

Influence of Participative Leadership Style on Public Health Service Delivery in County Governments in the Western Kenya Region

Leonard Momos Juma¹
Dr. Shitseswa E. Ayub²
Dr. Umulkher Ali³

¹momoslen@gmail.com
²ayubsa@yahoo.com
³aumulkher@mmust.ac.ke

¹Ph.D, Student, ^{2,3}Ph. D, Lecturers, Masinde Muliro University of Science and Technology [MMUST], Nairobi, Kenya

ABSTRACT

Poor health service delivery has been linked to the devolution of health services, with some health workers walking off the job due to inadequate pay and unsafe working conditions. This research aimed at establishing the influence of participative leadership style on public health service delivery by county governments in the Western Kenya region. Taking a positivist approach, the study was anchored on participative leadership theory. Descriptive survey and causal-comparative research designs were adopted with a target population of 966 personnel consisting of the CECMs, Chief Officers, Directors, and County Nursing Officer for Health, Medical Superintendents, Hospital Administrator, Human Resource Officer, Head of Pharmacy, Head of Nursing, Health Records Information Officer, Head of Laboratory, Head of Clinical Services and number of patients admitted, treated and discharged drawn from all four counties of Bungoma, Busia, Kakamega, and Vihiga. Primary data was collected using both structured questionnaires and interview schedules. Qualitative data was analysed by content analysis while quantitative data was analysed using both descriptive and inferential statistics. The SPSS Software version 26 was used for statistical analysis which was both descriptive whereby frequencies, percentages, means, and standard deviation were clearly shown in the form of both tables, models and charts. The hypothesis tested for significance of the study at 5% significance level. From the results, the beta value for participative leadership from the regression model was 0.777 at $p < 0.05$. Participative leadership explains 60.4% ($R^2 = 0.604$) of the variance in public health service delivery. Therefore, the hypothesis was rejected. The study recommends establishing transparent and straightforward policies and procedures for managing human resources, which are essential for promoting productivity, equity, and workplace peace. In order to improve service delivery, the report suggests that county governments implement methods to promote collaborative decision-making. Consultation is a necessary part of the decision making process. In this regard, as many of the perspectives of workers who are directly affected by the decision as are feasible should be considered.

Keywords: Participative Leadership, Service Delivery, Health Care, Western Kenya

I. INTRODUCTION

The Sustainable Development Goals (SDGs) recognize universal health care as a significant and laudable objective. The goal of universal health coverage is to ease the way toward more prosperous and fair societies and economies by ensuring that all people, regardless of their ability to pay, have access to the healthcare they need. Without prioritizing health care quality, universal health coverage should not even be considered, much less implemented. Care must be efficient, risk-free, and tailored to the wants and requirements of the communities they are meant to benefit. In addition, care delivery should be timely, equitable across populations, coordinated across the care continuum and across the life course, and resource-efficient at all points (World Bank, 2018).

Lu, shih, Kittipittayakorn, and Lian (2013) state that the healthcare industry is one of the largest in the service sector, and that the provision of healthcare services is an integral aspect of service delivery for the economic and social well-being of any nation. The provision of health services is important to every health system and is widely recognized as a key factor in reaching the SDGs (World Health Organization, 2016). Costly service provision, speedy service delivery, easy access to health facilities, and healthcare providers that fulfill their service mission all contribute to health service delivery in the health business (Akachi & Kruk, 2017). The promotion of universal health coverage (UHC) is a core tenet of the healthcare sector's infrastructure for delivering healthcare services to everyone who need them (Zodpey et al., 2018).

According to Wang (2016), the main causes of inefficient service delivery in Chinese hospitals were a lack of coordination, insufficient staff, a lack of enthusiasm, and the absence of supportive legislation. In India, researchers Mohanan, Hay, and Mor (2016) showed that enhanced health service delivery may be achieved by strengthening

institutional capacity, increasing financial resource mobilization, enhancing governance, and implementing data-driven policies. Healthcare personnel in Switzerland are more productive when they have access to sufficient resources, positive working relationships, social amenities, and modern infrastructure, as pointed out by Gilles (2014).

Africa as a continent faces a significant difficulty in the delivery of healthcare services because the vast majority of its poor population does not have access to these services (Akokuwebe & Adekanbi, 2017). Although many African countries signed the Abuja declaration, which urged governments to devote at least 15% of their budgets to healthcare and guarantee universal health coverage, few have met even these modest goals (Ahenkan & Osei-Kojo, 2014).

Assefa (2017) conducted research in Ethiopia and found that the country's impressive progress in broadening health sector growth has been bolstered by comprehensive initiatives aimed at enhancing investments in healthcare. Health care access has been limited by a number of factors, including a failure to reach marginally-alienated communities, insufficient poverty reduction, and inadequate educational opportunities. According to research by Akokuwebe et al. (2017), service delivery in Nigerian hospitals is significantly impacted by corruption and inadequate distribution of medical supplies.

Kenya (2016) notes that customers are dissatisfied when their expectation of the health service surpasses their assessment of the health care got. Public hospitals in Nairobi County, he found, were hampered in their ability to provide health care due to issues with information system integration, drug supply, decision making, and responsibility delegation. This research aimed to determine if and how public health service delivery in health facilities in Western Kenya's Region was affected by the leadership style of its managers, the availability of its human resources, and the strength of its culture.

Kibicho (2015) argued that senior management buy-in, well-defined processes and systems, clear lines of communication, and strong leadership are all crucial to the success of a company's plan implementation. Riaz (2016) shown that senior management's backing is influenced by a number of different factors, including company culture, employee development, leadership style, and recognition and incentive programs. Consequently, the current research used variables for the major independent variable such as leadership style, human resource capacity, and organizational culture.

When leaders practice a style of leadership known as participative leadership, employees and subordinates are given a voice in decision-making rather than having that power vested solely in the hands of the boss (Amanchukwu, 2015). In particular, the term democratic leadership is commonly used to describe a leadership style that encourages participation from subordinates. Kahai (1997), states that where there is consultation among team members during decision making and procedures of problem solving, we have participative leadership. Moreover, Bass (1990) had earlier described participatory leadership as: the equalization of authority and sharing of problem-solving with followers by consulting them before making a decision. People are given more say in decision-making in a participatory leadership style (Vroom, 2019).

At its core, participative leadership is the emulation of a leader's ability to establish a collaborative, supportive, empowering, and democratic workplace. This method works well in any group where members are expected to contribute and share their thoughts and opinions. The term participative leadership, which is also known as shared leadership or democratic leadership, is a style of leadership in which team members are given more say in the group's or team's decision-making. Any group, from a little company to the federal government, can benefit from this style of leadership. According to Gipson (2017), a leadership style characterized by participation is welcoming, flexible, and effective. It's a method of leadership in which the boss models a consensus reached by the group as a whole. It's common practice to allow members of the group to voice their opinion.

The devolution of healthcare in Kenya began with the devolution of power between the national and county governments following the adoption of a new constitution in 2010. (Wahome, 2019). In Kenya, healthcare is one of the areas that has been given more authority to county governments under the Transition to Devolved Government Act (2012). (Waithaka & Barasa, 2018). It is proposed in the National Health Policy (2012) that County Health Departments be reformed, with one of its primary responsibilities being the establishment of an effective institutional framework to ensure the safe administration and distribution of healthcare services across the County (Gitonga & Keiyoro, 2017).

UHC ensures that everyone has access to the primary, secondary, tertiary, and quaternary care they need to live a healthy and productive life, including the services necessary to maintain and improve health without causing undue financial hardship (World Health Organization, 2016). Despite significant health investments, health outcomes remain unsatisfactorily low, especially in large parts of the developing globe. It is completely unacceptable that half of the world's population lacks access to basic healthcare (Achia et al 2015). Generally speaking, the best healthcare service delivery models can be found in more developed countries like the United Kingdom, Canada, Norway, and

Sweden. These models are supported by the implementation of universal health coverage, the nationalization of health services, and a robust health system (Papanicolas, Woskie, and Jha, 2018).

The Constitution of Kenya, adopted in 2010, ensures that all Kenyans have access to quality healthcare that is based on their individual rights. It means Kenyans have a right to the best possible health, which includes access to medical care and reproductive services (Article 43). Local governments are responsible for providing basic healthcare services, but the federal government continues to set health policy, provide technical help to counties, and manage national referral health centers. In order to better meet the specific health needs of their constituents, foster greater citizen engagement, and expedite the allocation of scarce resources, County Governments were given authority over this sector. Yet, the industry is currently plagued with enormous difficulties in virtually all Counties, such as capacity gaps, human resource shortages, a lack of crucial legal and institutional infrastructure, widespread corruption, and a contentious relationship with the central government (Kimathi, 2017). Healthcare as a whole has been unable to move forward, and some health indicator data suggests that it may have even gone backwards, as a result of these difficulties (Kimathi, 2017).

Andove and Nzulwa's (2018) research in Machakos County on the barriers to the strategic delivery of public health services found that ineffective management of the healthcare system inside the facility, issues with management, a failure to adopt a supply-driven approach to healthcare management, and a lack of resources that promote the efficiency of public health service management were all factors impeding service delivery. Whether or if the facility's bad management style hinders its employees' ability to adapt to a changing environment was not made clear. According to Ochola's (2016) research on the determinants of strategy implementation in public health facilities in Mombasa County, Kenya, he discovered that staff lacked enough training in the evaluation and monitoring of the strategy's progress.

On the other hand, despite the adoption of the Constitution's fourth schedule, Counties nevertheless face ongoing issues that have a negative effect on health service delivery (Achia & Mageto, 2015). Poor health services, a lack of contemporary equipment and facilities, and a lack of accessible health facilities are just a few of the many obstacles that make it difficult to gain access to healthcare in the Public Sector (Ministry of Health, 2014). These problems inspired us to investigate what influences strategy implementation and how counties in Western Kenya's region provide public health services.

1.1 Statement of the Research Problem

Reluctance to recognize existing problems is one of the greatest barriers to health care progress. Another challenge is identifying and implementing effective interventions competently. Leadership is a cliché in the field of health care quality improvement, but without it, there is no way to instill the notion that improvement is feasible in order to motivate collective action (Dixon-Woods, McNicol, & Martin, 2012). The legal framework established by the Constitution of 2010 ensures a comprehensive, rights-based approach to the provision of healthcare services to Kenyans. It indicates that Kenyans are entitled to the greatest achievable health standards, which includes the right to healthcare services and reproductive health care (Article 43). The principal human resource concerns are shortages, failure to develop enough numbers of healthcare professionals, maldistribution of current employees, and inadequate skills of many healthcare personnel (Holtz & Elsaywy, 2013), and these issues have undermined the government's capacity to deliver important healthcare projects, such as access to healthcare for all, at the levels it wishes to maintain (Ataguba et al., 2012). It is believed that the decentralized government will provide better public health services than the central government. With the devolution of the health services sector, incidences of health workers resigning due to bad working conditions and a lack of equipment, among other issues, have been observed, resulting in inadequate health service delivery.

The studies by Kariuki (2021); Andove and Nzulwa (2018); and Ochola (2016) had contextual gaps because they focused on Kasarani Sub County, Kenya, Machakos County, and Mombasa County, Kenya, whereas Western Kenya County Governments were the focus of the present research. In light of these gaps in understanding of the conceptual, methodological, and contextual factors influencing the delivery of public health services by County Governments in Western Kenya Region, the present study aimed to identify and quantify the elements that influence these outcomes. The studies by Kariuki (2021), Andove and Nzulwa (2018), Ochola (2016), Mwangi (2020), and Kiana (2016) were also conceptually incorrect and had a limited scope because they only addressed organizational cultures and styles, organizational communication, organizational structures, and the capability of the health facilities, as well as ineffective and inconsistent management of the healthcare system in the facility, management issues, and a driven style of providing healthcare services. None of these researches have focused on the leadership styles and public health service delivery in the County Governments of Western Kenya Region.

1.2 Purpose of the study

The study sought to establish the influence of participative leadership style on public health service delivery in County Governments in Western Kenya Region.

1.4 Research Hypothesis

H₀₁: Participative Leadership style has no statistical significant influence on Public Health Service Delivery in County Governments in Western Kenya Region.

II. LITERATURE REVIEW

2.1 Theoretical Review

The study is anchored on Participative Leadership Theory. Kurt Lewin put forth this hypothesis during the 1930s and 1940s. And in 1973, Professor Victor Vroom and Phillip Yetton released *The Normative Model of Leadership Behavior*, where they explored the results of include subordinates in the decision-making process. The theories of participatory leadership that resulted from their studies are widely used today. The American academic Likert (1961) introduced the idea of participation leadership in his book *A New Model of Management* after conducting extensive experimental research on democratic leadership. Additionally, he singled out the three cornerstones of participative leadership theory: mutual support, group decision, and high standards.

It is characterized as participative leadership by Kahai et al. (1997). Those who work under this style of management have a voice in decision-making, are given more responsibility, and are actively encouraged to contribute to the conclusion. There are two more features of participatory leadership that are supported by the literature: first, employees are consulted before decision making so that they may work together to solve problems, and second, employees are provided with resources to aid them in the course of their work (Kahai et al., 1997; Lam et al., 2015; Li et al., 2018).

Huang et al. (2010), who conducted extensive research on participatory leadership, agree that this style of management necessitates a greater emphasis on employee engagement in decision-making and the free flow of information and ideas (Xiang and Long, 2013; Lam et al., 2015; Li et al., 2018). The essence of leadership is clearly carrying out various managerial tasks, such as consulting people before making choices, and the essence of participative leadership is obviously fostering employee participation in corporate decision-making (Benoliel & Somech, 2014). We have defined participative leadership as a set of leadership behaviors that encourages subordinates to participate in decision-making by providing them with sufficient autonomy, helpful knowledge and other resources, and positive reinforcement in order to consult them before making decisions to address work-related challenges, as evidenced by numerous studies and real-world experiences (Huang et al., 2010; Chan, 2019).

In this work, we apply the theory of participatory leadership to shed light on the factors—including inputs and recommendations, consultations, new ideas and innovation, decision making—crucial to the effective execution of policies for providing public health services. The study's overarching goal was to examine the theoretical connections between participatory leadership and a concrete indicator of county government performance in Western Kenya. The primary hypothesis of the investigation was inspired by this theory.

2.2 Empirical Review

Sfantou, Laliotis, Sifaki-Pistoll, Matalliotakis, and Patelarou (2017) investigated if a correlation exists between various leadership styles and healthcare quality indicators. Medline (through the PubMed interface of the National Library of Medicine) and EMBASE were combed through for relevant results between 2004 and 2015. This review was driven by the question, is there any association between leadership style in healthcare settings and quality of care? Our search yielded eighteen papers that partly or wholly addressed our scholarly inquiry. Quality of care and related metrics were found to be significantly correlated with a leadership style that encourages participation from staff. Both patients and healthcare providers viewed strong leadership as essential to the delivery of coordinated and integrated care. Given the desktop review nature of the study, it is difficult to generalize the findings because of a lack of methodological support.

Warri (2021) analyzed how different leadership styles affected the quality of care provided by medical professionals. Descriptive research methods were employed, and the sample size was determined at random among 150 CBCHS health personnel. Information was gathered via surveys with predetermined answers and processed with IBM SPSS Statistics 20. Good public relations and customer service are more likely to persist under a leader with a participatory style of management. Yet, the results were not statistically significant, therefore the link between

leadership styles and output quality cannot be substantiated. It is also impossible to assess external validity because the sample frame was not indicated in the study.

Kyalo, Otieno, and Tenambergen (2018) set out to identify the impact that managerial ethos has on the successful implementation of health management information systems (IHMIS). The research strategy employed a combination of qualitative and quantitative techniques. Two hundred and eighty participants were randomly selected from a pool of eligible participants, and then further classified into three categories based on their healthcare status (tier 1, 2, and 3). Members of the sub-county and county health management teams, as well as those in charge of medical records and information, filled out the surveys. Success in any business depends in large part on the careful selection and use of different types of leadership. When leaders have complete access to relevant data, they are better able to put their vision into action. Yet, research shows that a leadership style characterized by participation has a negative and non-significant impact on the successful integration of HMIS. One aspect of service delivery that was examined in the study was the linking of health management information systems. There was also little indication that qualitative and quantitative data were triangulated.

Chepkonga and Nyaga (2019) looked into how a hospital's leadership style affected patient care. Two hundred seventy hospital workers and ten thousand patients in the Mbagathi region of Nairobi City County were the subjects of this research. The 398 workers and patients were selected using a simple random selection method, while the 8 management personnel were counted during a census. Both quantitative and qualitative primary data were employed in this investigation. A questionnaire was used to collect primary data from the relevant parties, and responses were recorded using a 5-point Likert scale. The administration of the district hospital was interviewed using an interview guide as well. The results showed that a more open and democratic style of leadership was associated with better service provision in Kenya's public hospitals. Staff members' familiarity with their tasks and responsibilities, as well as the management's and staff's ability to work together toward common goals, were found to have a positive impact on hospital service quality. The data does not appear to have been triangulated using quantitative and qualitative methods. The hospitals in the Mbagathi district of Nairobi City County were the only ones included in the study. No information on the method utilized to collect information from staff and patients was provided in the study.

Kanyua and Thiane (2017) conducted research in Embu County, Kenya, to determine the effect that different types of leadership have on the delivery of health services. The research strategy used here was a descriptive one. Stratified sampling was used in this analysis. There were 110 total participants in the survey. In order to describe the data, the researcher made use of descriptive statistics including frequency distribution tables and percentages. According to the research, County Government has a policy on leadership style, and employees are not allowed to make many decisions without first consulting with their superiors. The study selectively sampled a small number of participants without specifying its intended audience. There was also no inferential study showing how the leadership style of County officials affected the actual provision of services to the public.

Pahi, Ahmed, Sheikh, Dakhan, and Ramayah (2020) studies Pakistan's health care industry. They looked into the relationship between leadership style and service quality. Data from 315 medical officers in 43 public hospitals in Sindh, Pakistan, were gathered using a quantitative survey strategy. This study used cognitive dissonance and path-goal theories to examine how different types of leadership can affect service quality commitment while role clarity acts as a moderator. The data provides confirmation of the clear causal links between transformational and transactional leadership styles and a company's dedication to providing high-quality service. All of the hypothesized links except the one between laissez-faire leadership and dedication to service quality were found to have substantial support in the data. Two leadership styles, transformational and laissez-faire, were shown to have moderated connections with service quality commitment, but the relationship between transactional leadership and service quality commitment was unaffected by role clarity.

III. METHODOLOGY

3.1 Research Philosophy

This study utilized the positivist research philosophy, which is consistent with the notion that realism is stable.

3.2 Research Design

This study employed both causal-comparative and descriptive survey research designs. Causal-comparative research is a feasible research method that can be employed when other methods fail. The descriptive survey approach was chosen because it enables the researcher to collect information systematically using questionnaires, compile it, present it, analyze it using SPSS, and interpret it. Often, descriptive research requires the collection of information by

data analysis, surveys, interviews, or observation. The design also aids the researcher in providing accurate descriptions of goods.

3.3 Study Location

The research was carried out in the county governments of Former Western Province. Bungoma, Kakamega, Vihiga, and Busia are the counties.

3.4 Target Population

The total target population for this study consisted of nine hundred and sixty six staff from the four (4) County Referral Hospitals and 29 Sub-County Hospitals. These were four (4) CECMs - Health, four (4) Chief Officers-Health, four (4) Directors-Health, four (4) County Nursing Officers, 33 Medical Superintendents, 33 Hospital Administrators, 33 Human Resource Officers, 33 Head of Pharmacy, 33 Head of Nursing, 33 Head of Laboratory, 33 Head of Clinical Services, 33 Health Records and Information Officers and 686 patients who were admitted, treated and discharged between July-September, 2022). These patients were selected from the Health Records and Information Officers' records. The study focused only on the Referral and Sub County Hospitals since they were well equipped in terms of facilities and specialists and offer variety of serviced to the patients (See Table 1).

Table 1

Target Population

S/N	Categories of Respondents	Bungoma	Kakamega	Busia	Vihiga	Total
	Ministry of Health					
1	CECM – Health	1	1	1	1	4
2	Chief Officer – Health	1	1	1	1	4
3	County Director	1	1	1	1	4
4	County Nursing Officer	1	1	1	1	4
	Sub Total					16
	Referral Hospital					
1	Medical Superintendents	1	1	1	1	4
2	Hospital Administrators	1	1	1	1	4
3	Human Resource Officers	1	1	1	1	4
4	Head of pharmacy	1	1	1	1	4
5	Head of Nursing	1	1	1	1	4
6	Head of laboratory	1	1	1	1	4
7	Head of Clinical Services	1	1	1	1	4
8	Health Records and Information Officers	1	1	1	1	4
	Sub Total					32
	Sub–County Hospitals					
1	Medical Superintendents	9	10	6	4	29
2	Hospital Administrators	9	10	6	4	29
3	Human Resource Officers	9	10	6	4	29
4	Head of Pharmacy	9	10	6	4	29
5	Head of Nursing	9	10	6	4	29
6	Head of laboratory	9	10	6	4	29
7	Head of Clinical Services	9	10	6	4	29
8	Health Records and Information Officers	9	10	6	4	29
9	Number of Patients Admitted, Treated & Discharged (July-September, 2022)	175 (18)	215 (22)	153 (15)	143(14)	686(69)
	Sub Total					918
	TOTAL					966

Source: County Human Resource Departments (2022)

3.5 Sampling Techniques and Sample Size

The population of the four counties and the people who lived there were split up into several groups. Researchers employed stratified random sampling because it allows them to collect data from a subset of the population that is representative of the whole. The study adopted census method for the 264{32 + (29x8)} staff since the number was small and accessible and 10% of 686 (69) patients who were selected through simple random



sampling technique, thus giving a total sample size of 333 respondents who responded to the questionnaires. A total of 16 staff comprising CECMs, Chief Officers, County Directors and County Nursing Officers were interviewed and therefore did not respond to the questionnaires.

3.6 Data Collection Instruments

The study included primary and secondary sources. Primary data is information that the researcher collects himself through questionnaires and interviews. Secondary data means data collected by someone else earlier, for example data from the patients kept by the Health Records and Information Officers. The researcher used both structured and unstructured questionnaires and the use of interviews which elicited appropriate responses for the study. Primary and secondary sources were used to compile quantitative and qualitative data, respectively.

3.7 Validity and Reliability of Research Instruments

The data collecting instrument's content validity was established after being reviewed by a panel of experts who offered their thoughts on each question and indicated whether they found it to be pertinent or not. Construct and face validity were also employed in the research. Construct validity was achieved by investigating multiple facets of the construct of interest through a sequence of interconnected questions. The questionnaire was found to have high face validity because it only asked about topics that were actually of interest to the respondents.

Internal consistency reliability was calculated using the Cronbach alpha formula (Kim & Cha, 2002). This study followed Gupta's (2004) recommendation that a minimum alpha value of 0.7 be used for item loadings. The purpose of this was to make sure that the measurements obtained from the data gathering instruments were correct (valid) and reliable (consistent) throughout several uses. Using the SPSS statistical program, data generated during the pilot study was analyzed to determine the reliability of the instrument.

Table 2
Reliability Analysis Results

Reliability Statistics		
Variables	Cronbach's Alpha	No. of Items
Participative Leadership Style	0.762	08
Public Health Service Delivery	0.853	10

3.8 Descriptive Statistics

The researcher employed descriptive statistics such as the mean, standard deviation, and range of values to characterize the data.

3.9 Hypothesis Testing

As each hypothesis is predicated on a single response variable that linearly depends on a set of predictor variables, we tested them all by employing a multiple regression model. The starting point for any hypothesis test is the null hypothesis, or H₀ (Kaur, 2015). The T-test and the F-test were used to examine the hypotheses. Table 3 outlines the methodology used to examine the four hypotheses.

Table 3
Hypothesis Testing

Hypothesis Statement	Hypothesis Testing	Model
H ₀₁ : Participative Leadership style has no significant influence on the service delivery of County Governments in Western Kenya Region.	$H_{01}: \beta_1 = 0$ $H_{0A}: \beta_1 \neq 0$ Reject H_{01} if $\beta_1 \neq 0$ and P value ≤ 0.05 otherwise fail to reject H_{01} if $\beta_1 = 0$ and P value $> \alpha$ $\alpha = 0.05$	$Y = \beta_0 + \beta_1 X_1 + \epsilon$

IV. FINDINGS

4.1 Response Rate

The study ascertained the response rate so that the researcher could assess whether or not it was adequate for interpreting and reporting the results. With a sample size of 333 people, a total of 333 questionnaires were sent out; 264 went to medical professionals, and 69 were given out to patients (via telephone). There was a response rate of 93.6% from healthcare providers and 68.1% from patients, for a total of 294 completed surveys. There were 39 non-responses, including 22 from patients and 17 from medical staff. Gibson (2017) argues that any response rate of 50 per cent or more is adequate for drawing conclusions from the study. Hence, the response rates of 247 (93.6%) health professionals and 47 (68.1%) patients were adequate to provide credible data.

4.2 Demographic Characteristics of the Sample

This section gives the conclusions regarding the respondents' demographic profiles. The study's data were assessed for gender disparities, age, educational backgrounds, length of public health care delivery experience, job roles of respondents in County Governments in the Western Kenya Region, and other factors. The demographic characteristics resulted in the following:

4.2.1 Gender Distribution in the Sample

The study sought to establish the respondents' gender. Table 4 depicts the study results.

Table 4 Gender of Respondents

Gender	Frequency	Percentage
Male	174	59.2
Female	120	40.8
Total	294	100.0

According to the data presented in Table 4, 174 (59.2%) of the respondents were male, while 120 (40.8%) were female. The data analysis revealed a significant gender gap between the responders, with the majority being male. That's why it's crucial for organizations like the Ministry of Health to strictly adhere to gender parity guidelines when hiring new staff. As a result, we can rest assured that no service delays will occur because we have sufficient numbers of women on staff to deal with the problems that arise because of gender. This is significant since scholars such as Eden and Ackermann (2013) have identified gender as one of the cultural factors influencing service delivery within organizations. Others agree that service delivery in community execution of strategic plans needs to include both sexes to be successful (Demirkaya, 2015)

4.2.2 Age Distribution in the Sample

According to findings, respondents were between the ages of 25 and 34, while 31% were in the 35-44 age bracket. A sizable percentage of the sample (39% to be exact) also fell between the age ranges of 45 to 54. Recruitment, training, deployment, succession planning, and overall strategic direction are all affected by the age of the respondents. These results corroborate the claims of (Mwendo, 2009) that the vast majority of people working for county governments are either nearing the end of their careers or are planning to retire in the coming decade because of their advanced age. Furthermore, 31% of respondents were between the ages of 35 and 44, suggesting that people in this age range are typically active, experienced, responsible, and knowledgeable (Kimani, 2015).

4.2.3 Educational level Distribution in the Sample

Respondents represented a diverse spectrum of academic pursuits and levels of completion. The respondents' degree of schooling was of particular interest to the researcher. Results of respondents' educational attainment. Findings from the question on respondents' highest level of education reveal that nearly half (43%) of respondents had completed at least one year of college. Twenty-four percent of respondents held a master's degree, 33 percent held a diploma/Higher National Diploma, and 3.6 percent held a PhD. The fact that most respondents have at least a bachelor's degree suggests that human capital development efforts by county governments in Western Kenya Region have been fruitful. The efficacy and efficiency with which services are provided are enhanced when competent workers are readily available.

4.2.4 Length of Service

The study sought to determine the respondents' period of service. Figure 4.3 shows the study results.

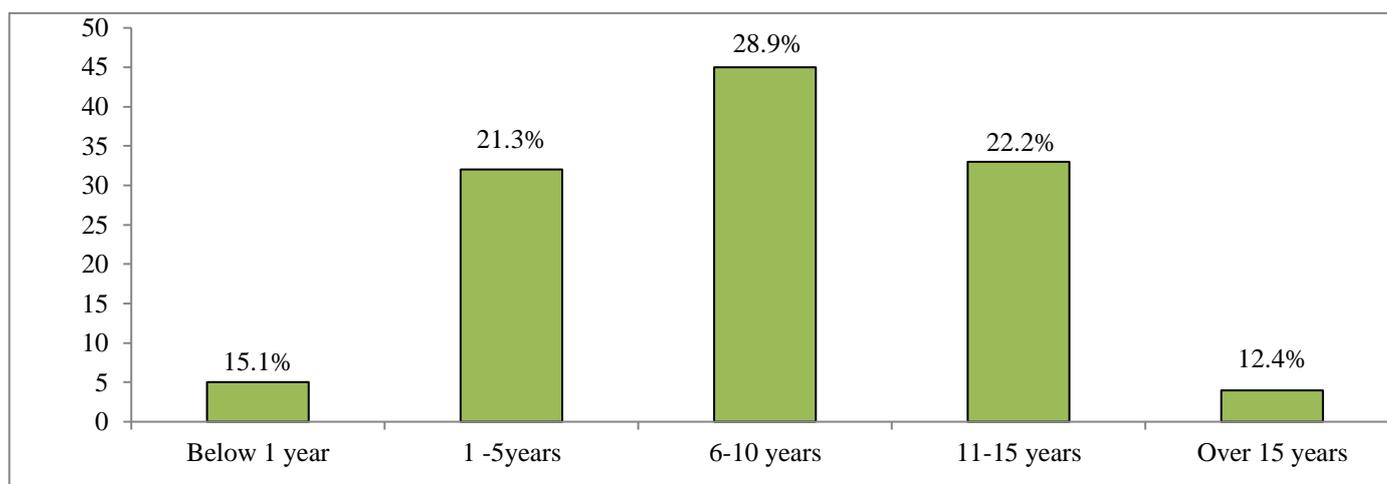


Figure 1
Length of Service Distribution in the Sample (n = 247)

Figure 1 shows that most respondents had served long enough to provide credible responses on the strategy implementation determinants and public health service delivery in the Public Health Facilities. This is because 28.9% of respondents had 6-10 years of experience and another batch of 22.2% had been in the service between 11-15 years. This, together with the fact that the vast majority of respondents have been with their current employer for more than 11 years, suggests that they have the requisite experience to comprehend workplace events, are more competent in their roles, and are highly valued by their clients. Just over a quarter (21.3%) of employees had been with the company for between 1 and 5 years, while nearly one-fifth (15.1%) had been with the company for less than a year. Employees with extended service translate into useful experience in the execution of service delivery, as noted by Ghafoor (2013), whose research is supported by the results shown in Figure 4.3. As seen in Figure 4.3, the respondents' average term of service is displayed as a bar graph.

4.2.5 Job Designation of the Respondents

The respondents were designated as shown in the Table 5. These are job positions for the various staff that took part during data collection exercise.

Table 5
Job Designation of the Respondents

Job Designation	Frequency	Percentage
Medical Superintendents	25	10.1
Hospital Administrators	35	14.2
Human Resource Officers	14	5.6
Head of Pharmacy	36	14.6
Head of Nursing	31	12.6
Head of Laboratory	38	15.4
Head of Clinical Services	33	13.3
Health Records Information Officers	35	14.2
Total	247	100.0

There were 25 medical superintendents (10.1%), 35 hospital administrators (14.2%), 14 human resource officers (5.6%), 36 heads of pharmacy, 31 heads of nursing, 38 heads of laboratory, 33 heads of clinical services, and 35 heads of health records information officers (14.2%). These officers were fairly portrayed, as they are the ones in charge of running the hospitals and are consequently familiar with their daily operations. Observations on the ground revealed that Human Resource Officer roles were unfilled in a number of institutions, with Hospital Administrators doing their duties in their absence. Given the hospital administrators' apparent lack of resources, HR departments often

fall short in areas such as talent management, pay and benefits, staff development, regulatory compliance, and workplace safety.

4.3 Descriptive Results

4.3.1 Participative Leadership Style

The extent to which respondents agreed with assertions about the impact of the Participative Leadership Style on county governments was surveyed. The researcher determined the mean and standard deviation of the Participative Leadership Style effect components to gauge the extent to which participants agreed with the research questions. Table 6 details the study's results.

Table 6

Participative Leadership Style on Public Health Service Delivery

Statement	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Mean/SD
Leadership is flexible and open to change	3 1.0%	13 4.4%	28 9.5%	138 46.9%	112 38.1%	4.17 0.85
Leadership does consultation for new idea	11 3.7%	42 14.3%	27 9.2%	82 27.9%	132 44.9%	3.96 1.21
Leadership encourages & motivate new ideas	30 10.2%	15 5.1%	19 6.5%	92 31.3%	138 46.9%	4.00 1.29
Leadership style is enabling effective strategies implementation	4 1.4%	12 4.1%	24 8.2%	71 24.1%	183 62.2%	4.42 0.90
When workers are involved in decision making it increases their service delivery significantly	14 4.8%	35 11.9%	6 2.0%	60 20.4%	179 60.9%	4.21 1.22
Leadership approaches affect workers level of service delivery.	27 9.2%	29 9.9%	18 6.1%	52 17.7%	168 57.1%	4.03 1.36
Participation can be a contributing factor in increasing service delivery	14 4.8%	38 12.9%	11 3.7%	85 28.9%	146 49.7%	4.06 1.22
The ability to participate in decision making serves as a morale boost for the employees.	20 6.8%	33 11.2%	6 2.0%	66 22.4%	169 57.5%	4.13 1.28
Average of Organizational Performance	Mean= 4.12	%Mean 82.4	Std. Deviation (SD) = 1.17		Variance = 1.39	

The majority of respondents (85%) agreed that the leadership was adaptable and open to change, as measured by a mean of 4.17 and a standard deviation of 0.85; the results also indicated that respondents conduct consultations for new ideas, as measured by a mean of 3.96 and a standard deviation of 1.21, with 72.8% of respondents agreeing and 18% disapproving.

The mean response to the question of whether or not the leadership fosters and motivates new ideas was 4.00, with a standard deviation of 1.29; 31.3% agreed, 46.9% strongly agreed, and 15.3% disagreed. The mean score on the question of whether or not a participative leadership style allows for successful plan execution was 4.42, with a standard deviation of 0.90. Of those polled, 24.1% gave their assent, 62.2% gave their strong assent, and 5.5% voiced their disagreement. When asked if employee participation in decision-making increases service delivery, respondents gave a mean score of 4.21 (standard deviation of 1.22) and a range of responses from 20.4% agreement to 60.9% strong agreement and 16.7% disagreement; respondents also gave a mean score of 4.04 (standard deviation of 1.36) and a range of responses from 0% agreement to 100% agreement on the impact of leadership styles on service levels. There were 168 people who strongly agreed (57.1%), 52 people who agreed (17.7%), and 56 people who disagreed (19.1%). With a mean score of 4.06 and a standard deviation of 1.22, respondents agreed that involvement might be a contributing factor in improving service delivery 85 (28.9%) of the time, strongly agreed 146 (49.7%) of the time, and disagreed 52 (17.7%) of the time. Lastly, on this study's construct, 235 respondents (78.6%) agreed that giving workers a voice in important decisions improves workplace morale (mean score: 4.13, standard deviation: 1.283). Overall, respondents agreed on the questions asked about participative leadership in relation to public health service delivery in County Governments in the Western Kenya Region, giving those questions an average mean score of 4.12 (average mean % of 82.4), standard deviation of 1.17, and variance of 1.39.

The County Executive Committee Member (CECM) Health, County Chief Officers, County Directors, and

County Nursing Officers all contributed qualitative information. In response to a question about the relationship between participative management and the provision of public health services:

The respondents were candid that indeed the leadership was flexible and open to change to some good extent, though there were cases where some leaders were rigid. The respondents gave their opinions that they do consult for new ideas, encourage and motivate new ideas but there were challenges associated with implementation of the new ideas which don't see the light of the day. The leadership was categorical that they encourage staff to participate in decision making and this has boosted the morale of the employees and ultimately contributing to enhanced public health service delivery to some good extent. The respondents also noted that staff absence, delay in reporting to work, politics and non- commitment have negatively affected public health service delivery.

According to the results, respondents are in agreement with the idea that participative leadership is positively correlated with service delivery in Kenya's public hospitals, as suggested by Sfantou, Laliotis, Sifaki-Pistolla, Matalliotakis, and Patelarou (2017), who found a correlation between leadership styles and healthcare quality indicators. Chepkonga and Nyaga's (2019) research into the impact of leadership style on service quality in public hospitals echoed same sentiments. In this study, we found that a more participative leadership style was associated with better service provision in Kenya's public hospitals.

4.3.2 Public Health Service Delivery

The purpose of this study was to use a Likert-type scale to compile descriptive statistics on the quality of public health services provided by County Governments in the Western Kenya Region. The responses were rated as shown in Table 7.

Table 7

Public Health Service Delivery

Statement	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Mean/ SD
Health services are well managed resulting in higher customer satisfaction	39	12	22	90	131	3.89
	13.3%	4.1%	7.5%	30.6%	44.6%	1.37
Discharge of services by staff is satisfactory	6	15	24	98	151	4.26
	2%	5.1%	8.2%	33.3%	51.3%	0.96
Health services are delivered in a timely manner to the patients	34	48	27	84	101	3.58
	11.6%	16.3%	9.2%	28.6%	34.4%	1.40
Services are direct and accessible with no undue barriers of cost, language, culture, or geography	11	22	22	92	147	4.16
	3.7%	7.5%	7.5%	31.3%	50%	1.10
Quality of medical care received is good	6	52	35	96	105	3.82
	2%	17.7%	11.9%	32.7%	35.7%	1.16
Services may be provided in the home, the community, the workplace, or health facilities as appropriate	7	53	39	107	88	3.73
	2.4%	19%	13.3%	36.4%	29.9%	1.14
There is transparency and good communication between care provider (doctors/nurses/attendants) and patient(s)	20	46	23	102	103	3.76
	6.8%	15.6%	7.8%	34.7%	35%	1.27
The program targets and deadlines are executed within the stipulated timeframes	5	51	51	104	83	3.71
	1.7%	17.3%	17.3%	35.4%	28.2%	1.11
There is good accessibility to doctors and other medical professionals	00	00	149	122	23	3.57
	0.0%	0.0%	50.7%	41.5%	7.8%	0.64
Services offered are affordable	00	18	129	129	18	3.50
	0.0%	6.1%	43.9%	43.9%	6.1%	0.71
Average of Public Health Service Delivery	Mean= 3.80	%Mean 76%	Std. Deviation (SD) = 1.09		Variance = 1.07	

With a mean score of 3.89 and standard deviation of 1.37, 221 (75.2%) of respondents agreed that well-managed health services lead to increased customer satisfaction, whereas 39 (13.3%) strongly disagreed and 12 (4.1%) disagreed. With a mean of 4.26 and a standard deviation of 0.96, most respondents (151, or 51.3%) agreed that staff performance was satisfactory, while 98, or 33.3%, agreed and 6(or 2%), or 5.1%, severely disagreed. The average rating for how promptly patients receive health care services was 3.58, with a standard deviation of 1.40. Sixty-three percent (63%) of those surveyed had a favourable opinion, while 82 (27.1%) did not.

The mean score was 4.16 with a standard deviation of 1.10. This indicates that services are straightforward

and easily accessible, with no unnecessary obstacles of price, language, culture, or location. Almost eighty-three percent (239) of respondents gave their assent, while only eleven percent (33) voiced their disagreement. With a mean of 3.81 and a standard deviation of 1.16, 201 (68.4%) of respondents agreed that the quality of medical treatment received is good, while 58 (19.7%) held negative opinions.

A total of 205 (69.7%) of respondents agreed with the statement that there is openness and good communication between the care provider (doctors/nurses/attendants) and the patient(s), with 46 (15.6%) strongly disagreeing and 20 (6.8%) disagreeing. The mean score for this item was 3.76, and the standard deviation was 1.27. The average score on the question of whether or not the program's goals and deadlines are met within the allotted period was 3.71, with a standard deviation of 1.11. One hundred eighty-seven (187) people (or 63.6% of respondents) had positive opinions, whereas 56 people (19%) had negative opinions. With a mean of 3.57 and a standard deviation of 0.64, 145 respondents (49.3%) agreed that access to doctors and other medical professionals is excellent. As a final metric, the mean value for the provision of reasonably priced services was 3.50, with a standard deviation of 0.71. 147 (50%) of respondents felt that the prices were fair, while 18 (6%) disagreed. The average value for this variable was 3.80, which is around 76% of the time, and the average standard deviation was 1.09.

The County Executive Committee Member (CECM) health, Chief Officers, County Director and County Nursing Officer for health when interviewed on the related to public health service delivery, the following were their responses:

The respondents said that the health services in Hospitals were well managed with a minimum wastage of resources to some good extent. The respondents gave their views that Hospital Managers were allocated the necessary authority and are held accountable for overall performance and results. They further said that some of the officers who have been found culpable usually take responsibility of their actions, some have even been suspended. The Hospital Managers are doing their best to ensure public health services are delivered timely to the patients. The public health services to some good extent are accessible to the patients though some remote areas are negatively affected since they don't have adequate resources and therefore deliveries of health services are hampered.

Given these findings, it was clear that public health care delivery was being provided to a certain degree, albeit not completely. Millennium Development Goals (MDGs, 2015) found that in low and middle-income countries, overall, child mortality fell by 53%, maternal mortality fell by 42%, and new HIV infections declined by more than 38%, so these findings are also consistent with the views on the extent of providing public health service delivery. Uneven improvement was also a problem. Preventable mortality rates remained high in low-income, rural, and inaccessible groups. Quality-adjusted (effective) coverage was significantly lower than crude service coverage in a study of eight countries in sub-Saharan Africa, with averages of 28% for prenatal care, 26% for family planning, and 21% for sick child care (Leslie, Ndiaye, & Kruk, 2017). In five countries in sub-Saharan Africa, primary care facilities saw over 40 percent of all facility-based births despite severe shortages in both resources and technical skill (Kruk et al., 2016). These reports show that the County Governments in the Western Kenya Region still have insufficient resources to provide adequate public health services.

4.4 Hypotheses Testing

The purpose of this study was to determine the relationship between participatory leadership and the provision of public health services by County Governments in Western Kenya. *H₀₁ was the hypothesized outcome. There is no correlation between participatory leadership and the delivery of public health services in County Governments in the Western Kenya Region.* In order to examine the Hypothesis, the model $Y = \beta_0 + \beta_1 X_1 + \varepsilon$ was fitted. Where Y is the dependent variable (delivery of public health services), β_0 is the coefficient of regression, and ε is an error term. The model summary for the regression study between participatory leadership and public health care delivery is shown in Table 8. Changes in participative leadership explain 60.4% of public health care delivery, as measured by an R-squared value of 0.604%. This implied that characteristics excluded from the model accounted for 39.6% of public health service delivery.



Table 8

Model Summary for Participative Leadership

Model Summary									
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.777 ^a	.604	.602	.35398	.604	445.042	1	292	.000

a. Predictors: (Constant), participative leadership

a. Predictors: (Constant), participative leadership

b. Dependent Variable: public health service delivery

Table 9 below shows analysis on variance (ANOVA) showing the regression model between participative leadership and public health service delivery.

Table 9

ANOVA between Participative Leadership and Public health Service Delivery

ANOVA ^a						
Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	55.764	1	55.764	445.042	.000 ^b
	Residual	36.587	292	.125		
	Total	92.351	293			

a. Dependent Variable: Public health service delivery

b. Predictors: (Constant), Participative leadership

The F test yielded a result of $F=445.042$, $p<0.05$, indicating that the model adequately explains the variation in the dependent variable. This also indicates that participative leadership is a useful predictor of the delivery of public health services.

The regression coefficients for the model between participatory leadership and public health service delivery are displayed in Table 10. The statistically favorable and significant results ($\beta=0.479$, $\beta=0.777$, and $t=21.096$, $p=0.000$) indicate that participative leadership positively impacts public health service delivery.

Table 10

Regression Coefficients between Participative Leadership and Public Health Service Delivery

Coefficients ^a						
Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		β	Std. Error	Beta		
1	(Constant)	1.746	.096		18.235	.000
	Participative leadership	.479	.023	.777	21.096	.000

a. Dependent Variable: service delivery of public health

a. Dependent Variable: service delivery of public health

The regression model's results indicated that it might be used to foretell the extent to which participative leadership affects the provision of public health services. There was a significant correlation between participative leadership and the provision of public health services, and the regression model appeared as follows: $Y = \beta_0 + \beta_1 X_1 + \epsilon$

Based on the findings obtained, the model equation was: $Y = 1.746 + 0.479X_1$

Since β_1 is statistically different from zero, the null hypothesis was rejected, and it was determined that participative leadership had a significant impact on the delivery of public health services. When there is more participation from leaders, public health services improve by 0.479 units. Similar conclusions were reached by Sfantou et al. (2017), Warri (2021), and Chepkonga and Nyaga (2019): that staff members' familiarity with their tasks and responsibilities, as well as the quality of the working relationship between management and staff, affected the quality of care provided by hospitals. Quality of care and related metrics were found to be significantly correlated with

a leadership style that encourages participation from staff. Chepkonga and Nyaga (2019) looked into how management techniques affected the standard of care provided in public hospitals. The results showed a favorable and statistically significant correlation between a more participative style of leadership and better patient care in Kenya's public hospitals. All of the hypothesized associations between leadership style and service quality in Pakistan's health care industry were supported except for the direct link between laissez-faire leadership and commitment to service quality, and role clarity was found to moderate the relationships between transformational leadership and laissez-faire leadership and commitment to service quality.

Sfantou et al. (2017) investigated the connection between management styles and various measures of healthcare quality. Quality of care and related metrics were found to be significantly correlated with a leadership style that encourages participation from staff. Both patients and healthcare providers viewed strong leadership as essential to the delivery of coordinated and integrated care. Warri (2021) analyzed how different leadership styles affected the quality of care provided by medical professionals. Maintaining positive public and customer relations was found to be more difficult with more authoritarian leadership styles than with a more participative one.

It was the goal of the study by Kyalo, Otieno, and Tenambergen (2018) to determine how management styles affect the success of health information system implementations (IHMS). Yet, research indicates that a leadership style characterized by participative decision making has a negative and non-significant impact on the integration of HMIS. However, no efforts were made to verify the reliability of the results using a combination of qualitative and quantitative data.

4.5 Summary

The study sought to establish the respondents' opinion on the participative leadership in relation to public health service delivery in County Governments in Western Kenya Region. Results from the eight (8) questions had an average mean of 4.12. The respondents were almost unanimous on the question asked on the participative leadership in relation to public health service delivery in County Governments in Western Kenya Region. An R-squared of 0.604 indicates that 60.4% of public health service delivery is explained by changes in participative leadership. This implied that other factors which are left out in the model explained 39.6% of public health service delivery. The F test gave a value of $F=445.042$, $p<0.05$, which supports the goodness of fit of the model in explaining the variation in the dependent variable. It also means that participative leadership is a useful predictor of public health service delivery. Results were statistically positive and significant ($\beta=0.479$, $\beta=0.777$ and $t=21.096$, $p=0.000$) hence participative leadership positively and significantly affects public health service delivery. For every 1 unit increase in participative leadership, public health service delivery increases by 0.479 units.

V. CONCLUSIONS & RECOMMENDATIONS

5.1 Conclusion

The findings indicated that participative leadership had greatest influence on public health service delivery in County Governments in Western Kenya Region. Further findings indicated that participative leadership style enabled effective strategy implementation and when workers were involved in decision making it increased their service delivery significantly.

5.2 Recommendations

The study guides policy makers such as the National Government and County Government Executive on areas to streamline in the strategy implementation in public sector with robust participative leadership practices. Particular focus should not only be on participative leadership that was found to have a significant predictive ability to determine strategy implementation but also organizational factors which also played key role in strategy implementation. Although the study focused on County government, the government of Kenya can borrow a leaf from the study findings for policy purposes to enhance strategy implementation for the attainment of its vision 2030 goals.

The study advises that county governments adopt a participative leadership style and that ministerial leadership expand shared responsibility in their procedures in order to improve service delivery. This is only tenable if the leadership ensures the existence of clear work norms and organizational structures that facilitate delegating and allow all employees to perform their best without interference or favoritism from senior authorities.

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