make people participate in health decisions?

4. What governance structures would be inclusive?

5.How can we mobilize resources locally?

6.How can community own and commit sustain healthcare?

Data Collection Procedure

In a phenomenological study, the primary method of data collection involves conducting in-depth interviews and focus group discussions with participants (Creswell 2007). This study used phenomenological data collection methods of interviews, focus groups, observation, and documents and records. The utilization of phenomenological data collection allowed the researcher to elucidate the significance of political devolution impacts on health service provision as a phenomenon experienced by multiple individuals (Marshall & Rossman, 2006). The preferred approach for phenomenological data collection was through focus groups or interviews, with the most prevalent method being the unstructured or semi-structured interview (Colaizzi 1978, Wimpenny and Gass 2000).

This study used focus group discussions, interviews and observation to collect data. There were 45 participants for interview that were accessed through appointment and meetings that lasted one hour each at their offices or homes. The focus groups were thirteen made of nine participants and their meeting sites were compounds of the chiefs at Sigomre and Kirind for Sigmre Ward, Ambira and Rambula for Ugunja Ward, and at Sikalame and Sidindi for Sidindi Ward. The total number of participants for focus group discussions were 118.

Data Analysis

Phenomenological data analysis can be either content or thematic. Content analysis uses a descriptive approach in both coding of the data and its interpretation of quantitative counts of the codes (Downe-Wamboldt, 1992; Morgan, 1993). This study used thematic analysis as it is one of the most common forms of analysis within qualitative research. It emphasizes identifying, analyzing and interpreting patterns of meaning (or "themes") within qualitative data. Braun & Clarke, (2006) describes thematic analysis as a tool that provides a purely qualitative, detailed, and refinement of data.

Analysis puts in perspective of what it is and who needs to be involved in how people perceive health service delivery as a phenomenon. The health service delivery system consists of a diverse set of organizations and individuals, each with different perspective on the service rendered or received. For example, the perception of health service varies depending on the stakeholder.

Table 6 A to E. Data Grouping Responses

A. General Population

Category	**FGDs**		**Objectives**					
	Male	Female	M 1 F		M 2 F		M 3 F	
Adult men/women	18	24	18	24	16	23	14	29
Youth	10	26	10	26	19	26	10	26
PLWD	4	8	4	8	8		3	8
Health Service Provides	8	10	8	10	13		15	
TOTALS	**40**	**68**	**100**		**96**		**105**	

B. Faith and Special Interests

Category	**Interviews**		**Objectives**		
	Male	**Female**	**1**	**2**	**3**
Faith and Special Interest	4	5	9	8	9

C. Health Service Managers

Category	Interviews		Objectives		
	Male	**Female**	**1**	**2**	**3**
Health Service Managers	6	10	10	9	10

D. Political Leaders – Elected/Nominated/Opinion

Category	Interviews		Objectives		
	Male	**Female**	**1**	**2**	**3**
Elected/Nominated	2	0	2	2	2
Opinion Leaders	4	4	7	6	8
TOTALS	**6**	**4**	**9**	**8**	**10**

E. National and County Administration

Category	Interviews		Objectives		
	Male	**Female**	**1**	**2**	**3**
Leadership (DCC/ACC/Sub County/Ward Admin/Chiefs)	7	3	9	8	9
Assistant Chiefs	7	3	8	7	10
TOTALS	**14**	**6**	**17**	**15**	**19**

Understanding these varied perspectives is critical to ensuring the usefulness of the data set. Gathering these perspectives required broad engagement across the devolved health services to uncover factors affecting the effectiveness of the services actionable for different stakeholders. Each stakeholder has ability to affect the effectiveness, and whether the effectiveness captures process or health outcomes that are in most need of improvement, as a phenomenon.

This study applied Colaizzi's framework on strategy for phenomenological data analysis that has six steps.

Step 1 Transcripts reading to identify significant statements and phrases.

Step 2 Formulating and aggregating the meanings.

Step 3 Grouping the meanings into categories and clusters of themes resulting into ideas.

Step 4 Exhaustive description of the phenomenon reducing unnecessary information to keep the focus.

Step 5 Fundamental structure returns feedback to the participants

Step 6 Validation of exhaustive description and its fundamental structure.

The Colaizzi's framework used has its flow depicted in the diagram below.

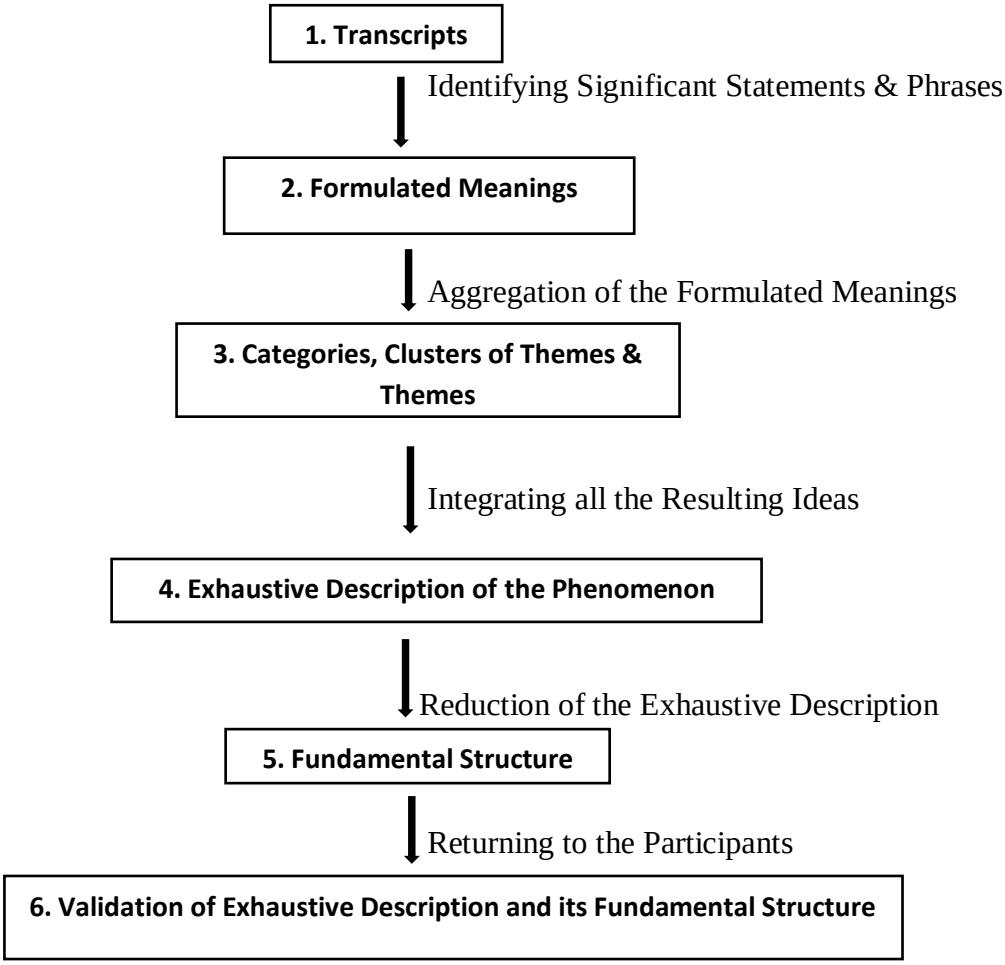


Figure 3: Colaizzi's Strategy for Phenomenological Data Analysis (Abu Sosha, 2012)

RESEARCH FINDINGS

Demographic Details

Demographics for this study were drawn from population for interviews and focus group discussions. The interview participants consist of elected or appointed officials, members of the public and county administration, influential figures, health service administrators, representatives of faith-based organizations, and individuals with special interests. On the other hand, the focus discussion group demographics are made of the assistant chiefs, people from each of the three wards (Ugunja, Sidindi and Sigomre). The overall summary of interviews and FGDs is on the table below.

Table 7: Summary of Interviews and FDG Participation

Groups	Participants	Total Response	Yes	No	No Response	% Yes	% No
Interview Responses	45	1305	433	872	0	**33%**	**67%**
FGDs Responses	118	3422	1262	2062	0	**37%**	**63%**
Totals	**163**	**4727**	**1695**	**2934**	**0**	**36%**	**64%**

The response rates indicate majority are not satisfied with health service delivery. For interviews, the elected, and health service management felt they could do better but due to policy constraints they are not meeting the expectations of their clients. The opinion and faith leaders showed little interest to know how the health service is delivered as they do use private hospitals. For FGD groups it is equally clear the population is not satisfied

with the services. To this group, provider staff attitudes, lack of medicines, and costs determines their satisfaction.

Data Presentation

Regression analysis helps identity which independent variables significantly impact the dependent variable. The research identified **impactful variables** as values, knowledge, resources, transport and medicine that are used to estimate relationship between dependent and independent variables, deemed the predictors. Because the predictions were dichotomous, binomial regression was applied. Data was organized into group and binary tree as follows:

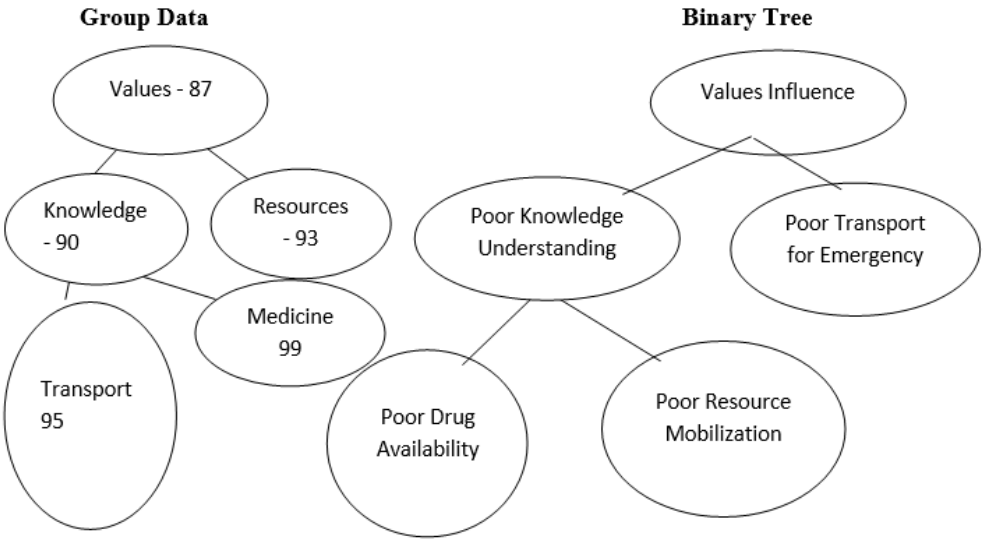
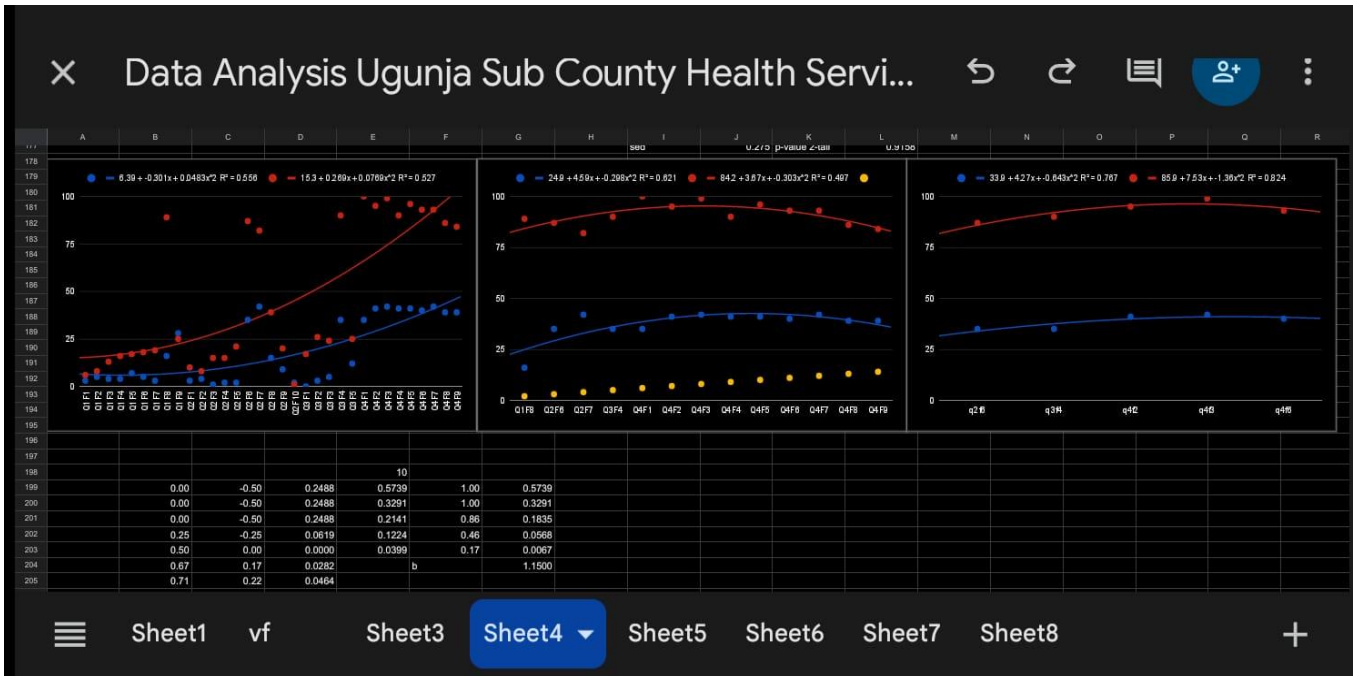


Figure 3 Objective 1 Group Data and Binary Tree

The variables activity responses are: values 87; knowledge 90; resources 93; transport 95; and medicine 99. These variables are determined and availed through political discourse. These five research variable questions and responses produced Pearson's Correlation value of R as 0.9959. This is a strong positive correlation of r squared = 0.99, P < .001showing high X variable scores going with high Y variable scores. This demonstrates that the governance of political devolution has a significant impact on the delivery of health services, as illustrated by data distribution in the charts below that show many variables falling far off, leading binomial and parabolic graph.



The researcher's raw data summary and highlights below show dissatisfaction with health service delivery. The facilities under organization structure are not adequately staffed and equipped for the desired services. Understaffing stress staff and make them burn out with attitude. Summary of responses in table below:

Table 8: Organization for health service delivery experience

Factors	Responses			Highlights
	Interview	FGD	Average	
Satisfaction	Not 100%	Not 100%	Not 100%	Bad staff PR
Civic Education / Concietization	No 100%	No 100%	No 100%	Government and politicians fear civic education.
Happiness	Not 95.7%	Not 100%	Not 97.85%	Staff have attitude
Perceptions	Not people centered 94%	Not people centered 100%	Not people centered 97%	Service needs to be people centered
Participation	No 95.75%	No 93.2%	No 94.48%	Participation is selective
Values Influence	Yes 91.32%	Yes 90.2%	Yes 90.76%	Culture, faith, modernity, technology and attitude influence access
Access /Affordable	Not 87%	Not 83.1%	Not 85.05%	Accessible but not affordable
Experiences	Bad 78%	Bad 90%	Bad 84%	Service directed by government on costs and resources
Customer Service	Poor 78.3%	Poor 84.7%	Poor 81.5%	Staff need training

Health service organizations must prioritize placing individuals and communities at the forefront to ensure a positive experience. Findings from this research indicate a high percentage of negative encounters (84%), leading to the perception that health service delivery lacks a people-centered approach (97%). Customer service is reported to be lacking (81.5%), with a significant majority of participants expressing dissatisfaction and unhappiness (98.93%) with the current state of health service delivery. Despite being accessible, health services are often deemed unaffordable (85.05%). Furthermore, the involvement of citizens in decision-making processes and civic education is heavily influenced by the political system, resulting in alienation (97.48%). The shaping of values is predominantly driven by attitudes, culture, faith, modernity, and technology (90.7%).

The appropriate theoretical framework for understanding the experiences of individuals is the qualitative approach that combines Husserl's phenomenology with Colaizzi's method of data analysis. This model emphasizes the involvement of individuals in the development and execution of efficient health service delivery systems. While the public influences the demand for services, the government controls the supply. The prevailing sentiment among individuals is that health service delivery lacks a people-centered approach. The government dictates the decisions and procedures related to health delivery of services without consulting the public. However, under a decentralized system, individuals should take charge of their health service delivery as they possess the necessary knowledge and skills to drive the process effectively. Individuals view health service delivery as a means of government control over their lives. The practice of cost-sharing is perceived as a profit-driven venture influenced by the pharmaceutical industry. Funds collected from patients are pooled at the county level, with little consideration for the revenue generated by each facility. Customer service provided by health service providers is widely criticized by various demographic groups, including individuals, service providers, managers, and public administrators. This negative perception of customer service highlights the need to evaluate the people skills training in medical school curricula.

The above key findings indicate that political devolution significantly influences health service delivery, with the health service being state-centric. This influence is supported by five research variable questions on values, knowledge, resources, transportation, and medication, as confirmed by Pearson's Correlation. Stakeholders express dissatisfaction with health service delivery concerning policy, resource allocation, medication availability, staff attitudes, and facility maintenance. To enhance health service delivery, a people-centered approach with polycentric coordination is essential.

In triangulation, FGD and Individual interviews data comparison contributed towards enriching the conceptualization of the political devolution impact on health service delivery, contextual circumstances and convergence of the central characteristic of health service delivery phenomenon.

Religion is a potential social capital partner in transforming our health services delivery at the grassroots, where majority of the people belong to different faith institutions. With its unique presence and reach within communities, religion proves valuable and reliable as a partner in health service delivery. The Church's teachings on healthcare are based on the principles of human dignity; common good, and solidarity. The fundamental values of the church teaching on health are guided by the following ethical standards:

- **Respect for human life and dignity**: The Church's teachings reaffirm the importance of human life and dignity.
- **Confidentiality**: The Church maintains the utmost confidentiality.
- **Consent**: The Church seeks consent from respondents.

RECOMMENDATIONS

Mitigating political devolution impact on health service delivery in Ugunja Sub County of Siaya County, Kenya requires:

1. The government to change attitude to accept that people and communities have people with knowledge, skills and are capable of understanding their problems with potential solutions; the center should let go the power from the center to sub national with commensurate resources; create structures for people engagement; open civic education and participation as provided in the constitution to allow decision choices to run at the bottom.
2. The government should adhere to the principles of the 2010 Constitution, which emphasizes that the ultimate power lies with the people and encourages inclusive and integrated engagement through well-defined structures. Also, the County Government needs to implement county operations according to County Government Act 2012 provisions with structure for village administration to connect to the people. At village level there is need to form Village Health Council to entrench people centered health services.
3. This study recommends the need for advocacy for political leadership to understand, adopt and reflect on the individual letters of the word influence: I for *integrity,* a virtue of leadership that should not be compromised. N for *nurturing,* a role that helps the leader and those lead to understand, own and commit to their responsibility for the common good. F for *faith,* foundation of values that leaders must commit to individually and those they lead and in what they do. L for *listening,* is the basis to understanding in communication and a trait for leadership. U for *understanding,* is a trait of leadership necessary in building relationships. E for *emotions,* feelings leaders experience in relations with society and maybe both positive or negative. N for *navigation,* a process the leader goes through to reach a consensus solution to community issues. C for *communication,* skills is an extremely important ability a leader must have, and entail listening and understanding. E for *exemplary,* a behavior models a leader must espouse in integrity, accountability, responsibility, understanding, faith and communication. Because the political leaders fail to understand how they influence service delivery as explained above, leaders tend to end up with flu effect (implies lack faith, do not listen and refuse to understand) that shake and shock the leadership.
4. People should be at the heart of service delivery

CONCLUSION

One of the fundamental challenges of devolution is its state-centric nature and long bureaucracy. Yet, in a democracy, politics is about stewardship and serving the centrality of the state. Service to the governed that is the object of devolution has yet to take root. However, devolution or decentralization gives the sub national entity political, administrative, and fiscal responsibility. The implementation of the devolution in Kenya is at the pleasure of the center on what and how they pass over resources to the sub national. For this reason, health service remains a co-function of both county and national governments. The government should change attitude to accept that people and communities have people with knowledge, skills and are capable of understanding their problems with potential solutions; the center should let go the power from the center to sub national with commensurate resources; create structures for people engagement; open civic education and participation as provided in the constitution to allow decision choices to run at the bottom.

People should be at the heart of service delivery. Placing individuals and communities at the forefront of health service delivery necessitates the government's acknowledgment of the need for collaboration and partnerships to meet service demands for the greater common good. Encouraging people as co-producers of services involves empowering them to engage in participatory processes to make demands on the government. Planning and executing health services demands for cross sector functional interface relations and coordination with other sectors like water, agriculture, education, environment and infrastructure. It is imperative that individuals are granted the opportunity to partake in decision-making processes as outlined in the constitution. Conversely, the government must enhance budgetary allocation and streamline disbursement methods to overcome challenges of inefficiency and incapacity. Alignment of healthcare values with societal norms stemming from traditions, cultures, religions, modernity, and technology is crucial.

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