An Assessment of the Service Delivery Capacity of the District Health Systems in Kenya

Abstract
This paper assesses the delivery capacity of District Health Management Boards (DHMBs) and District Health Management Teams (DHMTs) in Kenya’s health care system. It uses task network methodology and secondary data as well as information from key informants. The study identifies existence of an ineffective linkage/communication between institutions making up the District Health System (DHS), lack of capacity in the areas of planning and management, flawed selection process of the DHMBs, external influence (environment) and lack of physical resources as the main factors inhibiting the efficient delivery capacity of DHMB/Ts. The paper recommends cautious implementation of the decentralization strategy by the Ministry of Health as the process may end up creating a system at the district level that may be too complex for effective management and prudent financial procedures. Some specific recommendations include: a phased implementation of boards’ autonomy to engage district health staff; review of public sector rules and regulations to allow decentralisation of procurement and financial responsibilities; development of performance indicators to help DHMB/Ts define and measure progress towards achieving their goals; and putting in place a transparent criteria for selecting board members.

1. Introduction

1.1 Background and Problem Statement
Many countries in Sub-Saharan Africa are unable to provide adequate quality and coverage of health care services because of poor economic performance and dwindling resources. This has prompted many countries to advocate for the implementation of health sector reforms with a view to maximizing the use of available resources in improving access, efficiency and quality of health care services provided.

Consequently decentralization has been advocated as the key vehicle to drive health sector reforms. This is mainly because centralized systems are perceived to be expensive, inefficient and unresponsive to the needs of communities.

In the last two decades, decentralization as a policy strategy has been implemented in many sub-Saharan countries as part of a wider process of political, economic and technical reforms. The Alma-Ata Declaration of 1978\(^1\) that focused on Primary Health Care (PHC) gave a lot of impetus to decentralization as one of the central reform agenda that should be implemented as part of the health

\(^1\) Kenya adopted the WHO 1978 Alma-Ata Declaration and subsequently adopted the ten elements of PHC.
sector reform process. In addition, the World Health Organization (WHO) and the World Bank have supported decentralization as a key component of the health sector reforms (World Bank Report, 1993). Decentralization - transfer of fiscal, administrative, ownership and/or political authority in the health sector from the Ministry of Health (MoH) to lower levels - has been advocated as one of the ways through which efficiency in delivery of health care services could be improved. Cheema and Rondinelli (1983) and (Mills et al., 1990) generally argue that a decentralized system can lead to improved:

- Allocative efficiency, by allowing the mix of services and expenditures to be decided and shaped by the local users’ choices. Allocative efficiency is therefore achieved when health resources are devoted to the most needed services;
- Quality, accountability and transparency, due to community participation in the oversight and decision-making processes;
- Technical efficiency, through cost-consciousness at the periphery levels; and
- Equity, through distribution of resources targeting the marginalized and neglected regions.

In an attempt to improve efficiency and effectiveness in the delivery of health care services in Kenya and against the limitations of a centralized health care system, the Ministry of Health (MoH) adopted decentralization as the key strategy, with the district 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 1999-2004, have highlighted the Ministry of Health’s commitment to the implementation of the decentralization strategy.

To oversee health care delivery and health reforms at the district level, District Health Management Teams (DHMTs) and District Health Management Boards (DHMBs) were created in 1992, through 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 the central command. The aim was to empower the DHMBs to represent community interests in the implementation of health sector activities. By transferring power and decentralizing resources from the central level to the

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2 It is argued that since fiscal responsibilities rest with the local managers they have incentives to reduce costs by either tailoring local staff and procedures to local resources and circumstances rather than rely on centrally advocated procedures.

3 This refers to the local people that are within the jurisdiction that is receiving autonomy i.e. the district in this case.
An Assessment of the Service Delivery Capacity of the District Health Systems in Kenya

Periphery\(^4\), it was envisaged that the lower levels would enthusiastically be involved in identifying the community’s health needs and also actively participate in the implementation of health programmes and projects that would address local level needs. DHMB/Ts were therefore expected to make management and governance of health care services at the district more inclusive and responsive.

Operational guidelines outlining the roles and responsibilities of the different health institutions were also developed.\(^5\) The DHMBs and DHMTs were to assume greater responsibilities for managing and running health facilities in their jurisdiction, facilitated by the MoH through issuance of a single grant and training on how to prepare health plans based on the health needs of the respective districts. DHMBs became technically operational in October 1992 in phases depending on the time each received training on the new systems with the newly created districts having the latest formed DHMBs.

DHMB/Ts have not performed as expected by policy makers and administrators\(^6\). They have been ineffective with regard to overseeing provision of health care services in the district. Njau (1999) reported that due to lack of planning and management skills, Boards were not able to scrutinize DHMTs’ expenditure reports carefully to ensure spending as per the ministry’s guidelines. Accountability and transparency in the use of locally generated funds (cost sharing) has been a centre of controversy with rampant cases of misuse being reported (Comptroller and Audit report 2001/2002, on misuse of funds in Rachuonyo District). The Division of Health Care Financing at the MoH has continued to receive complaints of cases of fraud from the health facilities\(^7\). There is also a feeling of lack of ownership of health facilities/projects/programmes at the district by communities with some members accusing DHMB members of serving their own interests rather than the communities they purport to represent. Recent public debates have focused on the deteriorating conditions of the country’s health facilities, poorly maintained medical equipment and lack of such vital medical inputs such as drugs and laboratory reagents. This is in spite of the fact that DHMB/Ts were created to ensure prudent use of public and cost sharing resources in financing the improvement of health facilities.

\(^4\) Periphery in this case means the district because it where the administrative powers are directed (end point of decentralisation in this case).
\(^5\) MoH guidelines on DHMBs and DHMTs.
\(^6\) See table 1 on Roles and Responsibilities of the different levels including DHMB/Ts following decentralization
\(^7\) At least two cases in a month are being reported.
It is against this background that this paper assesses the service delivery capacity of the DHMBs and DHMTs, vis-à-vis what was expected of them as outlined in the MoH policy documents\(^8\). The paper will also inform the implementation of Sector Wide Approach (SWAps) by the MoH since a high and demonstrable management capacity at the district level is considered a key success criterion for a SWAp process.

Table 1 below provides a summary of the roles and responsibilities of the different tiers of the health care delivery system in Kenya as outlined by the MoH policy documents.

### 1.2 Study Objectives

The overall objective of the study was to assess the operational capacity of DHMBs and DHMTs, focusing on their performance in terms of their expected roles and responsibilities. The specific objectives were to:

1. Assess the effectiveness of linkages between DHMBs and DHMTs and between DHMB/Ts and partner institutions;
2. Assess the robustness of the criteria used in selection and recruitment of members of DHMT/Bs;
3. Assess the level of skills (empowerment) among members of the two institutions vis-a-vis the roles and responsibilities assigned to them (management capacity);
4. Identify operational constraints faced by DHMBs and DHMTs; and
5. Document the experiences of the DHMBs and DHMTs and offer possible remedies to the constraints inhibiting their capacity to deliver health care services.

This study is based on the premise that the ability of DHMB/Ts to deliver services depends on the effectiveness of linkages between the two institutions and other partner institutions. It is also dependent, on the criteria used to recruit members of the two institutions, competencies of the members and operational constraints faced by the DHMBs and DHMTs.

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Table 1: Roles and Responsibilities at the Three Levels of the Delivery System

<table>
<thead>
<tr>
<th>Level</th>
<th>Responsibilities</th>
<th>Comments</th>
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<tbody>
<tr>
<td>MoH headquarter</td>
<td>• Policy formulation and development.</td>
<td>• Weak in enforcing standards and regulatory mechanisms.</td>
</tr>
<tr>
<td></td>
<td>• Strategic planning.</td>
<td>• Involved in actual implementation of policies-conflict between policy</td>
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<tr>
<td></td>
<td>• Setting standards and regulatory mechanisms.</td>
<td>intentions and actual implementation.</td>
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<tr>
<td></td>
<td>• Regulating and coordinating health training.</td>
<td>• Failed to ensure equitable allocation of resources as resources both</td>
</tr>
<tr>
<td></td>
<td>• Coordination of donor activities.</td>
<td>human and financial are skewed in favour of urban and hospitals against</td>
</tr>
<tr>
<td></td>
<td>• Overseeing the implementation of health sector reforms.</td>
<td>rural and primary health care respectively.</td>
</tr>
<tr>
<td></td>
<td>• Ensuring equitable distribution of resources at national level.</td>
<td></td>
</tr>
<tr>
<td>Province- PMO/PHMT</td>
<td>• Supervision of district projects.</td>
<td>• Has failed to provide effective supervision to the district level.</td>
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<tr>
<td></td>
<td>• Implement, maintain and enforce standards.</td>
<td>• Weak in terms of maintaining and enforcing standards.</td>
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<tr>
<td></td>
<td>• Assist the districts in developing plans &amp; training activities.</td>
<td>• The HQ is actually assisting districts in preparation of plans and</td>
</tr>
<tr>
<td></td>
<td>• Has failed to provide effective supervision to the district level.</td>
<td>training activities-conflict between policy intention and actual</td>
</tr>
<tr>
<td></td>
<td>• Weak in terms of maintaining and enforcing standards.</td>
<td>implementation.</td>
</tr>
<tr>
<td>District/DHMB/Ts</td>
<td>• Preparation of work plans.</td>
<td>• Being assisted to prepare work plans by the HQ.</td>
</tr>
<tr>
<td></td>
<td>• Implementation of district plans.</td>
<td>• Weak implementation of district plans.</td>
</tr>
<tr>
<td></td>
<td>• Provision of health care (both curative and PHC).</td>
<td>• Has continued to provide poor quality of health care due to lack of</td>
</tr>
<tr>
<td></td>
<td>• Enforcing health standards.</td>
<td>both human and financial resources.</td>
</tr>
<tr>
<td></td>
<td>• Coordination &amp; supervision of health activities.</td>
<td>• DHMB/Ts weak in supervision of health care activities.</td>
</tr>
<tr>
<td></td>
<td>• Overseeing prudent expenditure at the district.</td>
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1.3 Organization of the Paper

The rest of this paper is organised in four sections. Section 2 gives a brief review of relevant literature; section 3 contains the study methodology; section 4 presents the study findings; and section 5 carries the conclusion and policy recommendations.

2. Literature Review

Literature on the capacity of district health systems to perform is very thin and what is available only dwells on skills and support in terms of DHMB/Ts empowerment by the authority to oversee smooth delivery of health care services at the district level. For instance, Gilson et al (1994), studied health systems in several African countries and highlighted an inadequate planning process, lack of management capacity and understanding within the district health management teams as some of the main factors affecting the service delivery capacity of district health systems. These weaknesses were also reported by a study on the Tanzania systems by Barnett and Ndeki (1992). In an attempt to respond to the skill needs of the district health managers, Barnett and Ndeki used the District
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Action Research and Education (DARE) approach. This approach of providing management skills to health managers was found to produce similar results at least in terms of improving planning and budgeting in the districts (Ahmed et al., 1993).

Ahmed et al., (1993) found out that within a year and with the use of the DARE approach, health management teams were able to identify health problems and develop interventions to address them. He came up with similar results in both rural and urban set ups in Tanzania. The focus in the urban districts was on the following key areas: increasing the availability of continuing education for health workers; establishing a library; preparing guidelines for good performance; and developing a system to recognise and reward the best workers. With regard to the rural districts the focus was on: improving the preparation and follow-up of supervisory activities through workshops and meetings involving members of the district health management teams.

Gambia embarked on a decentralisation policy in the health sector in 1990. Regional management teams were established to oversee delivery of health care services at the regions. However, very little was achieved in terms of improvement in delivery of health care services until a donor-funded management-strengthening project was established in 1991 (Conn et al., 1996). Through this project, both decentralised management and accountability were promoted and management capacity was developed using a ‘learning by doing’ approach. The capacity of DHMB/Ts to deliver services also depends on the degree of autonomy – decision space. Where fiscal decentralization has been effected, DHMBs and DHMTs have performed well. In Zambia, besides having autonomy in raising and spending cost-sharing revenues, district health offices receive direct transfers to their own bank accounts (both recurrent and donor funds – funds allocated to vertical programmes) and are given authority by Central Level (Ministry of Health) to develop and manage budget plans with the central approval. In Tanzania, according to Gilson et al., (1994), a major obstacle to district health development was the capacity of district managers who operated in a system that gave them limited authority. She summed up the obstacle facing district health development by noting that:

9 ‘The key terms: ‘action research’ and ‘education’ emphasise two central activities in the process. Action research is research conducted by people involved in a situation often used to analyse problems they themselves are experiencing, with the purpose of finding solutions to those problems and monitoring the process by which the solutions are implemented’.

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“District health managers often have limited motivation because of the combined effect of resource constraints, limited authority and inflexible administrative systems, while incentives to improve management, such as salary levels or opportunities for career development, are weak...health managers motivation is further undermined by their skill’s weaknesses” (p. 470).

In Uganda and Philippines (Bossert et al., 2002), local levels have been given powers to hire and fire the already devolved personnel. In the case of Uganda, the district based Ministry of Health personnel became district staff and were remunerated from the money under the delegated grant. In the case of Zambia attempts to increase control of local staff by de-linking health staff from the national system and allow District Health Management Boards to hire them directly was met with stiff resistance from health workers in 1998 as the DHMT questioned the technical capacity of DHMBs.

In an analysis of the Swedish experience, Anell (2000) suggested that two fundamentals are important for decentralisation to achieve the desired results. These are:
(i) The administrative level to which responsibility is delegated must be able to handle the new responsibilities;
(ii) They must have the capacity and are willing to do so; and
(iii) Incentives may be necessary to increase motivation.

The effectiveness on the part of the DHMBs is demonstrated in terms of the positive impact on the district health systems. Where in some districts, accountability has been enhanced and planning activities have been improved (Collins et al., 1994). According to Collins, Board members who received training on management of cost sharing were very active in supervision and management of the funds. In most cases their effectiveness has depended on their qualifications, meaning that in districts with DHMBs with relevant qualifications and experience, accountability of cost sharing funds has improved and cases of spending at source (before banking) are very few (Njau, 1999).

Owino and Korir (1997) reported the existence of short and uneven distribution of health personnel in most districts especially doctors and paramedic staff. This contributed to the formation of weak DHMTs that were deficient in financial and management skills. Gilson and Travis (1997) noted that although many personnel in the district health system in Kenya have undergone health management training courses, the districts are still geared towards providing health services according to centralized instructions and the opportunity to make local decisions is limited.
Owino et al., (2000) highlighted inadequate capacity in planning, budgeting, financial management coupled with weak monitoring and evaluation of plans and budgets as the critical factors that led to the poor performance of the DHMBs. Where DHMBs had skills in planning and budgeting revenues collected by facilities was reported to be high. Owino et al., (2001) reported that most of the board members were facing difficulties in monitoring expenditures mainly because they lacked financial and management skills. This coupled with the limited autonomy of the boards to perform control functions further contributed to the poor performance.

Generally, the literature on delivery capacity of DHMB/Ts focuses on skills and support in terms of empowering them to oversee the delivery of health care services at the district level. Most of the studies reviewed used primary and secondary data. Research instruments applied include focus group discussions, structured questionnaires, interview guides and observational guides. Key findings drawn from the literature reviewed include weak planning, lack of budgeting and financial management skills, limited autonomy granted to boards to perform central functions and inadequate resources to finance key health care activities.

Besides exploring the influence of skills and empowerment as key variables that affect the capacity of DHMB/Ts to perform in the Kenyan context, this study goes further and explores other variables like transparency and accountability, incentive systems, coordination and communication, public sector hierarchical style of decision-making, external environment-political and social factors, resource allocation and flow and management capacity. A comprehensive assessment of the factors that influence the service delivery capacity of DHMB/Ts is critical so as to generate an evidence base to inform policies on how best to improve their delivery capacity in an effort to improve delivery of health care services. The findings and recommendations of this paper will be useful in informing the discussions and implementation of SWAps.

3. Methodology

3.1 Analytical Framework

The study’s analytical framework hinges on the task network theory. The term task network\textsuperscript{10} refers to the range of organizations that are jointly involved in

\textsuperscript{10} The task network is a group of organisations/institutions jointly responsible for undertaking a particular activity/task.
performing a specific task (Hildebrand and Grindle, 1994; Cassels and Janovisky, 1996). It is through the interaction between the different actors in the network that a particular quantity and quality of a product or service is produced. Each of these actors undertakes different elements of the same task but the end result is due to the efforts of all the actors/groups making up the task network. In the case of the district health system, the task network involves interaction between the DHMBs, DHMTs, donors, NGOs, clients and the central government. These different groups have particular responsibilities for health care provision in a district and undertake different aspects of the same task. DHMB/Ts are therefore part of the institutions and structures created to facilitate efficient and effective functioning of the health systems at the district level.

Paul (1995), alluding to the emphasis given to community participation within health care strategies, stressed the importance of ensuring health care users are a group within the task network which is involved in every aspect of health care planning and management. In the case of the district health system, the health care users are usually represented through the DHMBs.

The case of the district health system in Kenya\textsuperscript{11} points to a wide-ranging task network for district level management. The groups involved include community committees charged with establishing annual health centre/dispensary plans; the DHMTs responsible for planning and budgeting, and managing health services within the district; the DHMBs, comprising of health sector managers and community representatives, which supports the DHMT in providing health care within the district; Hospital Management Boards/Teams (HMB/Ts) responsible for management of health services in hospitals; the Provincial Health Management Team (PHMT)-head by the Provincial Medical Officer (PMO)-responsible for supporting and supervising the districts; donors; NGOs; private sector institutions and the central Ministry of Health, responsible for policy formulation and development, regulating and coordinating health care delivery, etc. DHMB/Ts are therefore expected to work in close consultation with the management structures to improve governance and management of health care services at the district. The operational and functional linkage between DHMBs and DHMTs and DHMB/Ts and other institutions involved in health care delivery are shown in Figure 1.

\textsuperscript{11} See the health care system task network on page 10.
Figure 1: Health Care Delivery System Task Network

Source: Adapted from Owino et al (2000).
Capacity is often understood to be merely concerned with training of personnel in the skills required to implement their specified tasks. However, Hildebrand and Grindle (1994) show that capacity should be understood broadly. The dimensions of capacity should include: the capacity of the task network responsible for implementing a specific function and its tasks; the capacity of each organization within the task network; the public sector institutional environment which affects the functioning of the public sector organization; and the external environment which affects the functioning both of the task network and individual organizations within it. The authors identified four key factors that constrain task networks performance. They include limited capacity within an organization/institution, lack of effective coordination and communication between institutions, limited autonomy of decision-making power within the institutions and failure to involve organizations or institutions that play critical roles in service delivery or service utilization within a task network or interaction.

The availability and quality of human resources within an organization are critical factors that influence the capacity of an organization to deliver services. Two factors that influence availability of human resources are skills and training of personnel (Hildebrand and Grindle, 1994). For the case of a district management team or board, a mixture of skills are required to manage assets, deliver health care services, monitor and use feedback and motivate performance (Paul, 1995). In this case the skills required include both the analytical/technical skills relevant to planning and management. Hildebrand and Grindle linked inefficiencies, confusion and lack of morale within an organization to managers’ failure to familiarise themselves with standards of modern management.

Where skills are lacking, the most obvious way of developing them is through training courses. This can either be through basic, tertiary and technical training institutions and in service that provide on job training. As an investment, in-service can be very vital in terms of compensating for inadequate and inappropriate basic training (Paul, 1995).

The recruitment process within an organization must be able to attract the right people in terms of the relevant skills required to implement the specified tasks within an organization. Hildebrand and Grindle (1994) noted that competitiveness and openness are important factors in the recruitment process. This can be attained through public announcement of available posts and use of examinations/interviews by the selection board.

After the recruitment is done, the way the human resource is managed has an influence over their motivation, effectiveness and retention. This partly explains why the health sector in sub-Saharan African countries has been loosing personnel
to the private sector and donor-supported projects, which can afford to pay and provide better remuneration and incentives. Hildebrand and Grindle 1994 indicated that in the face of poor salaries other important incentives included the sense of organizational mission and involvement, job satisfaction, teamwork, rewards for good performance, training, fairness in job distribution etc.

Many public sector organizations suffer from a hierarchical style of decision-making process. Over-centralized and ineffective rules and regulations may lead to inflexibility and therefore hinder the accomplishment of important tasks (Cassels, 1995). The above style of decision-making allows little room for participation of the lower levels in decision-making, even in tasks for which lower levels have been given responsibility, and promote insufficient coordination both between the public institutions and other organizations.

In many developing countries, rules and regulations governing employment inhibits capacity to deliver services by the public system. Grindle and Hildebrand (1995) highlight five problems in relation to public sector employment. These are lack of effective performance standards; inability to hire and fire by the lower levels; too few rewards for good performance; an ineffective recruitment process cannot attract appropriate trained people; and promotion patterns that are based on too much seniority and too little on performance.

The external environment, which the public service organizations operate, has a bearing over capacity of individual actors within the task network to deliver services (Cassel and Janovsky, 1989). 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 political stability, degree of openness, participation, political leadership and vision and support of political leaders that influence the capacity of actors within a network to implement policies.

3.2 Study Variables

The study holds that for the DHMB/Ts to deliver health services in an efficient and effective way, the following factors are critical and therefore constitute the basis of analysis in this study.

**Communication and coordination:** The quality of linkages/communication between the organizations making up the task network has a bearing on the delivery performance of the individual organizations. The ability of members of
DHMBs to communicate among themselves or interact/communicate well with the DHMTs or other institutions has implications on the performance of the two institutions. The linkage/communication between DHMBs and DHMTs and between DHMB/Ts and other institutions was explored to determine how it has impacted on their service delivery capacity.

**Transparency and accountability:** The selection process of DHMBs determines the ability of the members to perform. This is partly due to the fact that the process may be skewed enough to allow structural weakness, some of which allow entry and participation of poor actors, in terms of capacity. The way DHMB/Ts members and other staff are recruited/deployed has an influence on the delivery capacity of DHMBs and DHMTs. The recruitment process must be able to attract people with appropriate skills to implement specified tasks. This was measured and assessed by examining whether the process of selecting/deploying DHMB/Ts members involved public announcement of available posts and use of examinations/interviews by the selection board.

**Management capacity:** Skills and tools to perform the tasks designated to the institutions also influence the delivery capacity of DHMBs and DHMTs. Where capacity building has been integrated in the whole process of systems development, diagnosis of shortcomings in specific areas of health care delivery becomes easier and can be easily addressed. Improvement in programme/project design, monitoring and implementation is thus achieved, leading to more cost-effective use of the limited resources. Management capacity was measured in terms of the level of education and level of financial, budgeting, planning and management training or induction training attained by the DHMB/Ts. Somehow related to management capacity is management systems. Good performance of managerial tasks within an organization needs not only trained manpower but also effective management systems, particularly human and financial resource related and broader information (Brinkerhoff and Ingle, 1989). Such systems help define realistic objectives, track distribution and use of financial resources. They are deemed to be critical mechanisms for ensuring accountability among managers and can therefore improve the functioning of DHMB/Ts. These systems include management information systems and budgeting and planning systems etc. Management systems were measured by the number of DHMTs members with training on planning and budgeting; and management information systems etc.

**Incentive and reward:** The way human resource is managed has a critical influence over their motivation and effectiveness. Important management issues include the type of rewards and incentives available, and the way the work force is utilized within an organization. Non financial incentives that can influence
performance include appropriate career structures with reasonable opportunities for advancement, training opportunities linked to performance, promotion for good performance, employee of the month programmes, competition to achieve performance goals, and involvement in work etc. Available incentives and rewards were assessed to establish how their availability or their absence influences the service delivery capacity of DHMB/Ts.

**Rules and regulations:** The rules and regulations governing the operation of DHMB/Ts within the district health system were assessed to determine how they impacted on the service delivery capacity of the DHMB/Ts. Such rules and regulations included financial management procedures, procurement procedures, employment rules and regulation etc. For instance how availability or lack of performance standards, procurement procedures, financial regulations, inability to hire and fire, and recruitment procedures affect the delivery capacity of DHMB/Ts.

**Resource allocation and flow:** The level and type of physical resources used in the delivery of health care services does influence the capacity of an organization to deliver services. Inadequate budgetary support can constraint the capacity to perform as it undermines funding for operating expenses. Poorly maintained equipment like computers and buildings have been found to undermine the quality of health care provided and community satisfaction in both urban and rural facilities. In addition, lack of some specific resources can undermine technical efficiency. For instance, in cases where health staff cannot deliver services due to lack of drugs, then technical efficiency is affected (Gilson and Mills, 1995). This was measured through examination of the size of the budgetary support provided to the districts, the number of times districts lacked drugs and other non-pharmaceutical supplies and quality and quantity of equipments at the disposal of the DHMB/Ts.

**External environment:** The external environment in which the DHMB/Ts operate has an influence on their capacity to delivery services. Potential external factors like budgetary support, political and social environment were explored and assessed to determine to what extent they influence the service delivery capacity of DHMB/Ts.

### 3.3 Data Sources, Type and Analysis

A desk review of secondary material at the Division of Healthcare Financing of the Ministry of Health was conducted to obtain secondary data. Primary data were obtained through focus group discussions and key informant discussions.
An Assessment of the Service Delivery Capacity of the District Health Systems in Kenya

with members of the DHMBs/DHMTs, senior managers in the Ministry of Health especially those managing the cost-sharing programme. Other key informants from key institutional partners and donor organizations were also interviewed. In total 20 key informants were interviewed which included four from donors and three from the NGOs sector. A total of six focus group discussions were also held to obtain vital primary data.

Each district has one DHMB and one DHMT. As such, the districts formed the sampling frame. When selecting the districts, DHMBs and DHMTs, those newly formed were included so as to capture characteristics unique to them. A few DHMBs and DHMTs that had been piloted in earlier studies were also selected to ensure representation of the characteristics of well established DHMBs and DHMTs. Njau’s performance classification of DHMBs was adopted. The performance classification of the DHMBs was in three bands namely: good – green; mediocre – amber; and poor – red. This was updated using data for year 2003 pertaining to reporting rates, revenue collection, banking and DHMBs meetings by province and district. The performance classification of the DHMBs was in three bands namely: good – green; mediocre – amber; and poor – red.

Data collection methods included review of records, observation, and both structured and unstructured interviews with key informants. The data collection instruments included unstructured interview guides and observation guides. Questions that formed the basis of the interview guides were structured under the following areas; DHMB/Ts capacity to perform, recruitment process of DHMB/Ts, DHMBs meetings, oversight role of DHMBs, DHMB/Ts linkage with other key institutions and DHMB/Ts qualification and skills. The instruments were first pre-tested to ensure quality and sustainability. The data analysis was mainly qualitative with limited quantitative inputs.

12 The key informants include senior staff of the District Administration Office, NGOs, mission facilities and donors in the respective districts.
4. Analysis of Findings

This section presents an analysis of the findings of this enquiry with a view to assessing the delivery capacity of the decentralized institutions.

4.1 Synthesized Analysis

This section provides a synthesized analysis of the key findings of the study.

**Communication and coordination:** The quality of interaction/communication between the DHMBs and DHMTs and DHMB/Ts and other institutions has a bearing on their performance. The linkage between DHMBs and DHMTs and between DHMB/Ts and other institutions making up the District Health System (task network) was found to be weak. This has adversely affected the efficiency and effectiveness of delivery of health care services in the districts as in most cases DHMBs delayed approval of district expenditures while DHMTs went without vital health inputs for lengthy periods of time, thereby affecting their performance.

According to the 2002 guidelines, Health Management Teams (HMTs) through Health Management Boards (HMBs) should forward their expenditure plans to the PMOs office for approval. However, judging from discussions with key informants, the DHMBs are unhappy with this arrangement as they feel that they are being by-passed given that their mandate covers the whole district, including HMBs. With the current trend of HMBs being established across the country, the powers of DHMBs are threatened with continuous erosion and may very soon be limited to overseeing the health centre and dispensary health activities. This is in spite of the DHMBs having been created to oversee health activities in the districts. This has undermined the DHMBs managerial efficiency and responsiveness to service users.

Members of DHMBs interviewed felt that while this procedure of forwarding expenditure plans directly to the PMO is fast, a critical opportunity for scrutiny by the DHMB is by-passed. In an effort to minimize the potential for conflicts, some districts have had some HMBs entering into informal arrangements with their DHMBs, just to ensure smooth flow of operations and peaceful co-existence, especially on matters regarding cost-sharing expenditure approval. Such informal arrangements are however not backed by any legal framework. They could thus be short-lived as these hospital boards begin to seek “independence” and start operating like other hospital boards across the country.
The consensual relationships have resulted in apathy on the part of some of the DHMBs while other HMBs have responded by withholding the 25 per cent of the cost-sharing money due to DHMB/Ts for PHC activities. This further affects the service delivery capacity of DHMBs, as they cannot realize their full potential in terms of delivery capacity.

Structural weaknesses between the Health Centre Management Committees (HCMCs)/Village Health Committees (VHCs) and DHMBs were also found. The 2002 guidelines require that after the HCMCs/VHCs scrutinize the cost-sharing requests from the Health Centre Management Teams (HCMTs) they should forward them, through DHMTs, to the DHMBs for approval. Members of the DHMBs interviewed complained of friction between them and the HCMCs/VHCs as the latter felt that they closer to the health centres and have been empowered by the Ministry of Health to oversee health services at the health centre and dispensary level. The DHMBs also felt that they have been explicitly empowered to supervise the HCMCs/VHCs given the lack of clear guidelines on how the two should interact. There is thus lack of clarity concerning the roles and functions of the DHMBs, particularly after the creation of the HCMCs/VHCs. Consequently, the roles and responsibilities of the DHMBs have been subjected to different interpretations, leading to confusion and discrepancy between policy as intended and its translation into action. This had adversely affected the delivery performance of DHMBs, as they cannot make frequent supervisory visits to health centres and dispensaries to inspect the quality of health care delivered by these institutions.

Other perceived structural weaknesses that affect service delivery capacity of DHMB/Ts relate to linkages/interactions between the PHMTs and the DHMB/Ts. For example, it is clearly stipulated that the PHMTs are to issue Authority to Incur Expenditure (AIEs), supervise the DHMBs and monitor and evaluate district programmes and projects. But some PHMTs have remained ineffective leaving most of the responsibilities to DHMTs. Functional failures at the level of PHMTs imply structural weaknesses in the chain of command in the DHS, thus affecting the delivery of health care services at the district level. DHMTs may require some specific instructions on how to conduct business but due to the unavailability of PHMTs to provide direction or supervision they end up not performing well. For instance, it was alleged by DHMBs members interviewed that some DHMT members were performing below par because of lack of supervision by the PHMT.

With regard to facilitation through provision of relevant information, it was observed that the DHMTs in some cases deliberately block access to vital health information by DHMBs that include MoH recurrent and development budget.
estimates, copies of AIEs issued to the districts by the MoH, health policy documents and guidelines etc. Owino et al., (2001) cited that access to some of the documents by DHMBs is constrained by the government secrecy act that restricts access to vital government documents. The DHMBs therefore operate without information to guide their operations, leading to financing of expenditure plans approved by DHMBs that do not conform to the district health priorities. The DHMBs members interviewed thus feared that they could have/or have approved expenditures that also attract funding from recurrent votes, leading to double financing of the same item. This is simply because DHMBs cannot access information to clarify the same.

On its part, the DHS has also failed to recognize the role of the private sector and NGOs in the delivery of health care services in the districts, despite the important role-played by the private sector and NGOs especially the mission facilities located in under-served rural areas. In the event that the private sector and NGOs get integrated into the district health system, their operations will require supervision by the DHMBs and DHMTs to ensure complementarity with the district health priorities. For this to work effectively, the perceived arrangement will need to be formalized. This could be achieved through inclusion of the private sector and NGOs in the management of health care services at the district level.

Donor financed projects/programmes by agencies such as World Health Organisation (WHO), United Nations Children’s Fund (UNICEF) and Japanese International Cooperation Agency (JICA) provide relatively vertically oriented programmes with some activities operated and managed exclusively by donors. This tends to limit the potential role of DHMTs and DHMBs in functional control and supervision of the programmes. For instance some resources in the process of immunization are exogenous to the control and management by DHMTs. Examples include procurement of vaccines, purchase of motor vehicles and cold chains. The DHMB and DHMT members interviewed complained of not having total control over the donor funded health activities. This in effect, tends to adversely affect the delivery capacity of the DHMB/Ts. Implementation of SWAp, is perceived to be a possible solution in the sense that donors will put all their money into one basket and proper planning and management by the DHMB/Ts would ensure that the money is spent on priority health needs of the districts, thus moving away from the vertical programmes, planned and managed by the centre.

**Transparency and accountability:** The process and quality recruitment/posting of DHMBs and DHMTs members has a bearing on the ability of the selected members to perform their tasks. Recruitment of the DHMBs starts with the
preparation of a list of nominees by the District Medical Officer of Health (DMoH) in consultation with the District Commissioner (DC) and other organs of the district. The DMoH then liaises with the PMO and key members of the PHMT in vetting the nominee list and subsequently forwarding it to the MoH headquarters in Nairobi for confirmation and gazettement.

The study found out that the selection process does not entail a formal public announcement to attract many qualified candidates, or even use of examinations/ interviews by a selection board to vet the nominees. The process therefore lacks transparency. Most of the DHMB/T’s members interviewed expressed reservations about the involvement of the DMoH in the whole process. Some even suggested a review of DMoH’s involvement. Involvement of the DC in the selection process was also questioned especially in terms of whether or not he represents the interests of the community. The DC is perceived to ensure selection of pro-system people who may not represent the interests of the community in the decision-making process with regard to matters pertaining to health activities in the district or unqualified members in terms of the required skills. Consideration of specialised skills in areas like planning, management and budgeting is never factored into the selection process. As such the DHMB members’ selection remains largely unacceptable to the local community stakeholders and more often than not leads to selection of unqualified people in terms of management capacity.

The MoH headquarters was also accused of gross interference with the whole process. Cases were revealed of MoH commonly replacing the names of nominees with preferred appointees. The appointees at times lacked the necessary skills to manage resources. Another concern had to do with why it takes a year or so for the MoH to gazette board members. This delay generates further anxiety, as nominees remain unsure of their legal status and fears of intentions on the part of MoH to interfere with the list. Experience of countries like Zambia should be avoided where the process of selection has had appointments made centrally, leading to selection of unqualified people.

Reservations were further expressed with regard to the constitution and deployment of DHMTs members, with the DMoH as the team leader among the departmental heads: District Health Administrator, District Public Health Nurse, District Public Health Officer, District Nutritionist, District Pharmacist, District Clinical Officer, and District Health Information Officer. The point of contention is that this was done in the absence of district staffing guidelines to inform the whole process. Key informants interviewed indicated that no skills or education background are considered in posting staff to the districts.
In terms of decision-making by the DHMBs and DHMTs, centralization of personnel management tends to significantly undermine local decision space and thus reflecting negatively on the service delivery capacity of DHMBs and DHMTs. And since a large portion of the health sector budget is absorbed by salaries in developing countries and because personnel has a strong influence on decision-making, the control of health workers remains largely ineffective as the DHMBs do not have control over the health workers in the district. DHMBs are therefore powerless when it comes to ensuring a particular standard of provision of health care services.

There is no legal framework empowering the DHMBs to manage district health staff especially with regard to hiring and firing of local staff, other than the casual workers. This has posed serious supervisory problems, resulting in tension and disinterest among board members. Where DHMBs recommend disciplinary action against certain health staff, such cases must go through the Ministry for sanctioning and end up taking longer than necessary.

**Management capacity**: The roles and responsibilities of the DHMB/Ts in service delivery are well documented in several MoH policy documents. The DHMBs are supposed to show a sense of social responsibility, foster community participation in health improvement, and uphold the ethical and quality standards commonly expected of service providers and public sector organizations. DHMBs were created to play critical roles in the administration, planning and management of the cost-sharing programme\(^\text{14}\).

The potential for effectiveness on the part of DHMBs has been demonstrated by an assessment, which confirmed that trained DHMBs have had a positive impact on the district health systems, by increasing accountability and in some cases increasing planning capacity in districts. Some board members have also become involved in supervision of cost sharing and in planning of funds utilization. However, their effectiveness has often depended on individual member’s qualifications and practical experience. The concern is that the selection process has not always ensured that the best people are selected for the jobs.

\(^{a}\) **Planning and administration**

With regard to planning, the guidelines stipulate that representatives of DHMBs are to actively participate alongside the DHMTs in the district health planning process. The DHMTs, through the DHMBs can initiate proposals for funding

either from the cost-sharing funds or from donors, but the proposals will need approval by the District Development Committees (DDCs). With regard to cost-sharing funds, the DHMTs’ responsibilities include planning and coordination of health activities in the district; and preparation of expenditure plans with reference to the MoH cost-sharing expenditure guidelines. The DHMBs then scrutinize the expenditure proposals to ensure they are line with the MoH guidelines and availability of funds in the bank account to finance the plans. This has to be done prior to approval of the proposals for onward transmission to the PHMTs for the final authority to spend. According to the NHSSP (1999-2004), the expenditure plans should only favour cost-effective programs and activities with direct impact on the health of the people in the district, in terms of reducing the disease burden and improving the health status of the population. The DHMBs should therefore accent mainly to expenditure plans that are consistent with the policy guidelines.

Findings from key informants indicated that DHMBs were approving plans that were not consistent with policy guidelines and in some cases expenditure on items that were also receiving funding from the recurrent vote. Members of DHMTs alleged that DHMBs were also not reviewing regularly revenue collections, expenditures, waivers and exemptions. This is simply because the DHMBs lack time and skills to conduct effective and thorough scrutiny on cost sharing plans and expenditures.

(b) Management of the cost-sharing programme
On the management of the cost-sharing programme, the DHMBs were created to play the role of a “watch dog”. This includes: review reports on user fees collections, expenditures, waivers and exemptions performance and status; review expenditure plans\(^{15}\), approve and if possible offer some advise on basis of the MoH guidelines; arrange for internal or external audit of the books of accounts and forward the report to the PMO for further action; handle patients’ complaints on matters pertaining to the management of cost sharing funds or quality of care provided by the facilities in the district; recommend new fee structure through the PMO and MoH\(^{16}\); and maintain a supervisory role over the entire cost-sharing programme in the district.

\(^{15}\) For both the 75% and the 25% that is meant for Primary Health Care Activities (PHC).

\(^{16}\) Division of Health Care Financing is the arm of MoH that Coordinates cost sharing activities at the national level.
To diligently perform the above duties, the DHMBs are entitled to information that would facilitate their work. Crucial information here includes the Recurrent (R11) and Development (D11) budget estimates, copies of AIEs issued to the districts by the MoH, health policy documents and guidelines etc.

Findings from the key informants and perusal from administrative records showed that the books of accounts had not been audited even where cases of fraud had been suspected. DHMBs have powers to request for external auditors in cases where they deem necessary. A forum where DHMBs would listen to patients had not been created even though most of the DHMB members felt that for the performance of the facilities in their jurisdiction to improve patients grievances needed to be addressed.

The DHMTs monitors activities in the whole district, overseeing projects and co-coordinating PHC activities. The DHMTs also review revenue collections, targets and expenditure plans and monitor collection performance. To facilitate effective performance of their roles, both the DHMBs and DHMTs have been divided into standing committees, based on different tasks to be undertaken. The committees include: (i) Primary Health Committee that oversees Primary Health Care (PHC) activities in the district; (ii) Quality Health Care Services Committee which plays the essential role of overseeing the MoH’s curative health services in the district, with special focus on the hospitals; and (iii) Finance Committee which is mandated to prepare and review expenditure plans based on the revenue collections.

Ideally, these standing committees require specific skills for effective and efficient performance of the tasks in question. Standing committees had been established in many districts, but they hardly ever meet. Reasons cited included lack of capacity in some specialized areas such as quality assurance, which is a key factor for effective running of some of the standing committees.

According to the Legal Notice No. 162 of the Public Health Act (Cap. 242), the Boards can hold a minimum of four meetings while standing committees should hold at least six meetings per year. In case of emergencies such as an outbreak of an epidemic or serious case for disciplinary action, special meetings can be convened. However, it was found that the number of board meetings held varied between districts probably suggesting different levels of commitment and management skills among the boards. DHMB meetings were not held regularly in many districts. Many of the DHMB sub-committees had been created but were not functional. The most active sub-committee in most if not all, of the boards was the finance and general-purpose committee. Some board members
interviewed alleged that they could not meet occasionally because of lack of quorum due to unavailability of some members. The leadership of the board was found to be critical to the functioning of the boards. Njau (1999) reported a positive relationship between the number of DHMB meetings and overall board performance.

The DHMBs were created to control cost-sharing expenditures through monitoring the implementation of the approved budget and reviewing expenditure reports presented to them during board meetings. Findings from key informants however, indicate difficulties for most of the boards to effectively monitor such expenditures mainly because the board members lacked financial and management skills. On the supervisory visits most of the members of the DHMBs interviewed reported that they hardly make any visits because they lack supervisory skills and, in most cases, lack transport and financial resources to facilitate the visits. Owino and Munga (1997) reported positive correlation between supervision and collections, banking and operations. Where boards made frequent supervisory visits, facilities’ revenue collection and banking as a percentage of collection was noted to be high. Table 2 below shows the number of supervisory visits made by the DHMBs of the respective districts.

Table 2: Number of Supervisory Visits to the Respective Districts

<table>
<thead>
<tr>
<th>Districts</th>
<th>Year and number of supervisory visits</th>
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<tbody>
<tr>
<td></td>
<td>2000</td>
</tr>
<tr>
<td>Thika</td>
<td>0</td>
</tr>
<tr>
<td>Kiambu</td>
<td>0</td>
</tr>
<tr>
<td>Kirinyaga</td>
<td>0</td>
</tr>
<tr>
<td>Machakos</td>
<td>0</td>
</tr>
<tr>
<td>Moiingi</td>
<td>0</td>
</tr>
<tr>
<td>Nyeri</td>
<td>0</td>
</tr>
</tbody>
</table>


As shown in table 2 above, the DHMBs of the six districts ended up conducting a limited number of supervisory visits due to lack of supervisory, financial and management skills. This in turn has had adverse implications on the implementation of quality health care services as well as financial management.
Where the visits are made, no specific agenda is prepared and they end up being “site visit tours” as put by some of the key informants.

Human resource is the most important part of the health care system in converting available inputs – drugs and other medical supplies, health technology and data – into better health outcomes. The health sector reform process has seen greater emphasis on systemic capacity development in recent years, as policy makers and administrators recognize the need for substantially qualified health managers to ensure successful health reforms. It is mainly for this reason that even in times of fiscal constraints, many developing countries, with the assistance of donors, are regularly funding capacity development for district health systems. Thus inadequate planning process, lack of management capacity and understanding within the district health management teams have been cited among the main factors affecting the service delivery capacity of district health systems.

**Incentives and reward:** Management of human resources after deployment is critical in influencing their motivation, effectiveness and retention. Important management issues include the types of rewards and incentives available, and the way staff is utilized within an organization or institution. Frequent loss of senior personnel in the district was reported and this tended to adversely affect service delivery. Low salaries were cited as a major factor that can explain lack of qualified people making up the DHMT members. In the face of poor salaries members of DHMT interviewed felt that job satisfaction, teamwork, reward or recognition for good performance, promotion for good performance and fairness in job distribution could attract or even retain the qualified staff. These incentives were however lacking. It was quite shocking to note that some health staff in the districts had stagnated in one job group for more than 10 or even 15 years.

Another important factor that was reported as influencing staff motivation and retention was whether or not trained professionals felt that their jobs, and the tasks they were asked to undertake commensurate with their training. The use of medically qualified staff to undertake administrative work for which they were not trained or which they are not interested explains at least why some District Managers (DMoH) performed poorly. The MoH headquarter was further blamed for staff imbalances between the HMTs and DHMTs on the basis of the fact that the MoH posts doctors who are consultants to head hospitals and fresh doctors to head the districts. Yet, the DMoH is expected to supervise the

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17Consultants are doctors who are specialised in particular field like paediatricians, gynaecologists etc while general doctors are doctors who are yet to specialise in any field. Consultants are deemed to be more senior than general doctors (general practitioners).
whole district, including the HMTs. This imbalance has caused friction in some districts as the medical-superintendents (consultants heading hospitals) and his staff feel that the DHMT members are too junior and incompetent to supervise them. In some cases, the DHMT feel inferior and therefore end up not making any supervisory visits.

In countries like Philippines and Zambia, establishment of DHMTs was followed by re-distribution of health personnel to the districts to match the roles and responsibilities they were expected to play as members of the newly constituted DHMTs. This was not the case in Kenya, as redeployment was not undertaken to address the imbalances. Where it was undertaken it lacked focus on addressing the imbalances arising from the constitution of the DHMTs and the roles they should play. It was also expected that future redeployment would be guided by fair distribution of skills required by members of the DHMTs, however this was not the case.

Shortages and uneven distribution of personnel was commonly reported in the sampled districts especially doctors and paramedic staff that led to formation of weak DHMTs in terms of financial and management skills. The same personnel feel neglected/ignored due to the poor remuneration and limited training opportunities in areas of management of cost-sharing. Negative impacts on the delivery capacity of DHMTs are thus manifested through time allocation divested to private practice at the expense of public work in the district; poor performance of district facilities in terms of cost sharing collections; banking and expenditure practices with some even spending at source. Internalizing change has been a major problem.

Many health personnel in the district health system were noted to have undergone health management training courses. But the districts are still inclined towards providing health services according to centralized instructions hence local level decision making was limited. The end results was low staff morale, contributing to high turn over as the management skills developed end up being lost from the system. Replacements often lack the required skills while resources to train new entrants are limited.

The DHMT members interviewed also alleged that the training accorded to them was ineffective in the sense that it comprised frequent workshops with limited or unknown impact and which mostly interfered with performance of their routine tasks. In most cases the training was provided to meet the needs of specific vertical programmes like immunization or reproductive health with very little on general management of health care services in the district. The few training opportunities in the MoH headquarters are allocated on basis of patronage.
As such a few people end up either being over-trained or attending courses not relevant to their professional practice. This again impacted negatively on their capacity to perform.

**Rules and regulations:** The rules and regulation governing the health sector and the civil service at large, was reported to be constraining the capacity of DHMB/Ts to deliver health care services. From discussions with key informants, the rules and regulation-related problems that were listed as major impediments to service delivery included: lack of effective performance standards; inability to fire and hire; lack of incentives and rewards for good performance; recruitment procedures that were not effective in attracting trained personnel; and deployment and promotion pattern that is based too much on seniority and too little on performance. These factors were reported to affect performance negatively in the whole public sector.

Also noted as important were rules and regulations governing procurement and financial management. In Kenya, public procurement is subject to a wide range of laws and regulations. The effect of these regulations is to remove procurement functions from the lower levels (district). Approval from Treasury is also required if district managers are to re-allocate monies from one line item or programme to another. The budget process indicates that unspent resources must be reverted to the higher levels with no benefit for the lower level that has controlled costs or is earning income. The limited managerial autonomy allowed by the above rules and regulations promotes centralized and over decentralized accountability, and so undermines managerial efficiency and responsiveness to deliver services. Centralized budgeting denies the managers a chance to exercise financial responsibility and therefore according them little incentive to use resources in a cost effective way.

Despite the guidelines giving DHMB/Ts authority to oversee management of both recurrent and development budget, the authority to oversee the budget has not been granted by MoH. Discrepancy therefore exists between policy intentions and implementation. The Ministry through NHSSP (1999-2004) had promised to empower DHMBs and DHMTs by providing them with a single line grant budget. This is yet to be implemented mainly because it requires amendment of the Exchequer and Audit Act to allow issuance of block grants to districts.

**Resource allocation and flow:** Inadequate budgetary support and delays in channeling the funds to the districts was seen as a serious constraint to the performance of the DHMB/Ts as it undermines financing of operations and maintenance expenses. Inadequate budgetary support has also prevented the provision of some types of services or services in areas that are more difficult
An Assessment of the Service Delivery Capacity of the District Health Systems in Kenya

and costly to reach. Key informants interviewed complained of lack of/inadequate resources to purchase inputs like x-ray supplies that are very important to the operations of a facility. For instance, the laboratory departments ended up operating below capacity due to inadequate supply of laboratory inputs. This undermines the DHMB/T’s morale and their capacity to deliver health services. One DHMT member lamented:

“...How do they expect us to provide quality and timely health care services when they do not even supply us with laboratory inputs or even enough drugs to last a month”.

Most DHMB/Ts members who were interviewed indicated that there was delay in disbursement of AIE’s from the headquarter and therefore delay in funding operating expenses. A recent study (Public Expenditure Tracking Report, 2004) in the health and education sector in Kenya indicated that scarcity of resources is not a very serious concern as being put. The problem lies in accessing these funds bureaucratically.

**External environment:** The external environment within which a district health system operates has critical influence over their capacity. The main external factors here include economic conditions, political and social factors. Members of DHMTs interviewed complained of gross interference with their work by key DHMB members especially on matters concerning procurement of goods and services and employment of casuals. Cases were sighted where key members of the board influenced the transfer of some key members of the DHMTs. Some DHMT members interviewed complained that some DHMB members do not necessary have the interest of the board’s activities at heart but merely attend meetings to solicit for tenders to supply the district facilities with goods and services.

In Thika, Nyeri and Kirinyaga districts, it was reported that politicians, community leaders and the civil society had influenced the effectiveness of the accountability structures positively. The politicians, community leaders and civil society have enforced accountability in a top-down fashion. Members of DHMB/Ts interviewed indicated that some politicians - councillors, members of parliament have formed a habit of making frequent and unexpected supervisory visits to ascertain whether drugs and non-pharmaceutical supplies are available in health facilities. They also monitor patients’ perception about quality of care provided by the facilities in their constituencies and therefore hold the DHMB/Ts accountable for any dissatisfaction expressed by patients. This was reported to have positively influenced the performance of DHMB/Ts.
Some policy pronouncements and developments have affected the effectiveness of DHMTs and DHMBs. For instance, the MoH has been giving mixed signals about its position on cost sharing. This was reported to be causing anxiety among DHMBs members who claim that their future as members of the boards may be under threat because scrapping user fees in public facilities may indicate that they are no longer required as there may be no funds to superintend. Such unstable policy environment was reported to be affecting the service delivery capacity of DHMBs.

4.2 Summary of Key Findings

Table 3 below provides a summary of the key findings of the study.

5. Conclusions and Policy Recommendations

5.1 Conclusion

The study set out to assess the delivery capacity of DHMB/Ts using available literature and primary data obtained from interviews with members of the DHMBs/DHMTs, senior managers in the MoH (especially those managing cost sharing programme) and senior managers of NGOs and donors in the respective districts.

The findings highlighted an ineffective and weak interactive linkage/communication between the DHMBs and DHMTs and between DHMB/Ts and other institutions in the district, all with negative impacts on their delivery capacity. The service delivery capacity of DHMB/Ts has also been adversely affected by the degree of autonomy (decision space) accorded to them by the MoH. Other factors inhibiting the service delivery capacity of DHMBs and DHMTs include lack of capacity in planning and priority setting, budgeting and administration, an ineffective monitoring and supervision mechanism, selection of incompetent DHMB/Ts members, external influence, weak incentive systems, inadequate budgetary support, rigid government rules and regulations and lack of clarity of the roles and responsibilities of the district institutions. This leads to the conclusion that the ministry should implement the decentralization strategy with a lot of care as the process may end up creating a system at the district level that may prove to be too complicated to manage and finance.
Table 3: Summary of Key Findings

<table>
<thead>
<tr>
<th>Study Factors</th>
<th>Findings</th>
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| Coordination and communication| • DHMBs feel that they are being by-passed by HMBs when it comes to expenditure approvals  
• DHMTs feel that some DHMB members are out to undermine them and vice versa (mistrust)  
• DHMTs have withheld some vital information from DHMBs  
• Some HMBs withhold the 25% meant for PHC  
• PHMTs have not effectively monitored DHMBs-left this function to DHMTs-Made few/no supervisory visits  
• Role of the private sector, NGOs and Donors is not recognized by the District Health System-Do not attend any DHMB meetings |
| Transparency and accountability| • Key institutions involved in selection of DHMBs- DMOH and DC’s office  
• Management skills and past record rarely taken into account  
• Only pro-DMoH and DC (pro-system) are nominated  
• Little vetting is done by PMO/PHMT  
• MoH HQ commonly replaces the names of nominated people  
• No public announcement to attract many qualified people  
• No examinations and interviews to vet the nominees  
• Frequent loss of key personnel to the private sector-medical specialists  
• DHMTs and other staff complained of lack Job satisfaction, teamwork, recognition for good performance, fairness in job distribution as the main factors leading to low morale beside the poor pay  
• Posting of consultants to head hospitals and fresh doctors to head DHMTs  
• No sound criteria is used to post staff to districts (distribution of staff to the districts)  
• DHMTs some times blocked access to vital information required by DHMBs |
| Management capacity           | • Board members lack financial and management skills to approve budgets/expenditure reports  
• No/few supervisory visits due to lack of supervisory skills  
• Lack of skills in quality assurance leading to lack of formation of vital standing committees like Quality Assurance, selection of limited number of board members.  
• Ineffective training accorded to DHMTs in the sense that it comprised too many workshops with limited on unknown impact and end up interfering with performance of routine tasks.  
• The few training opportunities are usually allocated to the district staff on the basis of patronage by MOH  
• DHMBs were at times approving activities that were drawing funding from recurrent vote-withholding of information-R11 and D11 from DHMBs  
• Approval of plans that are not consistent with policy guidelines  
• DHMBs rarely reviewed expenditures, waivers and exemptions as they lack time and skills  
• DHMB members feel that they are being undermined by district staff- DHMBs have no power to discipline staff and some standing committees were ineffective and others not functional |
| Incentives and reward         | Low salary coupled with lack of incentives and rewards for good performance |
| Rules and Regulation          | • Lack of performance standards  
• Deployment/promotion pattern based on number of years served and too little on performance  
• Treasury approval required in order to re-allocate monies from one vote to another  
• Procurement functions centralized |
| Resource allocation and flows | • Dilapidated facilities including buildings  
• Lack of basic tools like computers, offices for DHMBs etc  
• Inadequate budgetary support leading to lack of drugs and other medical supplies |
| External Environment         | • Gross interference of DHMTs work by DHMBs-on matters of procurement, hiring casuals, transfer of key staffs  
• Politicians influence the effectiveness of the accountability structures positively  
• Inconsistent policy statements |
5.2 Policy Recommendations

In order to improve the service delivery capacity of DHMB/Ts, the following recommendations are made:

(a) Clear definition of functions
The functions of the DHMBs should be clearly defined and separated from those of other institutions in the district. The functions and powers of the PMOs office and PHMTs should be re-defined to be more of facilitation of district health programmes and projects rather than of the current scenario where the PMO and his team are heavily involved in direct delivery of health care services at the district level. There is also need to clarify and separate the powers of the DHMTs and DHMBs in order to reduce excessive influence of the former over the latter. We would expect in future DHMBs to be granted more empowers through the amendment of The Public Health Act Cap 242 to allow the boards to superintend both recurrent and development budget.

(b) Transparency in selection of board members
Clear and transparent criteria for selecting board members should be put in place. The minimum qualification should be pegged to some level of a university or equivalent. The process should be guided by competitive bidding and handled by an independent committee with representation from the private sector, NGOs, religious organisations, donor community based in the district, and advertisement through the media with copies in DOs offices, chiefs and churches to ensure wider representation of local people. The list of nominees should also ensure gender parity. In addition, the deliberate effort should be made to ensure that board members demonstrate competencies, integrity and ethics, best practice governance and accountability skills, strategic leadership and possession of pre-requisite skills.

An eligibility checklist to guide selection of DHMBs members should include basic eligibility criteria with elements like nationality, level of education, and declaration of material conflict of interest considered. Other criteria that can be termed as specific exclusions should include criminal record of potential members, past performance as previous member of board and change in material wealth should also be considered.

As alluded earlier, the current composition of boards cannot allow any meaningful formation of sub-committees. In this line, we are proposing the number of board members to be increased from the current 10 to at least 15 to allow for the constitution of sub-committees with a mix of skills for effective management of the different activities of the committees. This calls for amendment of the Legal
An Assessment of the Service Delivery Capacity of the District Health Systems in Kenya

Notice No. 162 that stipulates nomination of seven to 10 members to allow for nomination of at least 15 members. Where the skills or pre-requisite qualities are lacking the MoH in consultation with the Headquarters should have powers to nominate two members to fill the gap, with the advise of the PHMT. The Minister should appoint people with financial or other large entity governance experience or people from rural areas or minority groups not represented among the nominated members.

(c) Remuneration of board members
Besides enhancing motivation of district health management teams and boards through greater control over resource allocation and authority action to meet local needs, a uniform remuneration package for DHMBs members should be paid to them using recurrent budget. In countries like New Zealand where boards are paid a standard package per month, the system is able to attract more qualified and competent members. Paying may appear to be expensive to the exchequer but it would be worthwhile if the boards alleviate the current district problems relating to management of health care services at the district level with, enormous social and economic costs.

To improve staff motivation, effectiveness and retention, incentives and rewards should be introduced. This will include promotion for good performance, training opportunities that are linked to good performance, appropriate career structures with reasonable opportunities for advancement, employee of the month awards programme and reward or recognition for good performance. These will motivate staff and help to improve their service delivery capacity.

(d) Continuous capacity building for DHMB/Ts on planning and priority setting, budgeting, administration and effective monitoring and supervision
A programme of continuous capacity building for DHMB/Ts on planning and priority setting, budgeting, administration and effective monitoring and supervision should be put in place at the district level to equip both the DHMT and DHMB members and other health personnel on pre-requisite skills for effective administration and management of health care delivery at the district level. The programme should avoid current weaknesses where only a few health personnel were taken to through the training courses having been selected without due transparency and in some cases the training not based on the needs at the district level. The MoH headquarters and old members of the PHMTs should also conduct induction sessions for the newly elected members.

Lessons should be borrowed from countries like Zambia, Uganda and Ghana where more comprehensive approaches to capacity building have been developed following advances in development of various district health management systems.
Thomas M. Maina and Thomas N. Kibua

- DHMTs and/or DHMBs. In these countries greater autonomy to the decentralised structure has been linked to training programmes directed towards strengthening technical capacity to prepare the DHMTs for their role in supporting the lower levels – health centres and dispensaries. In terms of systems development the focus in these countries has been on implementing systems of monitoring the performance of the districts in relation to service delivery and use of health resources.

(e) Phased implementation of boards’ autonomy
Centralisation of human resource management tends to undermine local decision space. Since boards were established to allow community participation and ensure accountability and transparency in the use of public resources, they should be empowered to engage district health staff. Experience from countries like Uganda and Philippines show that improvements in delivery capacity of DHMBs were recorded where district systems have been accorded powers to hire and fire district personnel mainly because decisions pertaining to discipline and employment of the right personnel are quick and efficient. The implementation of the said decentralization should be gradual to avoid confusion and uncertainty that marked the attempt to de-link health staff from the national system in Zambia’s case through to allow direct hiring by the District Health Boards a strategy that was avoided due to strong opposition by health staff and amidst allegations of financial mismanagement.

It should also be pilot-tested in a few districts, starting with junior health staff as suggested by Owino et al., (2001). Experiences from the piloted districts will be useful in informing the second phase, to be scaled-up into other districts and also targeting the middle and senior health staff.

(f) Improve budgetary support
Increased budgetary allocation to districts will go along way in ensuring availability of critical inputs like laboratory inputs and drugs. The delay in disbursing AIEs to the districts will also need to be addressed so as to ensure expenses like operation and maintenance are meet without delay as they are deemed to be very vital for health facilities to remain operational even in times of emergencies.

(g) Equipping the DHMB/Ts
The delivery capacity of DHMBs and DHMTs will greatly benefit from equipping them with the necessary tools to facilitate their operations. The equipments should include establishment of an office with a secretary and a messenger to start with and computers and printers etc, to allow the DHMBs be independent
of the DHMTs; vehicles to facilitate supervisory visits for each DHMB should be purchased using recurrent budget or source for donor assistance.

(h) Integrated approach
The integration of stakeholders’ interests and strategies incorporating activities of donors, private sector and NGOs within the district health system will go along way towards enhancing the provision of quality health care in the districts. This calls for restructuring of the district health system to allow joint planning, budgeting, monitoring and evaluation of district health projects. The recent initiative of district stakeholders’ forum in some districts should be seen as a move in the right direction, to allow stakeholders to interact over health care provision within a district health system. With the necessary policy framework and implementation of the SWAp strategy such forums will need supportive legal structures to ensure that the private sector, NGOs and donors are brought on board for a joint planning and management process at the district level.

(i) Developing of performance indicators
Key success or performance indicators will help DHMB/Ts to define and measure progress toward achieving their goals in health care delivery. Performance indicators should therefore be developed to facilitate assessment of the performance of the DHMB/Ts. The indicators could include among others: waiting time/list; availability of drugs; cleanliness of facilities; frequency of board and standing committees meetings; supervisory meetings held; collection and banking as a percentage of collection etc. These should then be published and reviewed periodically to compare inter-district performance and to motivate the DHMB/Ts.

References


Thomas M. Maina and Thomas N. Kibua


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Thomas M. Maina and Thomas N. Kibua

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