

11
RESPONSES OF CATHOLIC HEALTH CARE
INSTITUTIONS TO ENVIRONMENTAL CHANGES //

BY

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A MANAGEMENT RESEARCH PROJECT SUBMITTED IN
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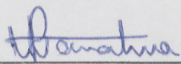
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DECLARATION

DEDICATION

I wish to dedicate this project to my children Emmanuel, Anne, and Paul (Jerry). They all

This Research project is my original work and has not been submitted for a degree
in any other university.

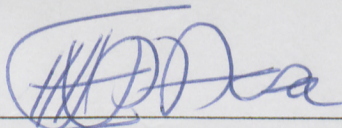
Signed: 

Date: 12/11/06

I also dedicate this project to my late husband Isaac Wafu and mum Anne Winjila.

PAMELA WAMALWA

This Research project has been submitted for examination with my approval as the
university supervisor.

Signed 

Date: 18/11/2006

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ACKNOWLEDGEMENT

I wish to give honour and glory to God for enabling me to undertake and successfully complete this study and particular to get the cooperation that was so critical to the success of the project. In the process of undertaking this study, I have received tremendous

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I wish to dedicate this project to my children Emmanuel, Anne, and Paul (Jerry). They all hold a very dear place in my heart and I thank God for their love and support, especially throughout the MBA programme. They have stood by me, prayed for me and loved me unconditionally as long as I can remember.

I also dedicate this project to my late husband Isaac Wafula and mum Anne Winjila.

My thanks also go to the Catholic health care institutions that participated in this study and who so graciously gave their time for the sake of this project. I want to single out Dr. Margaret A. Opolo of the Catholic Health Commission who was extremely supportive and called the Catholic health care institutions to participate in the study.

Finally and most important, my very sincere gratitude goes to my family. My sisters Lucy, Patricia and My friend Alex. I find no fitting words with which to thank you for your support, prayers, understanding and encouragement. May God bless you and may he make every desire of your heart in accordance with His will.

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My gratitude first goes to Prof. Aosa who was my supervisor. I thank him for his invaluable advice, his patience and wonderful countenance. I also thank the lecturers in the department of Business Administration who imparted their knowledge in me and challenged me academically, my fellow students for the good and sometimes tough times we shared throughout the grueling MBA programme, particularly for their willingness to share experiences.

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ABSTRACT

Organizations continually consume resources from the environment (as inputs), transform (throughput process) and release them (as output) to the same environment. The firm's environment is turbulence. In turbulence environment real time response is very important for the success of the organization. The success and indeed, survival of every organization depends on how well it relates with its challenges and how it positions itself to the external environment.

Catholic Health Care Institutions have been surviving in a changing external environment. The financing source of Catholic Health Care Institutions has completely changed and now heavily dependent on patient fees. Donations have tremendously declined and no longer reliable. Missionary expatriates are very few and government has long ceased to give grants. The staff turnover is very high in these institutions.

A cross sectional survey was used to find out the changes in the external environment that have affected Catholic Health care Institutions in Kenya and how they have responded to these changes. The population of interest was all Catholic health care institutions in Kenya. The population was limited to those health care institutions that are recognized as Catholic' and registered under the Catholic Health Commission. This was a total population of 417. A stratified random sample of 50 institutions was drawn and 38 participated in the study, representing 76% response rate.

The findings indicate that Catholic Health Care Institutions have been surviving in a changing external environment. The changes in economic, technological, social, cultural,

political and legal factors have affected the Catholic Health Care Institutions in varying degrees. Technology has enhanced communication and has led to efficiency. Many of the Catholic Health Care Institutions have stalled to the economic downturn. They are faced with a situation of declining utilization, accumulation of patient debts and threatened sustainability. The staff attrition rate is high. The Catholic Health Care institutions financial situation is weakened by unjust multiple levies such as the business permits by the local government and other professional bodies.

The Catholic Health Care Institutions have implemented different strategies in responding to the environmental changes. Some have put in place strategic plans. The strategic plan gives the institutions direction, clarity and guiding factor in their operation. Some started medical training school to enable them to provide quality and qualified health care professionals at an affordable price. Others have income generating activities, to generate funds to support health care services. Community health programs have been put in place. Health staff Training and development, changing organization structure, computerization of operations, retrenchment and rationalization have been done to some extend.

The findings of this study should be understood and evaluated in light of the limitations of the study. This study is especially helpful to Catholic Health Care Institution and management, as it will sensitize them on the impact that the macro-environment changes are having on the Catholic Health Care Institutions. The findings are thus expected to help the Catholic Health Care Institutions to identify strategic gaps in their

strategic responses and enable them to better respond to environmental changes.

Government agencies may find the information useful in formulation of policy and a regulatory framework for the health industry.

Organizations are open systems that receive resources from the environment (as input), transform (throughput process) and release them (as output) to the same environment (Porter, 1985; Ansoff & McDonnell, 1990; David, 1997; Thomson & Strickland, 1998; Johnson & Scholes, 1999). This means that organizations are open systems, that is, they are environmental-dependent. Threatening the flow of inputs, through negative environmental forces, is tantamount to killing the organization.

The success and indeed, survival of every organization depends on how well it relates with its challenger and how it positions itself to the external environment. Informed estimates of the impact of these complex and dynamic external environmental considerations, through proper analysis, ensure an organizations success into the future (Pearson and Robinson, 1997; Johnson and Scholes 1999). An organization that does not take its external environment seriously will eventually perish.

In order, for organizations to achieve their goals and objectives, they have to continuously adjust to their environment (Pearson and Robinson, 1997). This environment is turbulent, constantly changing, and so it makes it imperative for organizations to continuously adapt their activities in order to survive. Organizations that do not adequately adjust to meet environmental challenges will experience a big problem – the strategic problem. This problem arises out of the maladjustment of any organization to its environment (Ansoff & McDonnell 1990).

CHAPTER ONE : INTRODUCTION

1.1 BACKGROUND

1.1.1 Strategic Response to External Environment

Organizations continually consume resources from the environment (as inputs) , transform (throughput process) and release them (as output) to the same environment (Porter, 1985; Ansoff & McDonnell , 1990; David , 1997; Thomson & Strickland , 1998; Johnson & Scholes , 1999). This means that organizations are open systems, that is, they are environmental- dependent. Threatening the flow of inputs, through negative environmental forces, is tantamount to killing the organization.

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Globalization, social, political, economic and technological changes have forced firms to make dramatic adjustments, not only in order to compete and prosper but also in order to survive. Such firms have enhanced their organizational performance through restructuring, reengineering, quality programs, building of alliances, mergers and acquisitions, strategic redirection, downsizing and culture change. Some of these organizations have undertaken their transformation efforts quite successfully. Others have experienced disappointing results with new strategies not well implemented, acquisitions that have not achieved expected synergies, reengineering and downsizing that have largely failed and quality programs that have not delivered the hoped for results (Kotler, 1996).

Ansoff (1987) notes that the environment is constantly changing , making it important for organizations to continuously adapt their operations in order to survive in this dynamic environment. Organizations need strategies to focus on their activities and deal with the emerging environmental challenges. Failure to do this may Jeopardise the future success of the organization (Aosa 1998).

1.1.2 Health Service Delivery in Kenya

Most of the health infrastructure in Kenya was put into place by the independence government from 1963 like in most parts of the post-colonial Africa as part of the popular nation building efforts. Prior to this , the organization and provision of health care and other welfare services during the colonial era in Africa had been dominated by voluntary organization, typically, Church Missions and Societies, particularly in the rural areas (Mburu, 1989; Vogel and Stephens, 1989). In most rural areas Church

Institutions were the first providers of health services and have remained in some cases the main or sole provider (Mburu 1989; Vogel and Stephens, 1989).

The 1980's marked a radical turn in planning the organization of health care in the developing world as the neo-liberalist health and social policies took hold (Helen and Jauho, 2002). To a great extent, liberalization through structural adjustment programs (SAPS) in sub Saharan Africa the 1980's and 1990's defined public sector development in the continent (Mwabu, 1998). Several actions in Kenya along this action can be cited for example the introduction of user fee in the public health system in 1989 as a form of marketization and decentralization of health services (Koivusalo and Ollila, 1996). Liberalization of licensing also brought about increased competition as the private sector expanded tremendously in the 1990's. This presented a turning point for Church facilities that now are being pressured to reorganize their units and establish for-profit functions along their not for profit structure (Wamai, 2004).

Over the latter half of the 20th century, health care systems around the world have undergone major transformations. Globalization processes outside the health sector redefine the framework for health policies that countries can put into practice. This influenced the capacities to allocate resources to the health sector, the structures and modes of functioning of the health care system. Also influenced the extent to which countries can practice health public policies outside the health sector (Ollila, Koivusalo, Baru, 2002:). According to the 2000 World Health Report (WHO, 2000), the development and reforms of modern health systems through the twentieth century have been prompted not only by perceived failures in health but also by a quest for greater efficiency, fairness and responsiveness to the expectations of the people that

the systems serve . The health system is faced with the fast changing health services and consumer demand from increasingly enlightened population.

Various development in the International level such as the Millennium Development Goals (MDGs); these goals include a number of direct and indirect references to health parameters. International investments in development of health care are to a major extent tied to these MDGs. The evolution of new strategies and approaches regarding the reduction of poverty and the relevance of investments in health care therein; these include among others Poverty Reduction Strategy Papers (PRSPs) and Sector Wide Approaches (SWAPs), which increasingly guide funding decisions by particularly bilateral and multilateral donors.

The introduction of United Nations (UN) led funding initiatives that target specific diseases, such as the Global Fund on AIDS, Malaria and TB (GFATM) (2001) and the UNAIDS and World Health Organization (WHO) led “3-by-5” initiative (2003), which intends to upscale availability of Anti Retroviral Treatment (ART). The massive support received by Government for its health budget by bilateral and multilateral donors – a positive fact in itself – has created imbalances in an already precarious equilibrium (Giusti., 2003). The aforementioned developments call for proactive action by the Church, so that Church health institutions may preserve and enlarge their unique contribution made to health service provision.

1.1.3 Catholic Health Care Institutions in Kenya

Health care services in Kenya are provided by three main players, namely the Government (Ministry of Health), Faith Based Organizations (Kenya Episcopal Conference and Christian Health Association of Kenya) and the private sector. The

Government provides 50% of Health care services while the Faith based organizations provides 40% and the private sector provides 10% (GOK, 2004).

Table 1: Health Care Institutions by Ownership (Government, Christian Health Association of Kenya and Kenya Episcopal Conference Catholic Secretariat)

Institution Type	Government of Kenya	Christian Health Association of Kenya (CHAK)for Protestant Churches	Kenya Episcopal Conference Catholic Secretariat (KEC)	CHAK/KEC
Hospital	147	24	44	68
Health Centres	460	47	92	139
Dispensaries	1630	311	281	592
Community Based Health Care Programs		52	46	98
	2237	434	463	897

Source: Government of Kenya, 2006

The number of health services belonging to the Faith Based Organizations makes a sizeable component of the country health system. The proportion is much higher particularly in remote areas where government institutions may be few.

1.1.3 Catholic Health Care Institutions in Kenya

The Catholic Health Care Institutions in Kenya has a long history of service in the health sector, dating back to pre-independent Kenya in the early 1900s and continuing to present day. Catholic Health Care Institutions provides health care to the

community in the remote places where other health providing agencies are unable to have any health providing infrastructure. (Ndungu, 1984).

To date the Catholic Health Care Institutions still form the bulk of not-for-profit non-government health providers with a coordinating body, Catholic Health Commission under the Kenya Episcopal Conference Catholic Secretariat. The Health Care Institutions founded and managed by the Catholic Church are an essential part of the universal Mission of the Church, an expression of the Healing Ministry the Church has received from Jesus Christ. (Kenya Catholic Secretariat, 2000)

The Catholic Church is credited with having quite reliable health institutions even in some very remote parts of this country, where very poor infrastructure does not make economic sense to private-for-profit health care providers. These are attributed only to sacrifice servant leadership and upholding Christian values of love, integrity, dignity, justice, equity and openness, strong heart for the poor. The Catholic values identity, creates so much inspiration and is a source of quality care seen from a holistic perspective.

The high poverty levels in the country and the impact of HIV/AIDS has created additional difficulties in people's ability to pay for health services. More than 56% of Kenyans currently live below the poverty line and have less than a dollar per day to spend on everything needed to live (GOK, 2005). The heavy burden of providing health care to the poor has often fallen heavily on the mission hospitals, which are perceived as the last frontier where mercy might be shown to the poor sick who have been turned away elsewhere (CHAK, 2001).

The beginning of the third millennium poses to the Catholic Health Care Institutions a

The Catholic health care provision finds itself increasingly subjected to developments over which it has little control. These concern international and local changes in thinking on the relationship between health (care) and socio-economic development, on strategies for health services delivery, on new funding arrangements and priorities (Medicus Mundi International, 2004) . These developments impose new demands on Catholic Health Care Institutions while many institutions already for years face a survival mode situation, due to lack of finances and human resources. The challenges are even greater due to the fact that in many locations a large part of the population has lost connection to socio-economic development and /or are facing hardship due to HIV/AIDS.

1.2 RESEARCH PROBLEM

The Department for International Development (DFID) Country assistance plan has highlighted HIV/AIDS as a major development constraint in Kenya. (DFID, 2005). During the last decade, HIV/AIDS has come to be seen as a complex medical, social, political, cultural and human rights problem. This situation calls for innovative concepts on Catholic Health Care Institutions, which include new ways of leadership and new mechanisms to promote Catholic health care provision with specific emphasis on the plight of the poor. New opportunities avail themselves at the same time since the international community has underlined the necessity to include civil society participation in poverty reduction strategies. However, it is essential that the Catholic Health Institutions enhances its institutional performance in terms of accountability, transparency and quality of care.

The beginning of the third millennium poses to the Catholic Health Care Institutions a complex set of challenges that require a strategic thinking and response. Faithfulness to the mission received by Jesus Christ 2000 years ago means, today, being able to start and manage a process of adoption within a clearly identified strategy. In the last decade the speed of change in the external environment has magnified internal problems and weakness. The beginning of the third millennium sees a Catholic Health Care Institutions in need of a deep and radical response, without its existence and faithfulness to the original mission is threatened (Medicus Mundi International, 2004). It is expected that Catholic Health Care Institutions have to adapt to such changes for their survival.

1.2 RESEARCH PROBLEM

Organizations continually consume resources from the environment (as inputs), transform (throughput process) and release them (as output) to the same environment. The success and indeed, survival of every organization depends on how well it relates with its challenges and how it positions itself to the external environment. An organization that does not take its external environment seriously will eventually perish. For organizations to achieve their goals and objectives, they have to constantly adjust to their environment. This environment is turbulent, constantly changing, and so it makes it imperative for organizations to continuously adapt their activities in order to survive.

Catholic Health Care Institutions have been surviving in a changing external environment. They are facing social, economic, technological and political climate in which change is the only constant. The financing source of Catholic Health Care

Institutions has completely changed and now heavily dependent on patient fees. Donations have tremendously declined and no longer reliable. Missionary expatriates are very few and government has long ceased to give grants. The staff turnover is very high in these institutions.

To determine how institutions are responding to the changes in the environment, it is important to carry out studies on organizations in various sectors of the economy. In this regard, studies have been done in the dairy industry in Kenya (Bett, 1995); motor industry in Kenya (Kombo, 1997); the oil industry in Kenya (Chepkwony, 2001) and the brewing industry in Kenya (Njau, 2000). No study was however found on Catholic Health Care Institutions in Kenya. The closest study found was on Strategic responses of Christian Churches in Kenya to changes in the external environment (Muturi 2003).

The findings from research on firms in other industries are not useful in helping understand the problems and responses by the Catholic Health Care Institutions. Hence the current study seeks to investigate the environment changes that are affecting the Catholic Health Care Institutions and how they are responding to the changes. This study sought to answer the following questions:

- i. What changes have occurred in the external environment which has affected the Catholic Health care Institutions in Kenya?
- ii. How the Catholic Health Care Institutions have responded to environmental changes in Kenya?

1.3 THE STUDY OBJECTIVE

The study had two objectives. These were:

- i. To determine the changes in the external environment which have affected the Catholic Health Care Institutions in Kenya.
- ii. To investigate the responses of Catholic Health Care Institutions to their environment in Kenya.

1.4 IMPORTANCE OF THE STUDY

This study will benefit the Catholic Health Care Institutions and management, as it will sensitize them on the impact that the macro-environment changes are having on the Catholic Health Care Institutions. The findings are thus expected to help the Catholic Health Care Institutions to identify strategic gaps in their strategic responses and enable them to better respond to environmental changes. The study will help Catholic Health Care Institutions workers to become proactive, they will always have plans for the short –term and medium term for their business. Government agencies may find the information useful in formulation of policy and a regulatory framework for the health industry. The study will also contribute to the body of knowledge and researchers and scholars will undertake further studies in a related field.

CHAPTER TWO: LITERATURE REVIEW

2.1 ORGANIZATION AND THE ENVIRONMENT

The external environmental changes do impact on the operational dynamics of the organizations' internal environment and creates a mismatch on the already existing strategies that link the two environments. The external environment can be described as all conditions that affect a firm's strategic options but which are beyond the firm's control (Pearce and Robinson, 1991). Forces at work in the external environment are dynamic and include economic, political, technological and social factors (Kotler and Armstrong, 1990).

The external factors influence organization's choice of direction and action, which can be categorized as the remote, industry and operating environment. A number of authors (Chandler, 1962; Andrews, 1971; Daft, 1986 and Porter, 1991) variously point out that firms are environment dependent and changes in the environment shape opportunities and challenges facing the organization. It is extensive understanding of the environment that will help a firm define its objectives and develop competitive strategies. An understanding of the environment therefore enables a firm to define its objectives and to develop new strategies that are best suited to cope with the change.

Responses basically refers to decisions and actions that are undertaken by organizations and entail both short and long term effects to the company, are company-wide in scope and involve the deployment of the firms' resources in their implementation. Porter (1980) argues that, knowledge of the underlying sources of competitive pressure provides the groundwork for strategic agenda in action. Indeed,

when firms are faced with unfamiliar changes the need to revise their strategies becomes a top priority.

Dess and Origer (1980) argue that, looking beyond the organizations' immediate operating environment to the industry in which it competes has long been advocated. In similar circumstances, Aguilar (1967) observed that managers must shift their environment scanning from the immediate areas in which the firm competes to the industry as whole. Porter (1980) takes a similar stand. He points out that the essence of formulating a competitive strategy is relating the company to its environment and the Key aspects of the firms' environment is the industry in which it competes. He further noted that industry characteristics strongly influence the alignment options available to the firm.

Dess and Bland (1984) gave a theoretical and empirical support for what they described as the essential features of industry environment. They include the availability of resources with which the environment can support sustained organizational growth; the extent of unpredictable change in environment elements, and heterogeneity of and range of environmental activities. Environmental assessment is considered an antecedent activity to the formulation of company objectives and competitive methods. Aldrich and Mindlins (1978), considered the three dimensions by seeing the environment as source of both information and resource reservoir and the starting point of strategy formulation.

Porter (1996) asserts that, the proximate environment will define many of the input markets the firm has to draw on, the information that guides strategic choices,

incentives and pressures on the firms to both innovative and accumulate skills or resources overtime. Competitive advantage then may reside as much in the environment as in individual firm.

Porter (1991) argues that the environment shapes how activities are configured uniquely and what commitments can be made successfully. The environment is therefore important in providing initial insight that underpins competitive advantage, the inputs needed to act on it, an accumulated knowledge and skills over time and the forces needed to keep progressing. He further argues that the environment through its attributes affects both the firm's initial conditions and its managerial choices.

2.2 THE CONCEPT OF STRATEGY

Strategy may be defined as the broad program and goals to help an organization achieve success. Strategy is the match between an organization's resources and skills, the environmental opportunities and risks it faces, and the purposes it wishes to accomplish (Schendel and Hofer, 1979). The environment is changing rapidly and it is important for an organization to constantly adapt its activities to reflect the new requirements of the environment. Having a strategy therefore enables an organization to ensure that the operational decisions are made with the long term interests of the organization. Without strategy, operational decisions could have a negative impact on the long term objectives of the organization (Bruce and Langdon, 2000).

According to Pearce and Robinson (1999), strategy can be viewed as building defense against competitive forces or as filing positions in the industry, where forces are weakest. Porter (1980) sees strategy as being all about competition and trying to gain

competitive advantage. Strategy can also be viewed as a pattern of actions and resource allocations designed to achieve the goals of the organization (Bateman and Zeithaml, 1990).

By implementing strategy, the organization endeavours to match the skills and resources of the organization to the opportunities found in the external environment. The decisions and actions taken will lead to the development of an effective strategy, which will help to achieve organizational objectives (Jauch and Glueck, 1988).

The main challenge that managers are faced with is to ensure the survival and success of the organizations they manage. These organizations can only be successful if they adjust to meet the environmental challenges. Failure to do this will cause the organization to experience a strategy problem, which arises out of a mismatch between the output of the company and the demands of the market place (Ansoff, 1984). Strategy therefore enables managers to deal with potential problems that may face their organizations (Aosa, 1998). Consequently, strategy is a tool that offers significant help for coping with turbulence confronted by organizations (Ansoff and McDonnell, 1990). Strategy requires to be taken seriously as a managerial tool, not only for the firm but also for a broad spectrum of social organizations.

2.3 RESPONSE OF ORGANIZATIONS TO CHANGED ENVIRONMENT CONDITIONS

Hall (1980) studied how large manufacturing corporations in America were affected when their external environment became turbulent. He observed that the "success formulas" which brought prosperity when the environment was stable, were no longer

working and were being replaced with strategic choices that were becoming essential to survive in a hostile environment, organizations need to re-direct their attention to re-defining their business as a crucial step to formulation of survival strategies. Organizations must also look beyond competitors today and those that may become competitors tomorrow and exploit new markets.

Organizations must adapt their strategies to new environments (Ansoff, 1999). *Changes in the external environment will require new strategies, which will in turn* call for reformed organizational capability. According to Thompson and Strickland (1993), it is necessary for organizations to utilize environmental scanning techniques, so as to predict environmental changes. Such scanning involves studying and interpreting social, political, economic and technological events so as to identify trends that could eventually affect the industry. Environmental scanning enables the manager to become aware of developments that could pose new opportunities and threats to the organization.

Kotler (1998) observed that marketing plays a critical role in the company's strategic planning process and that it is the most significant contributor to this process. Marketing plays a role in defining the business mission, analyzing the environment, competitive and business situations. According to Kotler, marketing functions also involve developing objectives, goals, strategies, defining products, markets and distribution. The involvement of marketing extends to development of programs and operating plans that are linked with the strategic plan. In view of the fact that strategic plans have to do with strategic responses, the marketing components articulated by Kotler form an integral part of the strategic response.

Porter (1980) floated generic competitive strategies which can assist a firm develop a competitive edge over its competitors in a competitive environment. He suggested that a firm could develop a strategy of overall cost leadership differentiation strategy and focus strategy.

Porter (1980) asserts that to achieve cost leadership in an industry, a firm can adopt functional policies and resort to aggressive construction of efficient scale facilities. This is possible by sourcing inputs from cheaper suppliers or by putting up state of the art equipment, which can reduce costs of customer service delays and minimize the cost of errors. Porter (1980) went further and concluded that, cost leadership can assist a firm to response favorably when dealing with customers who are price sensitive.

According to Porter (1980), a firm can adopt a strategy of differentiating its products or services as a way of creating something that is considered unique industry –wide. For instance, product uniqueness can be achieved through design and creation of innovative features. The firm can then carry out aggressive promotions emphasizing the product uniqueness so as to build a strong brand loyalty to defend itself against competitors' products.

In the focus strategy, Porter (1980) argues that, firms have to focus on a particular buyer group, segmentation of the product line or geographical market. This assertion is based on the realization that in competitive environment, firms should trim their operations and target specific markets so as to develop a competitive edge.

Ansoff (1999) discusses the role of general management in the organization's strategic response. He states that for an organization to implement a strategic response, three components are essential. These are the right climate (will to respond), competence (ability to respond) and capacity (volume of response). These three components are the responsibility of the general management. The general management should therefore ensure that the organization engages in behavior, which will optimize the attainment of the organization's long-term objectives. Climate setting determines the organizational culture and it involves the mentality and power positions of the managers. Competence determines the organizations structures, systems and shared knowledge and involves the talents, skills and knowledge of the management. Capacity to accommodate the various management challenges that may arise over time.

Bett (1995) studied the dairy industry in Kenya and found that due to the on-going economic reforms in the country, firms in this industry made certain adjustments in their marketing mix components of product, price, promotion and place in order to adapt to changes and remain competitive in the liberalized industry. Bett also noted that in addition, the firms adopted market driven strategies by engaging in market segmentation and market planning so as to cope with the competitive environmental challenges. The firms also focused in their competitors' activities and undertook to know what was happening within the industry and the markets. They were flexible and adaptive.

Steel and Webster (1992) found out that small enterprises in Ghana adapted to the competitive environment as a result of Structural Adjustment Programmes (SAPs) , by altering their product mixes. This enabled these firms to compete with imports. Changes in product mix were prevalent in those sectors whose products were more vulnerable to competition from standardized imports. The firms also shifted their market strategies by seeking newly opened market niches. Further, in their endeavour to reduce cost, most firms changed their input sourcing behaviours and opted for cheaper sources. Most firms also shed labour in their bid to manage costs.

Kombo (1997) found that as a result of the ongoing economic reforms, firms in the motor industry adjusted their variables substantially so as to survive in a competitive environment. The firms in this industry introduced new technologies of product development, differentiated their products, segmented and targeted their customers more and improved customer service. They also made significant changes to marketing mix variables of promotion, price and distribution in response to competition.

Thiga (2002) found that in response to the environmental turbulence that characterized the aviation industry, all the airlines surveyed had in one way or another adapted strategies that enabled them to cope with the changed environmental conditions. Most of them had formed alliances and partnerships so as to quickly globalize their route networks, thus giving them a competitive edge.

Njau (2000) found that in its response to threats posed by increased competition due to liberalization, EAB Ltd, adjusted the strategic variables of products, promotion,

cost structure, market research and development and market predisposition. Njau noted that there was a concerted effort to differentiate the company's products. The company also adopted cost structure strategies involving changes in the management structure and staff retrenchment.

Chepkwony (2001) found that firms operating in the oil industry laid more emphasis on strategic planning. Many of these firms also re-designed their organizational structure in a bid to making the organizations more efficient. The firms has also formed strategic alliances and engaged in mergers in an effort to reduce costs and be more competitive. Most firms also adjust their product strategies so as to improve the quality of their products to meet the ever-changing needs of their customers. Chepkwony further found that there was more emphasis on research and development by most firms, which aimed at establishing the needs of their customers and also to help them keep abreast of the competitor activities.

2.4 ROLE OF GENERAL MANAGEMENT IN FACILITATING RESPONSES TO ENVIRONMENT CHANGES

Ansoff (1990) put into perspective the role of general management in a firms' strategic response. General management is the propensity and ability of the firm to engage in behavior, which optimizes attainment of the firms' near and long term objectives. He aptly puts it that, general management is about setting the right climate (will to respond), competence (ability to respond) and capacity (volume of response). He argues that, the three components are essential if the firm is to implement a strategic response.

Climate setting involves the mentality and power position of the managers. Competence involves talents, skills and knowledge of the management. It determines the organizational structures, systems and shared knowledge. Capacity on the other hand, entails the personal and organizational capability to accommodate the various management challenges as may arise from time to time.

Ansoff (1990) went further and conceptualized the effects of environment changes on the firm's strategy and capability. He proposed that there has to be a fit between the existing strategy and the prevailing environment for the organization to remain successful. The change in the internal capability involves changes in the company resources staff, management, finance, systems and policies. He stated that, once the strategy has changed, such change requires a corresponding change in the internal capability of the firm so as to fit with the new environment.

Osthuizer, et al (2000) argued that successful strategies could only be implemented through an organizational structure that links people's abilities and skills to the mission of the enterprise. They further stated that, the key to efficient information service of the future is to reduce reliance on managerial authority, create teams that share information and delegate responsibility far down the hierarchy. They continued to argue that, organizational processes must be transformed to deliver the right response at the right time to highly unique and transient user needs. They further observed that, faced with changing markets, advanced technology and increased competition, many information services have come to understand that the key to corporate success lies in transforming authority and delegating responsibility and accountability far down the hierarchy.

Modern executive must respond to the challenges posed by the organization's immediate and remote external environment (Aosa, 1992; Shimba, 1993; Pearson and Robinson, 1977). The immediate external environment includes competitors, suppliers, scarce resources, government agencies and customers whose preferences keep on shifting (Webb, 1989). The remote external environment comprises economic and social conditions, political priorities, and technological developments, all of which must be anticipated, monitored, assessed and incorporated into the executive's decision making (Pearce and Robinson, 1997) The success and indeed, survival of every organization depends on how well it relates with its challenges and how it positions itself to the external environment.

Care Institutions that are recognized as Catholic' and registered under the Catholic Health Commission. This was a total population of 417 Catholic Health Care Institutions obtained from the Inventory of the Catholic Church's response to HIV/AIDS in Kenya (Kenya Catholic Secretariat, 2006) ("Appendix III").

3.3 SAMPLE

The sample was stratified random sample by level based on the three levels of Hospitals, Health Centres, and Dispensaries. The Medical Practitioners and dentists Board has designated health care institutions based on defined guidelines and assessments by the district health management team in the following levels of Hospitals, Health Centres and Dispensaries. The strata's were based on the above three levels. A total of 50 health institutions were drawn of which 15 were hospitals, 15 health centre, and 20 dispensaries respectively.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 RESEARCH DESIGN

The Study was to investigate the response of Catholic Health Care Institutions in Kenya to environmental changes. A cross sectional survey was used to collect data, because the information required was not available from any other sources. It also allowed collection of same information from every respondent at a given point in time.

3.2 POPULATION OF STUDY

The population of interest was all Catholic Health Care Institutions in Kenya. The population was limited to those Health Care Institutions that are recognized as Catholic' and registered under the Catholic Health Commission. This was a total population of 417 Catholic Health Care Institutions obtained from the Inventory of the Catholic Church's response to HIV/AIDS in Kenya (Kenya Catholic Secretariat, 2006) ("Appendix III").

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4.1. DEMOGRAPHIC CHARACTERISTICS OF THE CHURCHES

3.4 DATA COLLECTION

Data was collected using semi-structured questionnaires ("Appendix II"). The questionnaire was developed from pertinent literature and was divided into three parts. Part one dealt with the bio-data of the Catholic Health Care Institutions, part two addressed the changes that have affected the Catholic Health Care Institutions while part three dealt with the response to change. The questionnaires were sent by mail to a drawn sample of Catholic Health Care Institutions. The respondents comprised of the Hospital Administrators, Matrons and the Persons In charge of the Catholic Health Care Institutions who were fully conversant with the strategic issues on their respective institutions. The data collection lasted a period of 6 weeks.

3.5 DATA ANALYSIS

The completed questionnaires were edited for completeness and consistency before processing. Both qualitative and quantitative data was collected. Quantitative data was analyzed by use of percentages to have a comparison of responses. Mean scores were used to calculate or indicate what adjustments had been adopted on the variables in response to environmental change. Qualitative information was analyzed by establishing the frequency of a given response to the question these frequencies were tabulated and hence conclusion made.

Table 2 Number of staff employed

Type	Mean Score	Std. Deviation
Hospital	143	55.3
Health Centre	21	19.5
Dispensaries	4	3.5

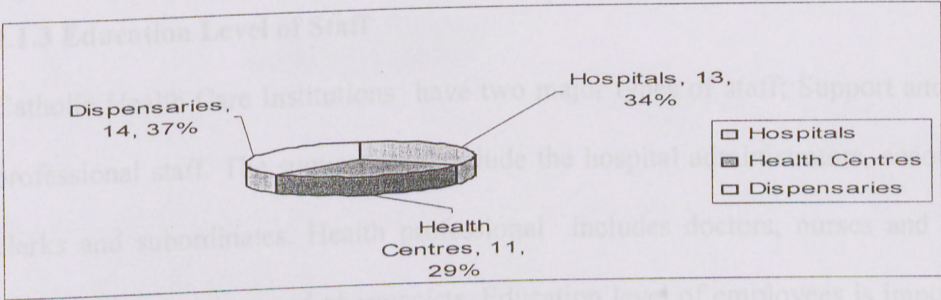
Source: The Questionnaire

CHAPTER FOUR: RESEARCH FINDINGS

4.1. DEMOGRAPHIC CHARACTERISTICS OF THE CHURCHES

A total of 38 Catholic Health Care Institutions responded out of the 50 Catholic Health care institutions that were targeted, representing 76% response rate. Figure 1 show that 37 % that respondent were dispensaries, 29 % health centres, while 34% hospitals.

Figure 1: Catholic Health Institutions that respondent



Source: The Questionnaires

4.1.1 Human Resource

Human resource is critical for the survival of Catholic Health Care Institutions. The number of employees to be recruited is determined by the level of institution. Table 2 indicates that averages of 143 staff were employed per hospital, an average of 21 per health centre, and an average of 4 employees per dispensary. Hence hospitals have more employee followed by health centres and lastly dispensaries.

Table 2 Number of staff employed

Type	Mean Score	Std. Deviation
Hospital	143	55.3
Health Centre	21	19.5
Dispensaries	4	.85

Source: The Questionnaire

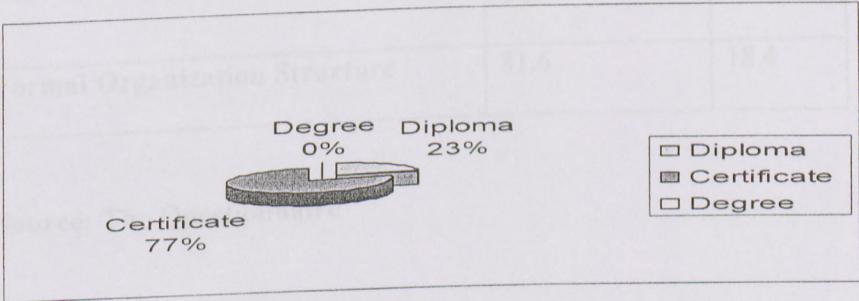
4.1. 2 Terms of Employment

Terms and conditions of employment are not uniform within the Catholic Health Care Institutions and differ from those offered by the civil service. Attrition of qualified health staff to public service and private practice remains a serious concern. The terms of employment are important in determining the staff retention, and motivation. 70 % of those who respondent have employed staff on contract basis, while 30% have employed on Permanent basis.

4.1.3 Education Level of Staff

Catholic Health Care Institutions have two major types of staff; Support and health professional staff. The support staff include the hospital administrators, accountants, clerks and subordinates. Health professional includes doctors, nurses and clinical office, lab technicians and pharmacists. Education level of employees is important to determine the available skill mix in an institution. Each staff requires certain level of skills for performing tasks and making day to day decisions. The figure 2 shows that 0% of the support staff in the institutions studied have degree level of education, 23% of the support staff have diploma level of education, while 77% of support staff have certificate level of education.

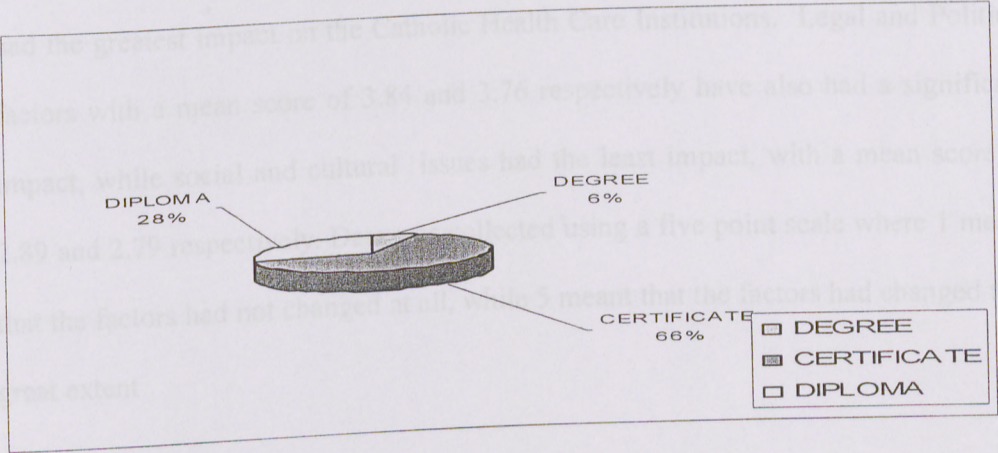
Figure 2: Academic Level of Support Staff in Catholic Health Institutions



Source: The Questionnaire.

Figure 3 shows that 6 % of the Health Staff in the institutions studied have degree level of education, 28 % of the Health Staff have diploma level of education, while 66% have certificate level of education.

Figure 3: Education Level of Health Staff in Catholic Health Institutions



Source: The Questionnaire.

4.1. 4 Organizational Structures

Organizational structure determines the governance system of any institution. The table 3 shows that 81. 6% of the Catholic Health care institutions have a formal organization structure, while 18.4 % do not have a formal organization structure.

Table 3: Formal Organization Structure

	Yes	No
Formal Organization Structure	81.6	18.4

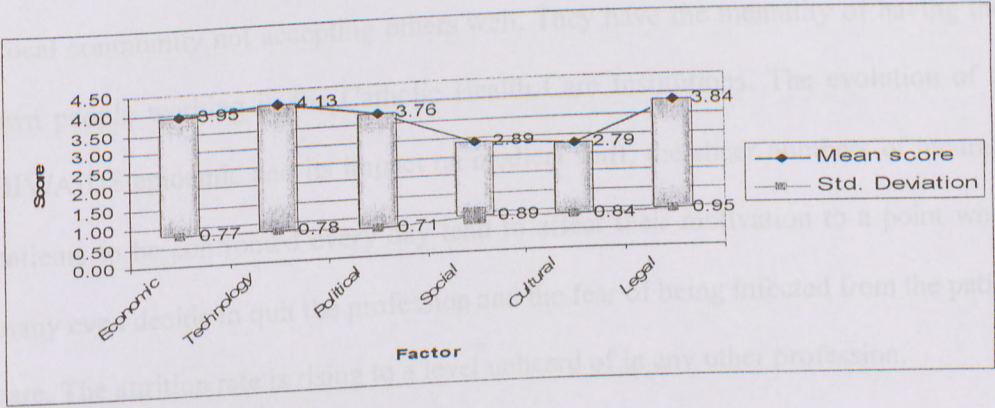
Source: The Questionnaire

4.2 ENVIRONMENTAL FACTORS THAT HAVE CHANGED

4.2.1 External Remote Environment

Factors in the external remote environment are dynamic and include economic, political, technological, legal and social factors. The figure 4 shows that technological factors with a mean score of 4.13 and economic factors with mean score of 3.95 have had the greatest impact on the Catholic Health Care Institutions. Legal and Political factors with a mean score of 3.84 and 3.76 respectively have also had a significant impact, while social and cultural issues had the least impact, with a mean score of 2.89 and 2.79 respectively. Data was collected using a five point scale where 1 meant that the factors had not changed at all, while 5 meant that the factors had changed to a great extent

Figure 4: Extent to Which Environmental Factors Have Changed



Source: The Questionnaire

4.2.1.1 Technological Factors

Technology has enhanced communication and has led to efficiency. It has also created the need to invest in computers and new equipment for laboratory, x-ray, and theatre and heightened the need to have well trained personnel. All this has created a

strain on the budget since the Catholic Health Care Institutions now have to increase their budgets so as to accommodate these. Similarly, very few Catholic health care institutions have access to the internet facilities.

4.2.1.4 Political and Legal Factors

4.2.1.2 Economic factors

Many of the Catholic Health Care Institutions have stalled to the economic downturn. They are faced with a situation of declining utilization, accumulation of patient debts and threatened sustainability. The financing source of Catholic Health Care Institutions has completely changed. The services are now heavily dependent on patient fees. In the wake of the departure of most donors and the loss of Government grants

4.2.1.3 Social and Cultural factors

Local community not accepting others well. They have the mentality of having their own people working in the Catholic Health Care Institutions. The evolution of the HIV/AIDS epidemic and its impact on medical staff: the sheer numbers of incurable patients to be confronted every day tend to affect their motivation to a point where many even decide to quit the profession and the fear of being infected from the patient care. The attrition rate is rising to a level unheard of in any other profession.

Demand for free treatment, "false assumption" held by the population that the church will forever freely provide the much-needed health and healing "packages" remains a bottleneck and sustains the status quo of rural underdevelopment. There are cultural conflicts between Western and traditional medicine. Groupings along tribal lines have

caused dis-unity in the seek and maintenance of healthy behaviours among the populace especially in the rural remote areas.

4.2.1 4 Political and Legal Factors

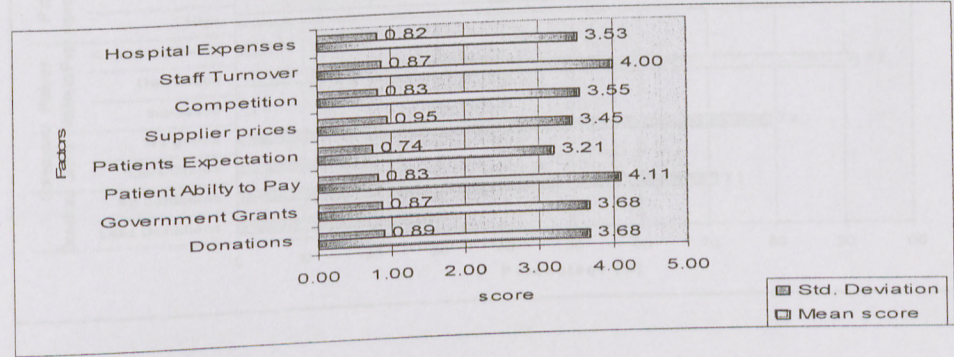
The stability or instability in the Nation is reflected in the general service provision by a Nation. Political Stability and constituency development funds have helped the Catholic health care institutions to improve a little step. Recent changes in the political scene has led to changes in the health sector for example National Health Insurance Funds (NHIF) that has to some extent positively affected the hospitals. Recent redeployment of staff to rural, hard to reach areas by the government to Catholic health care institutions has led to continuation of health service provision in his areas. Political interference by politicians has though in some health care institutions indirectly affected patient bills payment. The Catholic Health Care institutions financial situation is weakened by unjust multiple levies such as the business permits by the local government and other professional bodies.

4.2.2 Immediate External environment

The immediate external environment includes competitors, suppliers, scarce resources, government agencies and patients whose preferences keep on shifting. The extent of change in the immediate external environment of Catholic Health care Institutions is shown by figure 5. The highest level of change within the Catholic Health Care Institution was noted in the level of Patient ability to pay which had a mean score of 4.11, followed by staff turnover which had a mean score of 4.0. A significant level of change was noted in the government grants and donations which had a mean score of both 3.68. Competition, hospital expenses, and suppliers prices

had the following mean scores respectively; 3.55, 3.53 and 3.45. While the lowest level of change was noted in the level of expectation by patients which had a mean score of 3.21. Data was collected using a five point scale where 1 meant that the factors had not changed at all, while 5 meant that the factors had changed to a very large extent.

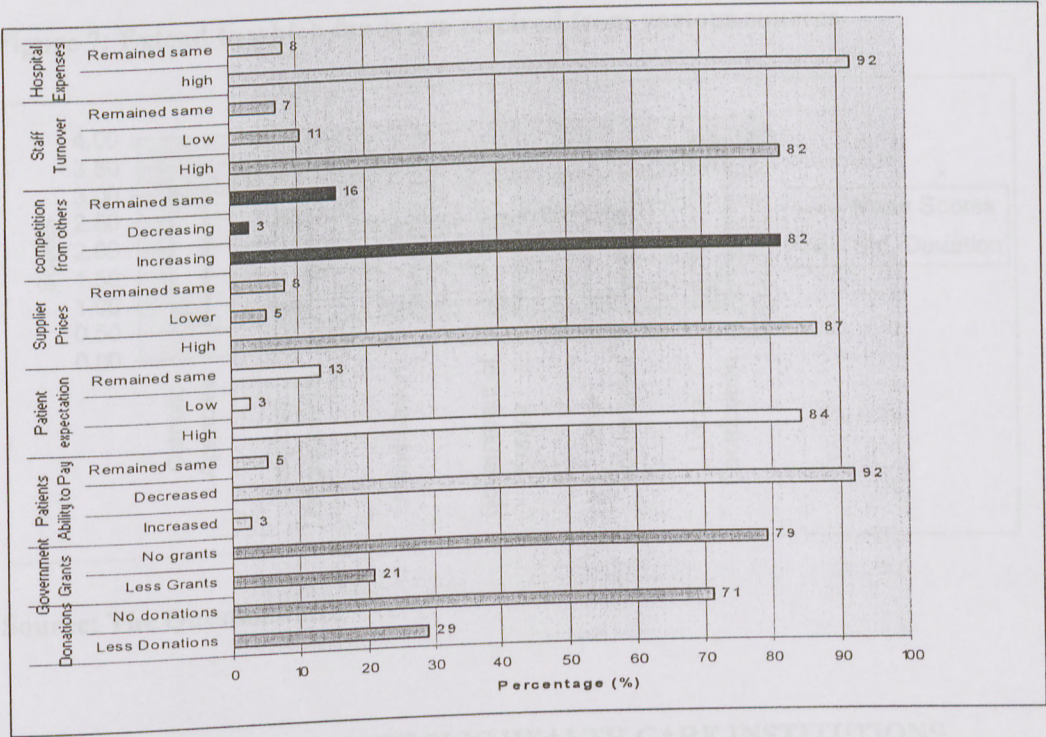
Figure 5: Extent of change in the immediate external environmental factors



Source: The Questionnaire

This figure 6 shows that in the last 10 years, with regard to hospital expenses 92 % of those who responded said that both the expenses had gone up and the patients ability to pay had decreased, 87 % said that suppliers prices had increased, 82% said that staff turnover and competition was high, 79% said that they received no grants from the government and 71 % said that they had received no donations.

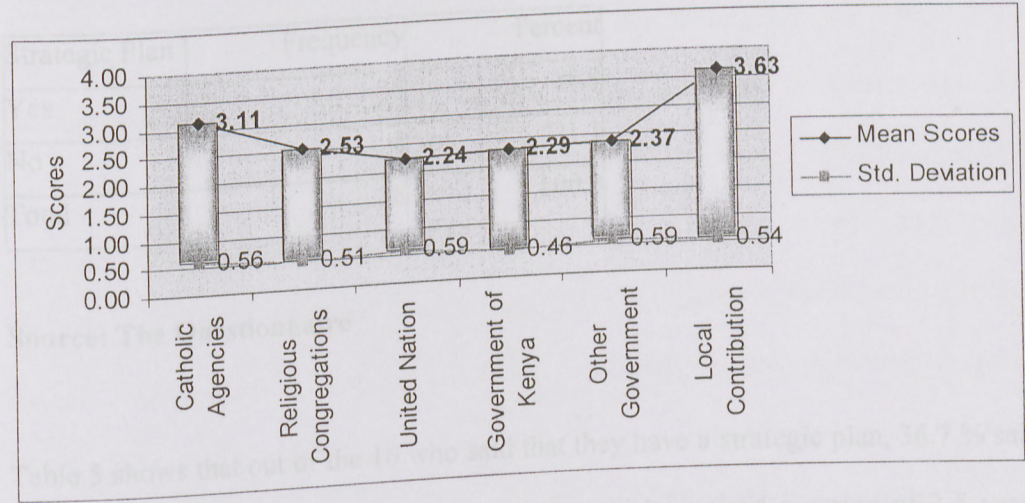
Figure 6: Change in the immediate external environmental factors



Source: The Questionnaire

The donations help to keep the Catholic Health Care Institutions afloat. In reality, donations are the absolute lifeline of most, if not all, Catholic Health Care Institutions. Yet these donations are insufficient, as they do not cover full costs, and they are not assured in the future.. Figure 7 indicates that the Catholic Health Care Institutions depend highly on local contribution and Catholic Agencies as sources of funding. The highest extend of funding within the Catholic Health Care Institution was noted to be the local contribution with a mean score of 3.63 , followed by catholic or Catholic related funding agencies with a mean score of 3.11, Religious congregations mean score of 2.53 , Other Governments mean score of 2.37 , Government of Kenya mean score of 2.29, and United Nations mean score of 2.24. Data was collected using a five point scale where 1 meant no funding at all, while 5 meant to a very large extend.

Figure 7: Extend to which funds are received from various sources



Source: The Questionnaire

4.3 RESPONSE BY THE CATHOLIC HEALTH CARE INSTITUTIONS

4.3.1 Strategic Plan

The Catholic Health Care Institutions realizes that the changing environment and the complexity and sophistication of business decision making requires strategic planning. This environment includes competitors, suppliers of increasingly scarce resources, government agencies monitoring adherence to an ever growing number of regulations and customers whose often inexplicable preference must be anticipated. Those that indicated they have a strategic plan said that it facilitates growth and fulfillment of their goals, guides them in fulfilling their mission statements and enables them to be effective in meeting their objectives. Table 4 shows that 78.9 % of the Catholic health care institutions have a strategic plan while 21.1 % do not have. Of the 30 that indicated that they have a strategic plan, 72% of them put it in place in the last 5 years, while the other 28% have had it for over 10 years.

Table 4: Catholic Health Care Institution who have strategic plan

Strategic Plan	Frequency	Percent
Yes	30	78.9
No	8	21.1
Total	38	100.0

Source: The Questionnaire

Table 5 shows that out of the 16 who said that they have a strategic plan, 36.7 % said that it covered a period of over 5 years, 30% said it covered a period of 2-5 years while 26.7 % said it covered a period of less than two years.

Table 5: Period covered by the Strategic Plan.

Period Covered by strategic plan	Frequency	Percentage
5 years	11	36.7
2- 5 years	9	30
2 years	8	26.7
Don't' Know	2	7.6
	30	100

Source Questionnaire.

Catholic Health Care Institutions reviews their strategic plan often to match changes in the external environment. The Institutions have identified the need for new strategic plan which determines the future strategic response. 44% of the Institutions said that they reviewed their strategic plan every year, while 56% reviewed it every other year.

4.3. 2 Empower people to achieve the vision

The staff empowerment in the Catholic Health Care Institutions is done through workshops. The staff are asked to determine for themselves the best way to implement strategies or attain objectives, rather than telling them in detail what to do. These gives the work meaning, serves as a source of self-esteem, and foster a sense of common purpose among the staff. The Catholic Heath Care Institutions acknowledges that it is important for the staff to understand the vision statements of the Institutions. Since it helps guide the actions and decisions of each member of the organization, which is especially important when individuals or groups are allowed considerable autonomy and discretion in their work decisions. 65 % of the respondents said that the strategic plan was communicated to all the staff members through holding of workshops.

4.3.3 Income Generating Activities

Income generating activities were started by Catholic health Care Institutions to generate funds towards of support health care services and also assist the community through the creation of employment. Medical training school have been started in some institutions to generate funds and also to enable them to provide quality and qualified health care professionals at an affordable price. Table 6 shows that 13.2 % of the respondents engage in other income generating activities, while 86.8 % do not. The income generating activities listed included medical trainings schools, farming and hospital canteen.

Table 6: Income Generating Activities

Income Generating Activities	Frequency	Percent
Yes	5	13.2
No	33	86.8
Total	38	100.0

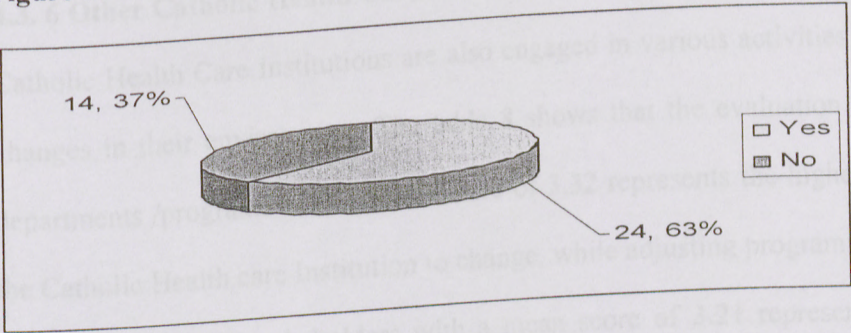
Source: The Questionnaire

4.3.4 Use of Computers

The management of Catholic Health Care Institutions recognizes that to survive and thrive they have to ensure that the technology, skills and systems used in the Institutions are adequate to run the Institutions and that the Institutions constantly reviews and adopts the same in order to remain competitive. Figure 8 shows that 63 % of the Catholic health care institutions use computers. Of the 24 that use computers the highest percentage 78 % uses computers for word processing, 20% for data management and only 2% use them to access the internet. 57% of those who have computers started using computers during the last 10 years.

Source: The Questionnaire

Figure 8: Use of computers by the Catholic Health Care Institutions



Source: The Questionnaire

4.3.5 Organizational Structure Revision

The Catholic Health Care Institutions have ensured that a proper management structure [organization, systems and people] is in place and made sure that the structure functions to maintain integrity, reputation and responsibility. Table 7 shows that 13.2 % of the Catholic health institutions studied revised their organization structure within the last two years, 23.7 % revised their organization structure the last five years, 15.8% revised their organization structure last ten years, while 28.9% have never revised their organization structure.

Table 7: Organization Structure Revision

Period	Organization Structure Revision	
	Frequency	Percentage
last two years	5	16
last five years	9	29
last ten years	6	19
never changed	11	35
	31	100

Source The Questionnaire

4.3.6 Other Catholic Health Care Institutions activities

Catholic Health Care Institutions are also engaged in various activities in response to changes in their environment. The table 8 shows that the evaluation of the various departments /programs with a mean score of 3.32 represents the highest response by the Catholic Health care Institution to change, while adjusting programs in the light of feed back from the stakeholders with a mean score of 3.21 represents a moderate response. Keeping up with what is going on with other innovative health care institutions with a means score 2.17 and Marketing 2.16 ranked the lowest. Data was

collected using a five point scale where 1 meant they did not engage in the activity at all, while 5 meant that they always engaged in the activity.

Table 8: Other Catholic Health care Institutions activities

	Mean Score	Standard Deviation
Department Performance	3.32	0.66
Innovation	2.17	0.74
Marketing	2.16	0.82
Stakeholders Views	3.21	0.86

Source The Questionnaire

4.3.7 Human Resource training and development

Past and emerging national, regional and global challenges have created a sense of urgency to undertake institutional reforms and adapt the ethos of good governance and best practices. The Catholic Health Care Institutions have acknowledged that this is only realizable through investment in development of skills and knowledge among staff which is necessary for maximization of one’s effectiveness. The institutions are committed to promoting staff empowerment as part of its strategic plan for improving efficiency in service delivery for institutional transformation. Professional excellence is something that goes hand in hand with the Catholic Health Care Institutions . For this reason, permanent training is required because today science and in particular medical science and technology are constantly advancing as a result of ongoing study, research and discoveries. For this medical schools attached to the hospitals for the formation of the entire health personnel are absolutely necessary.

4.3.8 Community empowerment

Catholic Health Care Institutions management recognizes that resources alone are not sufficient to enable them meet demands and ensure sustainable access. Effective community participation and involvement in financing, planning, implementation and managing programmes is therefore a critical requirement. Owing to their flexibility and grassroots programme focus, the Institutions have mobilized communities and imparted skills that empowers them to access their rights to services and to fulfill their role in managing and supporting these services. They have used the following strategies of developing and strengthening participatory methods and community structures, mobilization and sensitization about rights and responsibilities at community level.

4.3.9 Change of Management

In some areas the Catholic Health Care Institutions are influenced by two important factors. The first is the reduction in the numbers of those who belong to religious orders and the increase in the responsibility of the laity for a activity within the Institutions. The second is the dramatic change in the remuneration of health care professionals by government and by insurance companies. The result of these developments is that a number of hospitals, which were once the property of religious institution, have joined together to render their systems of management and expenditure more effective. Furthermore, merged or individual institutions have been entrusted to be administration of male and female members of the laity, and it is frequent that religious institutions have joined together to sustain one or more health care centers, or even transferred the responsibility to a different legal person and entity, thereby bringing about a complete secular administration and management of such institutions.

CHAPTER FIVE: SUMMARY, RECOMMENDATIONS AND CONCLUSIONS

5.1 SUMMARY

5.1.1 Change In The External Environment

The first objective sought to determine the changes in the external environment which have affected the Catholic Health Care Institutions. The factors were grouped into six broad categories as follows: - economic, technological, social, cultural, political and legal. The analysis revealed that all these factors affected the Catholic Health Care Institutions in varying degrees

The economic changes affected the Catholic Health Care Institutions to a very large extent and its effects were negative. The financing source of Catholic Health Care Institutions has completely changed. The institutions are now heavily dependent on patient fees. In the wake of the departure of most donors and the loss of Government grants, the level of utilization has been on the decline because of erosion of the purchasing power of the users. Major increase in poverty levels and the impact of HIV/AIDS has created additional difficulties in people's ability to pay for services. The main reason underlying this is over-reliance on out of pocket payment for services, which is susceptible to the state of the economy and household incomes. The cost of providing health care has also gone up significantly in past 10 years. The consequences of the decline in service utilization has been reduction of income which has further increased the cash flow problems for the faith-based health facilities.

The Church health facilities in Kenya are faced with a threatening human resource for health crisis. The major reasons for this crisis include: major decline of missionaries and volunteers, high turnover of professional health workers due to competitive

labour market and the dramatic change in the remuneration of health care professionals by Government and by Non Governmental Organizations. This situation has created pressure and financial instability which limits the Catholic Health Care Institutions ability to attract, retain, motivate and develop the critical human resource compliment necessary for optimal service delivery.

The technological changes also affected the Catholic Health Care Institutions to a very large extent, both positively and negatively. The positive effects were that there is ease of communication and enhanced operational efficiency. The study revealed that the means of communication within the health facilities had improved considerably within the last ten years. On the other hand however, the technological changes had a negative impact on the Catholic Health Care Institutions to the extent that they were expected to make investments in technology that they could not afford. The study revealed that the level of expectation by the patients had risen significantly in the last ten years and so had the level of patients' awareness. It would appear that these changes will continue into the future and there is need for the Catholic Health Care Institutions to keep up with the technological changes so that they can serve their patients more effectively. In view of the fact that technology is a factor that led to significant change in the Catholic Health Care Institutions, there is need for the Catholic Health Care Institutions to re-arrange their priorities and lay emphasis in this area, with a view to exploiting technological changes to their benefit.

Social-cultural changes also affected the Catholic health care institutions to the least extent, and its effects were largely negative. The scourge of HIV/AIDS and other

lifestyle diseases has led to an increased disease burden on the Catholic Health Care Institutions.

5.1.2 Response To The External Changes

The second objective was to determine the strategic responses of the Catholic Health Care Institutions to changes in the external environment. The results showed that the Catholic Health Care Institutions have implemented different strategies in responding to the environmental changes. Most of the Catholic Health Care Institutions indicated that they put in place a strategic plan within the last ten years. Most of the Institutions also said that the planning period covered is less than five years, which is an indication that they are able to respond quickly to the changes in the external environment.

Most institutions responded by using computers for their operations, particularly for word processing and data management. Most of the institutions however do not have internet access and therefore do not have electronic interaction with other Health Service Providers. One of the environmental factors that had the greatest impact on the institutions is technology, and one would expect that the response in this area should be rather strong and effective. The Catholic Health Care Institutions do not seem to have adopted appropriate strategies in response to the technological changes that affected them. They need to exploit the opportunities for effective health service provision that abound through the effective use of information technology such as use of websites. Information and communication technology should therefore be exploited optimally for the marketing of the health care institutions.

Some institutions utilized strategies of engaging in income generating activities such as medical training schools, farming and canteens among others so as to generate additional income. The additional income was able to support institutions projects that would otherwise not have been put in place through the dependence of patient's fee and donations. The health facilities that engaged in income generating activities are however a small minority and the majority seem to be depending on the patient fees and donations. Most of the Institutions indicated that donations had decreased, which were not sufficient to meet the current growing health care provision needs as a result of the harsh economic conditions, many of the Catholic Health Care Institutions projects had stalled. There is therefore need for Catholic Health Care Institutions to respond appropriately to the economic challenges that face them.

Health care institutions also responded by having Community Health Education and School Health Programmes, that enabled them to have a positive influence in the community and to market their health care services. Within the Institutions they also put in place programs and community activities such as the outreach services through mobile clinics. Most of the Catholic Health Care Institutions said that they sought the views of the congregation and regularly evaluated and adjusted the various departments so as to determine their performance. This is an indication that they responded to the needs of their members. Some changed management from the Missionary to the laity. Other responses that were adopted by the Catholic Health Care Institutions are the training and development of their staff particularly the Health Professionals so that they get continuous Medical Education through frequent workshops and seminars.

It is evident that the health care institutions used various strategic responses to varying degrees so as to ensure their continued effectiveness in their Endeavour to provide health care services.

5.2 LIMITATIONS OF THE STUDY

This study focused on strategic response by Catholic Health Care Institutions in Kenya, to external environmental changes. It therefore did not cover the non Catholic Health Care Institutions.

In view of the volatility of the external environment and in view of the fact that there was a limitation on the time allocated for the study, the Catholic Health Care Institutions are still responding to these changes and the changes that are taking place will not form part of this study.

The time allocated to the study may also have affected the response rate owing to the fact that it was not possible to wait for all the respondents to return their questionnaires

5.3 RECOMMENDATIONS

According to this study, the economic, technological, social, cultural, political and legal environment factors all led to change in the Catholic Health Care Institutions. It is evident that the Catholic Health Care Institutions are not immune to the environmental factors that affect business organizations. It is therefore imperative for the Catholic Health Care Institutions to regularly do an environmental analysis so as to determine the factors that affect it and to also establish the factors that have

changed and how they should respond to the said changes. Consequently the Catholic Health Care Institutions should demonstrate being proactive in their management.

One of the major environmental factors that led to change in the Catholic Health Care Institutions is the economic factor. While the Catholic Health Care Institutions have tremendous demands on their resources, it is apparent that the patients fee and donations that the institutions are depending on are not sufficient to meet their financial needs. The economic decline that has plagued other sectors of the economy is affecting the institutions adversely particularly through inability to complete crucial projects. In this regard, the Catholic Health Care Institutions need to invest in Income Generating Activities that will enable them to fund their projects. While some Catholic Health Care Institutions have taken this route, those that have done this are the minority. The Institutions also need to think of other long-term solutions to raise funds particularly in view of the fact that increasingly, the majority of them serve the poor and marginalized who are unable to meet their financial obligations. Consequently, sustainable financing strategies need to be formulated.

A new legal framework has to be designed to reduce the vulnerability of Catholic

Though Catholic Health Care Institutions serve the poor, this does not mean that a Catholic Health Care Institutions must provide free services. They must be Health Care Institutions where the Christian communion of goods is the norm. This means that the patient shares his own goods with the hospital and the hospital shares its own goods with the patient. Each party provides that which is in line with its capacities. A patient who is well off should cover all the costs for his treatment but a patient who is not in such a condition should provide what his reduced financial circumstances allow him to make available. Furthermore, the richest patients should be encouraged to give

a certain amount of their money to help those who cannot even pay for the necessary expenses of the hospital through service segmentation.

The other major environmental factor that led to change in the Catholic Health Care Institutions is the technological factor. The institutions are not doing enough to exploit the opportunities availed by technological innovation and neither are they effectively counteracting the threats posed by technology. Catholic Health Care Institutions needs to change their priorities and direct their resources to technology. Increased competition naturally forces organizations adopt improved ways of conducting business. Information Technology (IT) often has the potential to help organizations improve their systems. Information is a vital resource upon which viable competitive strategies can be developed. Information Technology entails the acquisition, processing, storage and dissemination of vocal, pictorial, textual and numeric information by a micro-electronic based combination of computing and telecommunication systems.

A new legal framework has to be designed to reduce the vulnerability of Catholic Health Care Institutions. Guided by civil law, Catholic Health Care Institutions have to integrated in one nation-wide system, for example “Company -not-for-profit“, and named “Catholic Health care institutions”. The legal protection will make it possible to professionalize management and administration, and to introduce unified policies for all Catholic Health Care Institutions. Moreover, should provide a base for negotiation with the Ministry of Health and Social Services.

According to the National Health Sector Strategic Plan 2005-2010 (NHSSP II) (GOK,2005) the Government acknowledges that the country cannot achieve the goal

reversing the declining health trends and revitalise service delivery without active involvement and partnership with other key stakeholders in the sector. Catholic Health Care Institutions consider themselves as partners with the Government. This would imply the need for equal partnership especially when called to integrate National Health priorities into their agencies development and action plans. Again processes to integrate institutions in current health development frameworks should be speeded up to allow timely uptake by Catholic Health Care Institutions of the benefits of collaborations. Having said so however, it should be emphasized that the process of integration should be approached cautiously so that none of the sector crowds out the other but instead each can operate in areas of comparative advantage.

study to be conducted, which will document Strategic Management Practices in the

The most suitable relationship between Public and Private Health Sector is a proposal to use a contractual approach. This is a way to enhance and formalise co-operation and integration between the various stakeholders, including (local) government and other providers, and Catholic Health Care Institutions in order to offer essential health services of sufficient quality at an affordable cost to a population in well-defined geographical areas, while prudently avoiding compromising the Church's identity in the process. Contractual relationship should be established with good negotiation skills otherwise poor negotiations can be punishing for both parties.

In conclusion, as has already been pointed out, the Catholic Health Care Institutions have not been studied, particularly with regard to strategy. This however is among the first steps in this direction. Though the findings of this study are more indicative than conclusive, I believe that this is an important step in studying strategy in the Catholic Health Care Institutions context.

5.4 SUGGESTIONS FOR FURTHER RESEARCH

This study documented the responses by Catholic Health Care Institutions in Kenya, to environmental changes. A study could be carried out to find out how the Faith Based Health Care Institutions in general i.e. both Catholic and Non-Catholic health Care Institutions in Kenya are responding to change in the external environment.

The area of Strategic Management in the Catholic Health Care Institutions is one that has not received much attention as far as research is concerned. In view of the increasing importance of the Catholic Health Care Institutions, there maybe need for a study to be conducted, which will document Strategic Management Practices in the Catholic Health Care Institutions in Kenya.

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APPENDIX I

LETTER OF REQUEST

Pamela Wamalwa
P.O. Box 13475 - 00800
Nairobi

KEC– Catholic Secretariat
Catholic Health Commission
P.O. Box 13475
Nairobi

Ref: Request for Survey Study in the Catholic Health care Institutions

I am an MBA student at the University of Nairobi doing study on responses of Catholic Health Care Institutions to environmental changes'. This study is a partial fulfillment of the award a master of business administration degree. I am requesting to be allowed to conduct the study in the Catholic Health Care Institutions.

The information provided will be kept confidential and it will only be used for the project's purposes. This is purely a research and no names will be printed. A copy of the final report will be given to you upon request.

Thank you for your assistance.

Yours faithfully,

Pamela Wamalwa

APPENDIX II

QUESTIONNAIRE

TO BE COMPLETED BY CATHOLIC HEALTH CARE INSTUTIONS

Section I

1. Institution/Project/Program Name.....District
- Diocese.....
2. What position do you hold in your health care institution
3. How long have you been in this health care institution?
-(years)
4. What is the size of your health care institution in terms of branches
- (please tick one)
- a) Hospital
- b) Health center
- c) Dispensary
5. How many staff does your health care institution have?.....
6. What are their terms of employment? (please tick one)
- a) All of them are on permanent
- b) Over 50% are on permanent
- c) Less than 50% are permanent
- d) None of them are permanent (on contract)
7. What percentage of your health staff falls in each of the following categories in
- terms of their academic background? (please indicate percentages as appropriate)
- a) Certificate
- b) Diploma
- c) University graduates
- d) Postgraduate
8. What percentage of your administrative/support staff falls in each of the following
- categories in terms of their academic background? (please indicate percentages as
- appropriate)
- a) Certificate
- b) Diploma
- c) University graduates

d) Post graduate ☐

9. What is the average monthly salary of your health staff? (please tick one)

	Less than 5,000/=	Between 5,000/= and 10,000/=	Between 10,000 and 20,000/=	Between 20,000 and 50,000/=	Between 50,000 and 100,000/=	Over 100,000/=
Doctors						
Clinical officers						
Registered Nurses						
Enrolled Nurses						
Lab staff						
Pharm Staff						
X- staff						

10. Does your health care institution have a formal Organization Structure? (please tick one)

Yes ☐ No ☐

11. If your answer to question 10 is "NO" proceed to section 2, if "YES" when was it put in place (state year).....

12. When is the last time your Organization Structure was revised (tick one)

- a) Within the last two years
- b) The last five years
- c) The last ten years
- d) Has never changed

Section 11

1. Please indicate the extent to which each of the following environmental factors has led to change in the recent years in your health care institution. Use a 5 point scale where 1= Not at all and 5 = to a very large extent.

1 2 3 4 5

- a) Economic
- b) Technology
- c) Political
- d) Social
- e) Cultural
- f) Legal
- g) Others (please specify)

2. How have you been affected by each of these factors

- a) Technology.....
.....
.....
- b) Economic.....
.....
.....
- c) Political.....
.....
.....
- d) Social.....
.....
.....
- e) Cultural.....
.....
.....
- f) Legal.....
.....
.....

3. What extent of change do you consider to have occurred in your health care institution in the last ten years, in each of the following? Use a five point scale where 1=Not at all and 5=to a very large extent.

- a) Availability of donations

1	2	3	4	5

- b) Government Grants
- c) Patients ability to pay
- d) Level of expectations by patients
- e) Suppliers prices
- f) Competition from other institutions
- g) Staff turnover
- h) Hospital Expenses

4. From the answers given in question 3 above, how have these factors changed?
(tick where appropriate)

- a) Availability of donations

- More donations
- Less donations
- No donations

- b) Government Grants

- More grants
- Less grants
- No grants

- c) Patients ability to pay

- Increased
- Decreased
- Remained the same

- d) Level of expectations by patients

- High
- Low
- Remained the same

- e) Suppliers prices

- Become higher
- Become lower
- Remained the same

- f) Competition from other institutions

- Increasing
- Decreasing

Remained the same

g) Staff Turn over

High

Low

Remained the same

h) Hospital Expenses

High

Low

Remained the same

5 What extent do you receive funding from the following in your health care institution in the last ten years, in each of the following? Use a five point scale where 1=Not at all and 5=to a very large extent.

1 2 3 4 5

Source of Funding

a) Catholic related agencies

b) Religious congregations

c) United Nations

d) Government of Kenya

e) Other Governments

(e.g. embassies or official development agencies)

f) Local Contribution

Section 111

1. Does your health care institution have a Vision and Mission statement?

Yes

No

2. If your answer is "NO", proceed to question 3. If your answer is "Yes":

a) Since when have you had a Vision and Mission statements? (state year).....

b) Why was it introduced.....

3. Do you have a Strategic Plan?

Yes

No

4. If your answer to question 3 is "No", proceed to question 9. If your answer is "Yes":

- a) Since when have you had a Strategic Plan (state year).....
- b) Why was it introduced.....
-
-
-

5. What period does your Strategic Plan cover? (please tick as appropriate)

- a) Less than two years ☐
- b) Between two and five years ☐
- c) Over five years ☐

6. How often is your Strategic Plan, reviewed?

- a) Every year ☐
- b) Every other year ☐
- c) Every two to three years ☐
- d) We never review it ☐

7. Is the Strategic Plan communicated to all staff members?

Yes ☐ No ☐

8. If the answer is "No", proceed to question 9. If "Yes", how is it communicated

(tick as appropriate)

- a) During meetings ☐
- b) Written communication ☐
- c) Other means (please specify).....

9. Do you have a Strategic Management Consultant? Yes ☐ No ☐

10. Do you hold Strategic Management workshops? Yes ☐ No ☐

11. Does your health institution have income generating activities? Yes ☐ No ☐

12. If your answer to question 11 is "NO", Please proceed to question 13 . if "Yes",

Please indicate

- a. Which ones
- b. Since when you have owned/ operated the activities
- c. Why you own /operate the activities?
-

13. Do you use computers in your health facility?

Yes ☐ since when (state year) ----- No. ☐

14. If your answer to question 13 is "No" proceed to question 15. If "Yes" for what purpose are they used? (tick as appropriate):

- a) Word processing ☐
- b) Data Management ☐
- c) Internet Facilities ☐

15. Indicate the extended to which each of the following is applicable to your health care institution. Use a point scale where 1 = not at all and 5 = always

- | | 1 | 2 | 3 | 4 | 5 |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a) Evaluation of various departments/
programs within the health institution
to determine their performance | ☐ | ☐ | ☐ | ☐ | ☐ |
| b) Keeping up with what is
going on with other innovative
health institutions | ☐ | ☐ | ☐ | ☐ | ☐ |
| c) Marketing Health care Institution
Services | ☐ | ☐ | ☐ | ☐ | ☐ |
| d) Formally seeking views of the
stakeholders | ☐ | ☐ | ☐ | ☐ | ☐ |
| e) Adjusting service in the light of
Feedback from stakeholders | ☐ | ☐ | ☐ | ☐ | ☐ |

16. From the answers given in question 15, if you undertake any of the activities, please indicate when you began undertaking them.

- a) Evaluation of various departments/ programs within the health institution to determine their performance. (Since when)
- b) Keeping up with what is going on with other innovative health institutions (Since when).
- c) Marketing Health care Institution activities. (Since when)
- d) Formally seeking views of the stakeholders. Since when
- e) Adjusting service in the light of Feedback from stakeholders. (Since when)

17. Indicate the extent of adjustment that have been adopted in response to change.

Use a five point scale, where 1 = no response while 5 = very high response.

	1	2	3	4	5
a) Long term planning					
b) Community Programms					
c) Additional services					
d) Vision/ Mission statement					
e) Training and development of health staff					
f) Training & development of support staff					
g) Selection of qualified staff					
h) Changing the organizational structure					
i) Retrenchment /rationalization of staff					
j) Computerization of operations					
k) Starting of income generating activities					

APPENDIX III
CATHOLIC HEALTH CARE INSTITUTIONS IN KENYA
TOTAL NO. OF: 417
HOSPITAL 44, HEALTH CENTRES 92, DISPENSARIES 281
HEALTH FACILITIES

Dispensaries 281

HEALTH UNITS PER DIOCESE	Dispensary
BUNGOMA DIOCESE	
1 Dispensary	
Busia District	
Dispensaries	Sirimba
Teso District	
ELDORET DIOCESE	
15 Dispensaries	
Keiyo district	
Dispensaries	Emsea (St. Stephen's)
	Singore (Assumption Sisters)
Marakwet district	
Dispensary	Immaculate Heart Of Mary (Nerkwo)
	Embobut
Nandi District	
Dispensaries	Tach Asis
	Holy Family (Ol lessos)
	St. Peter
	St. Boniface
	Kapsoya (Health Project)
Uasin Gishu District	
Dispensaries	Burnt Forest
	Our Lady of Lourdes – Turbo
	Mary Immaculate
	St. Kevina
	Moi's Bridge
	St. Ann
	Ancila
EMBU DIOCESE	
9 DISPENSARIES	
Embu District	
Dispensaries	Kevote
	Nguvu
	St. Gertrude
Mbeere District	
Dispensaries	Siakago Don Bosco
	Makima

HEALTH UNITS PER DIOCESE	Dispensary
	Mashamba
	Kitoloni
	Iriamurai
	Karaba/ Wangu
GARRISA DIOCESE	
17 Dispensaries	
Garissa District	
Dispensaries	Garissa MCH Clinic
Lamu District	
Dispensaries	Lake Kenyatta
	Moa
Mandera Distinct	
Dispensaries	Mandera clinic
	TBA Follow Up Programme
	Elwak Mobile Clinic
Tana River District	
Dispensaries	Emmaus
	Huruma
	Kiarukungu
	Mariamamu
	Maryknoll
	Rehema
	St. Francis
	Umoja
	Wema
Wajir district	
Dispensaries	Habaswein Clinic
	Wajir Girls Clinic
HOMA BAY DIOCESE	
14 Dispensaries	
Kuria district	
Dispensaries	Kebaroti
	St. Kizito
Migori District	
Dispensaries	Matoso
	St. Camillus
	Oyugis
	Nyasare
	Macalder
	Osongo
Rachuonyo District	
Dispensaries	Oriang

HEALTH UNITS PER DIOCESE	Dispensary
Suba District	
Dispensaries	Kadem
	Mbita
	Nyandiwa
	Roo
	St. Mary
ISIOLO DIOCESE	
4 DISPENSARIES	
Isiolo District	
Dispensaries	Isiolo
	Merti
	Ngaremara
	Oldonyiro
KAKAMEGA DIOCESE	
6 Dispensaries	
Kakamega District	
Dispensary	Lutaso
Vihiga District	
Dispensary	Chamakanga
Mumias Butere District	
Dispensary	St. Paul
Lugari District	
Dispensary	Chimoi
	Mautuma
	Koromaiti
KERICHO DIOCESE	
2 Dispensaries	
Kericho district	
Dispensaries	Guadalupe mobile clinic
	Mercy mobile clinic
KISII DIOCESE	
2 Dispensaries	
Kisii Central District	
Dispensaries	Nyabururu
	St, Anthony
KISUMU ARCHDIOCESE	
5 Dispensaries	
Bondo District	
Dispensaries	Nyangoma
Kisumu District	
Dispensary	Barkorwa
	Pandipieri
Nyando District	
Dispensaries	Awasi
	St. Clare's Bolo
KITALE DIOCESE	
8 Dispensaries	

HEALTH UNITS PER DIOCESE	Dispensary
Trans Nzoia District	
Dispensareis	Kitale Mobile/ Dispensary
	Kolongolo
	Mary Immaculate
West Pokot District	
Dispensary	Amakuriat
	Kabichibichi
	Kacheliba
	Sigor
	St. Stephen's Orwa
KITUI DIOCESE	
10 Dispensary	
Kitui District	
Dispensaries	Kitui
	Mutito PHC Project
	Mutomo PHC Project
	Mutune
	S.H.T Dispensary
	Miambani
	Kanyangi
	Kaviusini
Mwingi District	
Dispensary	Muthale PHC Project
	Nuu
LODWAR DIOCESE	
11 Dispensaries	
Dispensaries	Juluk
	Kataboi
	Kalemong
	Kalobeyei
	Lokangae
	Lokori PHC Project
	Lorengippi
	Lowarengak
	Nadapal
	Oropol
	St. Patrick
MACHAKOS DIOCESE	
16 Dispensaries	
Machakos District	
Dispensaries	Katangi
	Machakos PHC Project
	Makindu
	Matiliku
	Mavoloni (St. Kizito)

HEALTH UNITS PER DIOCESE	Dispensary
	Mitaboni
	Muthetheni
	St. Theresa's Thatha
	Kiwanza
	St. Joseph Mbiuni
	St. Michael
	St. Mary
Makueni District	
Dispensaries	Ikalaasa
	Kibwezi /Kambu
	Makueni
	Mbitini
MALINDI DIOCESE	
2 Dispensaries	
Dispensaries	Hongwe
	Tarasaa
MARALAL DIOCESE	
7 Dispensaries	
Samburu District	
Dispensaries	Baragoi
	Barsaloi
	Lodokejek
	Maralal (C.C.M)
	Sukuta Marmar
	Morigio
	Sererit
MARSABIT DIOCESE	
6 Dispensaries	
Marsabit District	
Dispensaries	Dirib Gombo
	Karare
	Kargi
	Maikona
	Korr (Don Bosco)
Moyale District	
Dispensary	Moyale
MERU DIOCESE	
27 Dispensaries	
Meru Central District	
Dispensaries	Igandene
	Gaturi
	Gitoro
	Kibirichia
	Kithatu
	Mahaka
	Mujwa
	Muoroga
	Nkabune
	Nkunjumu

HEALTH UNITS PER DIOCESE	Dispensary
	Ruiri
	St. Theresa - Timau
	Kaare
Marmanti District	
Dispensaries	Gatunga
	Matiri Girls Dispensaries
	Mitunguu
Meru North (Nyambene) District	
Dispensaries	Angili
	Kangetha
	Mkinduri
	Ndhambero
	Maua (st. Joseph)
	Amugenti
Meru South (Tharaka Nithi) District	
Dispensaries	Cheera
	Iruma
	Muthambi
	Kaariakomo
	Magundu
MOMBASA ARCHDIOCESE	
Dispensaries 14	
Kilifi District	
Dispensaries	Chonyi (St. Theresa)
	Giriama
	Kikambala
Kwale District	
Dispensary	Mivumoni
	Mrima
	Ukunda
	Mtumwa
Mombasa District	
Dispensary	St. Joseph
	Holy Ghost
	Likoni
	Mkindani
	Stella Maris
Taita Taveta District	
Dispensaries	Bura (St. Joseph)
	Eldoro
MURANGA DIOCESE	
13 Dispensaries	
Kirinyaga District	
Dispensaries	Kagio
	Kerugoya
	Kutus

HEALTH UNITS PER DIOCESE	Dispensary
	Sagana
	Difadhali
Maragua District	
Dispensaries	Saba Saba
	Ithanga
Muranga District	
Dispensaries	Don Bosco
	Gaturi
	Kiangunyi
	Mariira
	Mugoiri
	Ruchu
NAIROBI ARCHDIOCESE	
47 Dispensaries	
Kiambu District	
Dispensaries	Eastern Deanery AIDS Programme
	Kamunyaka Dispensary
	Gatitu
	Gicharani
	Holy Cross, Thigio
	Lioki
	Ting'ang'a (Comboni)
	Bethsaida Riara
	Makwa Kolping
	Most Precious Blood
	St. Stephen's (Kairi)
	Sacred Heart (Karuri)
Nairobi District	
Dispensaries	Bahati
	Afya Maendeleo Prog.
	Baraka Medical Centre
	CUEA Dispensary
	C.B.H.C. Programme St. Joseph Catholic Church Kahawa Sukari
	Bro. Andre
	St. Odilias
	Kibarage –Good News
	St. Joseph the Worker
	Kibera

HEALTH UNITS PER DIOCESE	Dispensary
	Kivuli Disp
	Little Sisters Of St. Francis
	Madaraka Mercy Sisters
	Maria Domenica
	Rescue Dada
	Riruta
	St. Angela Merici
	St. Brigid's (Mother & Child)
	St. Joseph Mukasa
	St. Theresa
	Uzima Dispensary
	Korogocho CBHWs
	Kibera MMM Riara Health Project
	Mukuru CBHC Project (Kwa Njenga)
	Kariobangi CBHC /AIDS centre
	St. Joseph
Thika District	
Dispensaries	Kamirithu
	St. Joseph's
	Kalimoni
	Kianguru
	Karinga
	Kiriko
	Little Sisters of the Poor
	Missionary Of Charity
	Riruta Disp. A.S.N.
NAKURU DIOCESE	
Baringo District	
Dispensaries	Barpello
	Kipsaraman CBHC
	Kositei CBHC
	Marigat CBHC
	Mogotio CBHC
	Salawa CBHC
Nakuru District	
Dispensaries	Gilgil Mobile Clinic
	Hekima
	Huruma

HEALTH UNITS PER DIOCESE	Dispensary
	Longonot mobile Clinic
	St. Francis Lower Subukia
	St. Martin de Porres
	Mother Kevin
	St. Clare's
	St. Anthony
NGONG DIOCESE	
8 DISPENSARIES	
Kajiado District	
Dispensary	Olkeri
	Loitokitok CBHC Programme
	Embul-bul
Narok District	
Dispensaries	Ilkerin
	Lemek –St. Anthony's
	Mulot
	Oloropil
	Enosubukia
Nyahururu DIOCESE	
9 Dispensaries	
Laikipia District	
Dispensaries	Ngarua
	Sipili
	Rumuruti

HEALTH UNITS PER DIOCESE	Dispensary
Nyandarua District	
Dispensaries	Ndaragwa
	Njabini
	Nyahururu
	Passenga –Ol Kalou
	St. Mathews
	Ol joro Orok
NYERI ARCHDIOCESE	
14 Dispensaries	
Nyeri District	
Dispensaries	Gatarakwa
	Giakaipei
	Gikumbo
	Gitunduti
	Kahiraini
	Karatina, C.C.M.
	Karima
	Little Flower
	Naromoru
	Othaya
	Nanyuki
	Witima
Laikipia District	
Dispensaries	Dol dol
	Mary Immaculte

Health Centres and Cottage Hospitals 92

HEALTH UNITS PER DIOCESE	Health Centre
BUNGOMA DIOCESE	
5 Health Centres	
Bungoma District	
Health centres	Kibabii
	St. Damiano Medical Centre
Busia District	
Health Centres	Butula
Teso District	
Health Centres	Amukura (st. Joseph)
	Chelelemuk (st. Mary)
ELDORET DIOCESE	
10 Health Centres	
Keiyo district	

HEALTH UNITS PER DIOCESE	Health Centre
Health Centres	Kapkoi
Marakwet district	
Health Centres	Arror
	Chesoi
	Chesongoch
	Endo
	St. Michael
Nandi District	
Health Centres	Kaiboi
	St. Joseph
	Kobujoi
	Chepterit
EMBU DIOCESE	
2 HEALTH CENTRES	
Embu District	
Health Centres	Nthagaiya
	Mother

HEALTH UNITS PER DIOCESE	Health Centre
	Mazzarello
HOMA BAY DIOCESE	
12 Health Centres	
Homa Bay District	
Health Centres	Asumbi
	Migori
	St. Paul's
Kuria district	
Health Centres	Isibania
Migori District	
Health Centres	Rakwaro
	St. Monica, Rapogi
	Ulanda
	Verna
Rachuonyo District	
Health Centres	Mawego
	Raruowa
Suba District	
Health Centres	Tonga
	St. Luke's
KAKAMEGA DIOCESE	
3 Health Centres	
Kakamega District	
Health Centres	Eregi
	Musoli (St. Pius)
Vihiga District	
Health Centres	Buyangu
KERICHO DIOCESE	
1 Health Centres	
Bomet District	
Kericho district	
Health Centre	St. Francis
KISII DIOCESE	
8 Health Centres	
Kisii Central District	
Health Centres	Mosocho
	Ritumbe
Kisii North (Nyamira) district	
Health Centres	Gekano
	Kiberigo
	Rangenyo
	St. Joseph's
Kisii South (Gucha) District	
Health Centres	Nyamagwa
	Sengera
KISUMU ARCHDIOCESE	

HEALTH UNITS PER DIOCESE	Health Centre
8 Health Centres	
Bondo District	
Health Centre	Lwak
Nyando District	
Health Centres	Koru
Siaya District	
Health Centres	Aluor
	Mbaga
	Rangala
	Ukwala
	Sega
	St. Elizabeth
	St. Stephen's Orwa
KITUI DIOCESE	
1 Health Centres	
Mwingi District	
Health Centre	Kimangao
LODWAR DIOCESE	
2 Health Centres	
Health Centres	Lorugumu
	Nakwamoru
MACHAKOS DIOCESE	
6 Health Centres	
Machakos District	
Health Centres	Kabaa St. Joseph
	Kathonzweni
	Misyani
	Ndithini
	Sabuu
	Matuu
	St. Theresa's Thatha
	Kiwanza
	St. Joseph Mbiuni
	St. Mary
MALINDI DIOCESE	
1 Health Centre	
Health Centre	Bahari (Marria Nuzzo)
MARALAL DIOCESE	
2 Health Centres	
Samburu District	
Health Centres	South Horr
	Archers Post
MARSABIT DIOCESE	
2 Health Centres	
Marsabit District	
Health Centres	Loyangalani

HEALTH UNITS PER DIOCESE	Health Centre
	North Horr
MERU DIOCESE	
4 Health Centres	
Meru Central District	
Health Centres	St. Theresa Kirua
	St. Theresa –Riji
Marmanti District	
Health Centres	Mukothima Maternity
Meru North (Nyambene) District	
Health Centres	Tuuru Marternity
Meru South (Tharaka Nithi) District	
MOMBASA ARCHDIOCESE	
3 Health Centres	
Kwale District	
Health Centres	Kichaka Simba
Mombasa District	
Health Centres	Mary Immaculate
	Mother Amadea
MURANGA DIOCESE	
3 Health Centres	
Kirinyaga District	
Health Centres	Baricho
	Kianyaga
Maragua District	
Health Centres	Ichagaki
NAIROBI ARCHDIOCESE	
9 Health Centres	
Kiambu District	
Health Centres	Kagwe

HEALTH UNITS PER DIOCESE	Health Centre
	Kereita
	Christian Brothers
Nairobi District	
Health Centres	Cottolego
	Maria Immaculata
	Nyina Wa Mumbi
Thika District	
Health Centres	Mangu
	Ngarariga
	Ndundu
NGONG DIOCESE	
7 HEALTH CENTRES	
Kajiado District	
Health Centres	Fatima – Lenkitem
	Fatima –Ongata Rongai
	Kiserian (St. Mary)
	Rombo
Narok District	
Health Centre	Entasekera
	Olokirikirai
Transmara District	
Health Centres	Abosi –St. Anthony's
NYERI ARCHDIOCESE	
3 Health Centres	
Nyeri District	
Health Centres	Gikondi
	Kaheti
	Kangaita

HOSPITALS 44

HEALTH UNITS PER DIOCESE	NAME
BUNGOMA DIOCESE	
2 Hospitals	
Bungoma District	
Hospitals	Misikhu
Busia District	
Hospitals	Holy Family
	Nangina
Eldoret Diocese	
1 Hospital	
Uasin Gishu District	
Hospital	St. Brigitta's
EMBU DIOCESE	
Hospital 1	

HEALTH UNITS PER DIOCESE	NAME
Embu District	Consolata Kyeni
HOMA BAY DIOCESE	
2 Hospital	
Migori District	
Hospitals	St. Joseph's Ombo
	St. Camillus
KAKAMEGA DIOCESE	
2 HOSPITALS	
Kakamega District	St. Elizabeth
Butere Mumias District	St. Mary's
KERICHO DIOCESE	

HEALTH UNITS PER DIOCESE	NAME
2 Hospital	
Kericho district	
Hospital	Kipchimchim
Buret District	Kaplong
KISII DIOCESE	
KISUMU ARCHDIOCESE	
1 Hospitals	
Kisumu District	
Hospital	St. Monica
Nyando District	St. Joseph Nyabondo
KITALE DIOCESE	
1 Hospitals	
Trans Nzoia District	
Hospitals	Kiminini
KISII DIOCESE	
1 Hospital	
Gucha District	Tabaka Mission
West Pokot	Ortum
KITUI DIOCESE	
2 Hospitals	
Kitui District	
Hospitals	Mutomo
Mwingi District	
Hospital	Muthale
LODWAR DIOCESE	
1 Hospital	
Hospital	Kakuma Mission
MACHAKOS DIOCESE	
2 Hospitals	
Machakos District	
Hospitals	Kilungu Hospital Bishop Kioko Hospital
MARSABIT DIOCESE	
2 Hospital	
Marsabit District	
Hospitals	Laisamis
Moyale District	
Hospitals	Sololo Mission
MARALAL DIOCESE	
HOSPITAL 1	
District Samburu	Wamba
MERU DIOCESE	
7Hospitals	
Meru Central District	
Hospitals	Chaaria Hospital St. Anne Igoji Cottolengo St. Orsola Matiri

HEALTH UNITS PER DIOCESE	NAME
	Consolata Nkubu
Meru South District	Chuka
Meru North (Nyambene) District	
Hospitals	Tigania
MURANGA DIOCESE	
3 Hospitals	
Kirinyaga District	
Hospitals	Mwea Mission
Muranga District	
Hospitals	Gaichanjiru Kiriaini
NAIROBI ARCHDIOCESE	
7 Hospitals	
Nairobi District	
Hospital	Jamaa St. Mary Mission The Mater
Kiambu District	Nazareth Hospital
Thika District	
Hospitals	St. Mulumba Mary Help of The Sick Kilimabongo
NYAHURURU DIOCESE	
1 Hospital	
Nyandarua Distrcit	North Kinangop
NAKURU DIOCESE	
1 Hospital	
Koibatek District	
Hospitals	Mercy –Eldama Ravine
NYERI ARCHDIOCESE	
2 Hospitals	
Nyeri District	
Hospitals	Consolata Mathari Mweiga
NGONG DIOCESE	
1Hospital	
Trans Mara Dsitric	St. Joseph's Kilgoris