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Full Length Research Paper

Administrative impact of restructured provincial administration on selected aspects of maintenance of law and order in Kenya in 2010 to 2014: A case study of Bomet county

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The aim of this study is to investigate the administrative impact of Restructured Provincial Administration (RPA) as independent variable on maintenance of law and order as dependent variable in Bomet County, Kenya from 2010 to 2014. Based on the theory of new-institutionalism, it focused on four selected aspects of maintenance of law and order measured from 2006 to 2010 and from 2010 to 2014, namely analysis of the nature and causes of crimes committed, the frequency of joint security operations on illicit brews and reasons for not conducting them, the duration of response to scenes of crimes and why and the frequency of security committees meetings and what informed them. It employed a descriptive survey design that targeted 223 respondents with a sample size of 143 from four security agencies purposively chosen namely the National Administration, the Kenya Police Service, the Administration Police Service and the National Intelligence Service. Data was collected through a questionnaire and analysis of written records. The study argues that the RPA had significant negative administrative consequences on the selected aspects in 2010 to 2014 compared to the period before. It contributed to increased personal, property and statutory crimes, the frequency of joint security operations on illicit brews dropped from weekly basis to monthly and need basis, the duration of response to scenes of crimes increased from minutes to hours, and that the frequency of security committees meetings increased to weekly and need basis from monthly and need basis. This negative administrative impact on the selected aspects is attributed to the changed command structure in the RPA, independent security institutions, inadequate resources and entry of County government of Bomet in 2013. The government should consider restructuring the four security agencies to streamline the command structure to enhance enforcement and coordination, establish a clear law and policy on liquor that is universal to all Counties to streamline joint operations on illicit brews, avail adequate resources to enhance response to scenes of crimes and fully operationalize Article 239 (5) of the Constitution of Kenya, 2010 to empower security committees.

Key words: Administrative impact, restructured provincial administration (RPA), maintenance of law and order, selected aspects, security agencies, periods 2006 to 2010 and 2010 to 2014, Bomet County.

INTRODUCTION

Public administration in common practice refers to the organization and operations of the executive branch of

government (Sahni and Vayunandan, 2012). It constitutes the public service that implements government policies. According to Ranney (1993), it is the obligation of any government to ensure security of its people and property and enhance socio-economic and political development. To achieve this objective, all nations whatever their system of government have a bureaucracy responsible for the administration of the internal affairs of the state and whose role and status are not political (ECA, 2010).

Kenya at independence in 1963 inherited a system of administration called Provincial Administration (PA) from the British colonial government. It was a 'top down' system of administration with its headquarters at the Office of the President and cascaded to all parts of the country. It comprised of the Provincial Commissioner heading a province, the District Commissioner heading a district, the District Officer heading a division, the Chief and the Assistant Chief heading a location and a sub location respectively, up to the village elders (Bagaka, 2011; Republic of Kenya, 2014a) A key function of the Provincial Administration before and after independence was maintenance of law and order.

The structure of the PA also comprised of other security agents namely the Administration Police (AP), the Kenya Police (KP) and the Special Branch. These were the enforcement wing of the Provincial Administration. The Kenya Police structure followed that of the PA from top to bottom, while the Administration Police worked under the direct command of the provincial administrators. This was provided for in the Administration Police Act Chapter 85 Laws of Kenya and the Chiefs Authority Act Chapter 128, both of which are repealed. According to Mbuba and Mugambi (2011), these agencies worked as one intact team in implementing security matters under the District Security Intelligence Committee (DSIC) chaired by the District Commissioner. The armed wing executed the decisions of the DSIC without citing operational independence.

As personal representatives of the President at the local levels, the provincial administrators exercised upward accountability as they followed orders of their seniors without question even when those orders were detrimental to the public interest. The executive exploited this upward accountability mechanism for political reasons especially during the one party, Kenya African National Union (KANU) rule in Kenya. Consequently, the institution was regarded as repressive and unresponsive to peoples' needs and advancing bad governance (Bagaka, 2011).

However, institutional reforms have been implemented over the years to transform the PA to an effective agency

of government that adheres to the rule of law and good governance (Republic of Kenya, 2014b). These reforms include the 1997 Inter- Parties Parliamentary Group (IPPG) resolutions, the Governance, Justice, Law and Order Sector (GJLOS) reforms of 2002, and the new Constitution of Kenya, 2010 that required restructuring of the Provincial Administration to align it with the County governments.

Restructuring of the PA is a new phenomenon in Kenya, and has been implemented in 2010 to 2014, pursuant to Section 17 of the Sixth Schedule of the Constitution of Kenya, 2010. However, the meaning and scope of restructuring the PA elicited a lot of public debate because of different interpretations given to it by various interested parties.

Some of these parties include the new County governments, the National Police Service with the Kenya Police Service and the Administration Police Service, the defunct Provincial Administration and the general public. Some interpreted it to mean 'scrapping', 'abolition' or 'disbanding' Provincial Administration. Others held the view that restructuring entails re-organizing the Provincial Administration to place it under the County government so that provincial administrators report directly to the Governors to avoid a situation of parallel system of administration at the County level.

Others interpreted that restructuring involved re-organization of the PA in terms of its functions, administrative procedures, institutional, policy and legislative frameworks. This group supports the retention of the PA but with reforms of the institution. The fact that the new constitution does not define the parameters of restructuring the PA explains why there are many interpretations (Republic of Kenya, 2015b, c).

Bomet County pursued the interpretation that restructuring entails re-organizing the Provincial Administration to place it under the County government so that provincial administrators report directly to the Governor to avoid a situation of parallel system of administration at the County level.

This interpretation was more pronounced in the County than in any other part of the country because of the fact that Bomet County was the first one to host the Chairman of the Council of Governors for two years consecutively in 2013 to 2015. It was also favoured by the new police services, which argued that the new constitution has set them independent of the Provincial Administration.

The management and coordination of security and other national government functions were increasingly constrained by the politics of devolution in Bomet County which, apparently was indifferent to the PA in its restructured form and the security agencies also seemed

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entrenched in the confusion.

According to reports from the Bomet County Commissioner's office (2013), the Chiefs were reporting that the APs had refused to take orders from them, citing their operational independence from the new constitutional order. The working relationship among the Administration Police Service (APS), the Kenya Police Service (KPS), the Provincial Administration and the National Intelligence Service (NIS) continued to expose rifts with dire consequences on the management of maintenance of law and order. Such was the situation that on 20th October, 2013, the Bomet County Commissioner and the Governor held Mashujaa Day celebrations in separate venues (Makiche, 2013). Has anyone, therefore, thought of the intended effects of restructuring the PA on the management of security agents as a core function of the national government in the Counties?

The enforcement of law and order in the locations weakened with the Chiefs reporting unusual working relationship with the APs and crime incidences being reported more often than before. This is corroborated by the Bomet Criminal Investigations Department reports and the Bomet Law Courts records (2010 to 2014). Analysis of the crime trends, especially those related to illicit brews and domestic issues in the County were on increase during restructuring of the PA in 2010 to 2014.

While this was happening in Bomet County, it seemed the problem was also experienced in other regions. This is evident in the government's action to summon a countywide security meeting at the Kenya School of Government (KSOG, 2013), Nairobi, on 20th, November, 2013, apparently to address the challenges. The meeting was attended by all the County Commissioners, all the APS and KPS commanders, the Inspector-General of police and the NIS Director-General. It was presided over by the Cabinet Secretary, Ministry of Interior and Coordination of National Government, Joseph Ole Lenku and his Principal Secretary.

After the meeting, it was reported in the media that 'Lenku Tells APs to obey Chiefs' Order' (Ombati and Awour, 2014), and that 'Lenku order baffling', (Editorial Team, 2013), to mention, but a few. However, all these scenarios indicate a dawn of confusion in the management of maintenance of law and order, especially at the lower levels of administration. What then, could have happened after restructuring the PA? Have the RPA achieved the intended effects of restructuring in regard to the maintenance of law and order in Bomet County in 2010 to 2014?

According to March and Olsen (2008), contemporary theories seem to have limitations in achieving the intended effects of restructuring public institutions. They argue that most of these theories assume that the mix of rules, routines, norms and identities that describe institutions change over time in response to historical experience. But in fact, most modern democracies seem

to have limited capacity for institutional design and reform and in particular for achieving intended effects of re-organization. However, Lufunyo (2013) argue that in any society, public sector reforms on service delivery keep on changing based on the circumstances at hand and the goal to be achieved with those reforms. Have the RPA then achieved the goal of improved management of maintenance of law and order in Bomet County in 2010 to 2014?

What have been the administrative impacts of the changed command structure (as routines and norms) for instance, among the four security agencies (the PA, the KPS, the APS and the NIS) on selected aspects of maintenance of law and order? Have the new design of the RPA and the independent police institutions had administrative impact on the maintenance of law and order in Bomet County, Kenya in 2010 to 2014?

These questions are perplexing because, despite restructuring the Provincial Administration in 2010 to 2014 to improve maintenance of law and order, rifts and confusion among the security agencies continued to be witnessed in Bomet County with dire consequences on increase in crimes. Security reports indicated an upsurge of crimes and imminent gaps in the management of maintenance of law and order by the Provincial Administration and conflicts with the County government in as far as the management of national security services was concerned (Bomet County Commissioner's office, 2013).

In other parts of the country, there was increased intensity of lawlessness and insecurity. For instance, according to the Kenya National Commission on Human Rights report (KNCHR, 2014), there was loss of lives and property in the Tana River massacre in 2012; the Westgate Mall terror attack in 2013; the Mpeketoni terror attack in 2014; Baragoi security officers deaths in 2012; Mandera terror attack in 2014 and a case where over one hundred people died due to consumption of illicit brews in 2014 across several Counties, among many other incidences.

As Hughes (2012) argues, reform is undertaken with the aim of improvement, but there has been so much reform, so much change that management capacity has not improved very much. Any process of change involves winners and losers, and among the losers might have been some valued parts of the traditional model of administration. Could restructuring the pillars of national security have left behind some valued parts of the former Provincial Administration in regard to maintenance of law and order?

It is against this background that this study conceptualized restructuring of the PA as the problem in regard to the delivery of maintenance of law and order in Bomet County in 2010 to 2014. The main objective of the study was to investigate the administrative impact of the RPA on four selected aspects of maintenance of law and order in the County in 2010 to 2014. These were

examining the nature and causes of crimes committed; establishing the frequency of joint security operations on illicit brews and reasons for not conducting them; establishing the duration of response to scenes of crimes by the security agencies and why and establishing the frequency of security committees meetings and what informed them. These formed the specific objectives of the study and were measured over a period of eight years, four years before restructuring the PA in 2006 to 2010 and four years in 2010 to 2014. It was therefore, imperative for the study to achieve these objectives by seeking answers to the questions:

1. What have been the administrative impacts of the RPA on the selected aspects of maintenance of law and order in Bomet County, in 2010 to 2014?
2. What was the nature and causes of crimes committed in Bomet County before the RPA in 2006 to 2010 and during 2010-2014?
3. What was the frequency of joint security operations on illicit brews and reasons for not conducting them in Bomet County before the RPA in 2006 to 2010 and during 2010 to 2014?
4. What was the duration of response to scenes of crimes and why by the security agencies in Bomet County before the RPA in 2006 to 2010 and during 2010 to 2014?
5. What was the frequency of security committees meetings and what informed them in Bomet County before the RPA in 2006 to 2010 and during 2010 to 2014?

Leading writers on the Provincial Administration in Kenya such as Bagaka (2011), Otswana (2012), Mbuba and Mugambi (2011), Mkutu et al. (2014), Sihanya (2011) and Republic of Kenya (2014, 2015), all have not focused on the administrative impact of the RPA on selected aspects of maintenance of law and order in Bomet County in 2010 to 2014. Here is thus the purpose of this research paper. This paper investigated the administrative impact of the RPA on selected aspects of maintenance of law and order in Bomet County in 2010 to 2014. It argues that the RPA had negative administrative impact on the fight against crimes, the frequency of joint security operations on illicit brews, the duration of response to scenes of crimes, and the frequency of security committee meetings in 2010 to 2014.

LITERATURE REVIEW

This part will examine the theoretical basis on which the organization and operations of the RPA was conceptualized and applied in maintenance of law and order in the society. The study was based on the theory of new-institutionalism as advanced by Powell (2007), Thoenig (2011), DiMaggio (1991) and Powell (2007).

The section will explore the general concept of new-institutionalism approach to organizations, then give a critical review of the basic tenets of the theory that

underscore the organization and operations of the RPA in the delivery of the selected aspects of maintenance of law and order. Finally, a discussion will be given on how the theory aides the conceptual framework and assists in the research design, analysis of the results and conclusions.

New- institutionalism belongs to the new approaches to institutional theory that have been criticisms to Max Weber's theory of bureaucracy for the last four decades. Since 1970s, Thoenig (2011) argues that public administration institutions as research domains have increasingly become less normative and more empirical. This perspective observes that political and administrative institutions are embedded in societal environments and function like specific social systems. Therefore, interactions between societal change and administrative reform are important aspects in institutional analysis. Based on this view, Kenya's transformation of the Provincial Administration (PA) to its restructured form today was a result of societal change that demanded responsive and accountable governance.

The main question advanced by this approach is whether public organizations' reforms match societal needs and whether they advance democratic participation (Thoenig, 2011). Have the process of restructuring the PA been participative and democratic enough to match the Kenya's needs as far as the organization and operations of the institution is concerned? The answer is yes because the process was sanctioned by Section 17 of the Sixth Schedule of the Constitution of Kenya 2010, which was passed through a referendum, and the subsequent laws passed by parliament. But the knowledge gap in this institutional analysis of restructuring the PA is the administrative impact of the RPA on the services delivered. What have been the administrative impacts of the RPA on selected aspects of maintenance of law and order in Bomet County in 2010 to 2014?

According to Powell (2007), organizational practices and structures are often either reflections of or responses to rules, beliefs and conventions built into the wider environment. These variables can be analyzed in respect to the RPA since restructuring involved reorganization in terms of its functions, administrative procedures, institutional, policy and legislative frameworks (Republic of Kenya, 2015a). Some of the restructured practices and structures were removal of direct command of the Administration Police (AP) from the PA and placed under the Inspector- General of police (IG) and two deputy IGs, and establishment of independent police services. The former structure of the PA put the Kenya Police, the Administration Police, the Special Branch (now NIS) and the PA intact and operated as one seamless machine to implement security matters (Mbuba and Mugambi, 2011).

But the wider environment demanded institutional reforms of the Provincial Administration. However, the reorganized practices and structures do not show the

administrative impact of the RPA on maintenance of law and order. How then, have the changed organizational practices and structures of the RPA impacted on the administration of selected aspects of maintenance of law and order in Bomet County in 2010 to 2014? This knowledge gap is widened by the fact that even these contemporary theories seem to have limitations in achieving the intended effects of restructuring public institutions as argued by March and Olsen (2008). They observe that most modern democracies seem to have limited capacity for institutional design and reform and in particular for achieving intended effects of reorganization. In re-designing and reforming the Provincial Administration to the RPA, has any research been done on achievements of the intended effects of restructuring the Provincial Administration? For instance, what has been achieved on the intended effects of reorganizing the security agencies into independent institutions in regard to the maintenance of law and order in 2010 to 2014?

Furthermore, restructuring of the PA can be reviewed on the basis of what DiMaggio and Powell (2007) referred to as institutional isomorphism. This is a constraining process that forces one unit in a population to resemble other units that face the same set of environmental conditions. In undergoing institutional isomorphism, organizations not only compete for resources and customers, but also for political power, institutional legitimacy and for social and economic fitness (DiMaggio and Powell, 2007).

The global pressure for public sector reforms in the late 1980s under the Structural Adjustment Programs (SAPs) initiated reforms in all public institutions in Kenya, including the PA that eventually underwent the institutional isomorphism to the RPA. But after restructuring, has the RPA gained the social, economic and institutional fitness to effectively maintain law and order? After isomorphism, what have been the administrative consequences of the RPA on the delivery of the selected aspects of maintenance of law and order in Bomet County in 2010 to 2014?

This theoretical discussion thus leads to the conceptualization of the RPA and the selected aspects of maintenance of law and order on a cause-effect relationship. The RPA involved change of organizational practices, structures and legal frameworks of the security agencies (the PA, the KPS, the APS and the NIS) that deal with maintenance of law and order. This reorganization should have institutional impact on the services delivered (Bangura, 2000).

Hence, in this conceptual framework, the RPA is the independent variable while the selected aspects of maintenance of law and order are the dependent variables. The cause-effect relationship of these variables can be explained through descriptive survey design where respondents' opinions were sought through a questionnaire and analyzed through cross tabulation of descriptive statistics such as percentages and frequencies. The dependent variables were subsequently

discussed.

Nature and causes of crimes committed in Bomet county before (2006 to 2010) and during 2010 to 2014

Crimes in this paper are defined as prohibited behavior that government deems harmful to society and is punishable by criminal. In Kenya, different crimes are categorized in the penal code Chapter 63 laws of Kenya (Revised 2009), for example crimes against a person, crimes against property, crimes against state, crimes against society, transnational crimes etc. Analysis of the nature and causes of crimes is an aspect or strategy of maintenance of law and order.

This study categorized crimes as follows; personal crimes (offences against person), property crimes (offences against property), statutory crimes (offences against state), crimes against humanity for example, political violence and transnational crimes e.g. terrorism, drug trafficking etc. The analysis of trends of these crimes in Bomet County before 2006 to 2010 and during 2010 to 2014 was vital in establishing the administrative impact of restructuring Provincial Administration on maintenance of law and order. The crime trends in Bomet County are compiled every month by the Criminal Investigations Department (CID) and annual national crimes statistics published by the National Police Service (NPS) headquarters (Bomet CID records, 2014; Republic of Kenya, NPS 2015). Analysis of crimes statistics is a practice that many countries undertake in management of security.

In developed countries such as the USA, crime statistics are published in what is known as Uniform Crime Reports (UCR). The statistics are analyzed by the Federal Bureau of Investigations (FBI) and used as an index of major crimes for example; murder, forcible rape, aggravated assaults, burglary, robbery, etc. (Sutherland, 1992).

In England and Wales, crimes statistics are compiled by British Crime Statistics (BCS) and analyzed as index of major crimes (Chaplin et al., 2014). It is thus a best practice that crimes statistics are analyzed and used as indicators of crimes trends at international, national and county levels. The nature and trends of crimes informs the status of maintenance of law and order, and the performance of law enforcement agencies in the society at any given time.

According to National Crime Research Centre, NCRC (2012), East Africa in general and Kenya in particular is a region of high and increasing crime rates due to various factors such as increasing poverty levels and inadequate economic opportunities available especially to the youth. Crime trends in Kenya are evolving in unprecedented rates and measures. Some of these crimes include organized criminal gangs (identified by NCRC as 46 in cities and main towns in Kenya), and they commit all sorts of crimes such as armed robberies, carjacking, illicit drugs trafficking, property thefts, economic fraud, to

mention but a few (NCRC, 2012).

In Bomet county, crime statistics shown categories of crimes against person for example, assaults, rapes, domestic violence; those against property such as thefts, robberies and crimes against state such as public disturbance, traffic offences, alcoholism and illicit brews offences (Bomet CID reports, 2014 and Bomet Law Courts, 2015).

The onset of County governments headed by Governors in 2013 and County Commissioners heading National security services further complicated maintenance of law and order. In Bomet County, operations of security agencies were constrained by the County government of Bomet's indifference to the constitutional provision for restructuring and existence of the Provincial Administration (Sixth Schedule, Section 17), and claims that the PA was irrelevant under the new constitution (Makiche, 2013).

This indifference by the devolved government, the establishment of independent police services and the fact that liquor licensing was devolved impacted on security agencies' delivery of maintenance of law and order during 2010 to 2014. The analysis of the nature and causes of crimes trends in Bomet County before 2006 to 2010 and during 2010 to 2014 is thus important as the crimes statistics reflect on the performance of the security agencies (the PA, the NIS, the APS and the KPS) and the status of maintenance of law and order.

According to a survey done by the GJLOS (2006), the office of the Chief was ranked the best in service delivery with over 70% of the disputes being resolved by the Provincial Administration. The reforms in GJLOS targeting the administrative officers had a positive impact on service delivery. Existing theories of institutional analysis indicate that reorganizing organizational practices and structures have consequences on the delivery of services (Powell, 2007; March and Olsen, 2008). What about the administrative impact of restructuring the PA on maintenance of law and order in 2010 to 2014? This leads to the question: what have been the administrative impact of the RPA on the nature and causes of crimes committed in Bomet County, in 2010 to 2014?

Whereas scholars in Kenya such as Bagaka (2011), Otwoma (2012), Mkutu et al. (2014), Mbuba and Mugambi (2011) and Republic of Kenya (2014, 2015) have extensively written on the Provincial Administration, they have not focused on the administrative impact of the RPA on the nature and causes of crimes in Bomet County in 2010 to 2014, hence the purpose of this research to fill the knowledge gap.

Frequency of joint security operations on illicit brews and reasons for not conducting them in Bomet County before (2006 to 2010) and during 2010 to 2014

Closely related to analysis of the nature and causes of

crimes is the aspect of joint security operations on illicit brews and reasons for not conducting them. Joint security operation in this research refers to collective and cooperative security activities to crackdown illicit brews by the security agencies.

Joint operation is an important aspect of maintenance of law and order. Illicit brew in this study is defined as illegal and unlicensed liquor that is prohibited by the government whether locally manufactured or imported from other countries. For example, *chang'aa* is illegal in Kenya while it is legal in Uganda and Tanzania (Rwanda's The New Times, 2015).

In Rwanda, illicit brews are outlawed and joint operations to eradicate them are done by the police, Rwanda's Defense Forces, District Administration Security Support Organization (DASSO), community policing and local authorities (Rwanda's The New Times, 2015). Prevalence of illicit brews thus is an indicator of inaction by the security agencies to effectively enforce law and order.

According to WHO (2011), about half of all alcohol drunk in Sub-Saharan Africa is produced illegally. In Africa, the informal brewing market is believed to be 3-5 times the value of the beer market. The social problems associated with the illicit alcohol market have been highlighted across Africa and have led to several governments focusing on discouraging the informal alcohol trade (Dutch Agricultural Development and Trading Company BV, 2013)

A survey done in Kenya by the National Authority for the Campaign against Alcohol and Drug Abuse (NACADA) in 2015, revealed that more than 6000 individuals die annually due to alcohol related problems. The report further states that illicit brews are the leading cause of these deaths and are the most popular alcoholic drinks among Kenyans (Sunday Nation, July 5th, 2015).

The same data revealed that 15% of Kenyans aged 15 to 64 years consume *chang'aa*, 40% of Kenyans aged 15 to 64 years have tested alcohol and 13% of people from all provinces except northern Kenya consume alcohol, and 12% of children aged 15 to 24 drink alcohol and Nairobi has the highest number of alcohol users in the 15 to 65 age clusters (Republic of Kenya, (2015)). The same information showed that Rift Valley, Central and Eastern provinces were also hard hit by alcoholism.

According to Bomet Law Courts (2015) records, cases related to alcoholism and illicit brews were on increasing trend in Bomet County in 2010 to 2014. Out of 1520 cases filed in 2009 to 2010, 106 cases were related to illicit brews; in 2010 to 2011, out of 1120 cases, 191 were on illicit brews; in 2011 to 2012, out of 1164 cases, they were 222; in 2012 alone, out of 973 cases filed, 205 were on illicit brews; in 2012 to 2013, out of 1252 cases, 307 were related to illicit brews while in 2013 to 2014, out of 1370 cases, 417 were on illicit brews (Bomet Law Courts, 2015).

Surprisingly, when H.E. President Kenyatta issued a

directive to eradicate illicit brews in the country in July 2015, in a barely one month's operations, a total of 4521.5 litres of *Chang'aa*, 61004 L of *Kangara*, 26,980 litres of *Busaa* and 8543 litres of second generation spirits were netted and 698 persons arraigned in court in Bomet County (Bomet County Commissioner's office, 2015; Bomet Law Courts, 2015).

Security operations have been going on to eradicate illicit brews and second generation spirits in Kenya. For example, in 2010, the government launched a 100 days Rapid Results Initiative (RRI) to crackdown on illicit brews and ensure that brewing and consumption of the same was reduced completely (Republic of Kenya, the National Assembly Report, 2010).

However, illicit brews prevalence in Kenya in general and Bomet County in particular have been on increase despite many strategies by the government agencies to eradicate them (NACADA, April-September report, 2014; Bomet Law Courts, 2015). Whereas the Provincial Administration and police officers have been on the forefront in the fight against illicit brews, there have been general allegations that brewing of illicit brews and trade in second generation spirits was as a result of in action by the security agencies (Republic of Kenya, the National Assembly Report, 2010).

Given these statistics and the fact that illicit brews are the leading causes of alcohol related deaths in Kenya, it is imperative to investigate the administrative impact of reorganizing the Provincial Administration on the frequency of joint security operations on illicit brews as a strategy of maintenance of law and order. This is supported by the theory of neo-institutionalism that argues that organizations do not always embrace strategies, structures and processes that enhance their performance, but instead react to and seek ways to accommodate pressures following external scrutiny and regulation (Powell, 2007).

Has restructuring the PA impacted on its strategies and structures to fight illicit brews in Kenya? For example, has the removal of direct command of the Administration Police from the Chiefs impacted on the war against the illicit brews? What then have been the administrative impacts of the RPA on the frequency of joint security operations on illicit brews in Bomet County in 2010 to 2014?

Duration of response to scenes of crimes and why in Bomet County before 2006 to 2010 and during 2010 to 2014

For the purposes of this research, the duration of response to scenes of crimes refers to the time security agencies take to react or answer to security emergencies and scenes of crimes. According to The Law Enforcement Magazine (2006), crime scene response is one of the most important and difficult aspects of patrol

work to master.

In the developed countries for example, the New York City in the USA, the response time is tracked because the speed with which officers arrive at a crime scene can be a crucial factor in catching criminals (The New York Times September, 2012). In some cases, quick response can reduce severity of injuries suffered by crime victims. Response time is an important measure of police performance, and an indicator of whether neighborhoods were being rigorously patrolled. Although police officials had observed that the more important measure was the level of crime reduction rather than the number of minutes it took the police officer to answer a call, response time had become a regular checklist for police performance in the New York City (The New York Times September, 2012).

In Kenya, although literature on the duration security agencies take to respond to scenes of crimes is scanty, the Kenyan police service is regarded almost solely a reactive force and demonstrates moderate proactive law enforcement techniques (OSAC, 2014).

According to Kenya 2014 Crime and Safety Report by Overseas Security Advisory Council (OSAC), the likelihood of the police responding to an incident would depend on the availability of personnel and fuel for police vehicles. The Kenyan police demonstrate moderate initiatives to deter or investigate crime (OSAC, 2015).

This report further indicates that police often lack equipment, resources, training and personnel to respond to calls for assistance or other emergencies. Available literature highlights that lack of reliable transport, deficits in human resource capacity and budgetary deficits are some of the challenges that lead to slow police response to scenes of crimes. Other factors affecting police response to scenes of crimes in Kenya include corruption, difficulties in managing ethnic relations and violence, proliferation of militia gangs and vigilantes and policing transnational crimes such as terrorism and cybercrimes (Omeje and Githigaro, 2010).

These challenges are also applicable in Bomet County. However, the response time to scenes of crimes in the County is not officially documented. But given the police officer to civilian ration in the County as 1: 200 compared to the national of 1:800 and the international ratio of 1:400, police response to incidents of crimes is definitely curtailed. Just like other parts of the country, the duration of response to scenes of crimes was largely affected by the availability of security personnel, transport, ethnic relations and violence at the border Counties (Bomet County Commissioner's office, 2015).

But how and why organizations behave as they do and with what consequences (Greenwood et al., 2008). Could the RPA and the independent police services have consequences on their operations to respond to scenes of crimes? The duration of response to scenes of crimes is a key aspect of maintenance of law and order, and therefore administration of its delivery would to a larger

extent help in answering this theoretical question of how and why organizations behave as they do. Now that the RPA established independent police services with parallel reporting mechanisms, removed the direct command of the AP from the Provincial Administration, what have been the administrative impacts of this reorganization on the duration of response to scenes of crimes in Bomet County in 2010 to 2014?

Investigation of the administrative impact of the RPA on this aspect of maintenance of law and order is critical because planning and coordination of police response to scenes of crimes as well as chain of command are administrative functions in the management of security services. For instance, in their contribution to the options for security after devolution in Kenya, Mktutu et al. (2014) cite coordination of security agencies as an emerging issue.

In the previous system of Provincial Administration, the command structure was clear and simple but today there is a confused structure where everyone thinks he or she is an independent agent (Njoka, 2014). What could be the consequences of the RPA and independent police services on the enforcement of response to scenes of crimes as a strategy to maintain law and order? Therefore from this review, it is emerging that the previous scholars had not focused on the administrative impact of the RPA on the duration of response to scenes of crimes and why in Bomet County in 2010 to 2014, hence a knowledge gap that this research sought to fill.

The frequency of security committees meetings and what informed them in Bomet County before 2006 to 2010 and during 2010 to 2014

Safety and security are top priorities in every society and addressing problems in these areas is important. Maintenance of law and order precedes safety and security in any country. However, according to Lukas (2016), until now there is no common theoretical basis on safety and security on which to address problems associated with the disciplines.

But as he proposes in his theory of safety and security, the approach mainly borrows from the already established theories such as the Copenhagen School of Security Studies securitization theory, the risk theory, the crisis theory and the causality theory (Lukas, 2016).

The securitization theory emphasizes the shift of safety and security studies from the military and international security to other security sectors such as political, human and environmental contexts. This approach identifies some political problem, transforms it into security problem and emphasizes the needs of solutions as the security problem. Based on this perspective therefore, management of security at all levels whether international, regional, national or local is a key political and administrative strategy in maintenance of law and

order. Some of the measures to solve security problems is utilization of security committee at all levels in the society.

At international level for instance, the United Nations Security Council is the top most security organ charged with maintenance of international peace and security (UN Security Council meeting practice, 2014). The risk theory evaluates which threats or negative effects that affect the reference object, with a goal to identify the worst possible impact of threats and preparation of solutions to the threats. This is probably the approach that the United Nations and individual countries utilized in establishing security organs and committees to address security problems.

For instance, since World War Two and with fresh surge in the 1990s, the need to maintain peace and security at regional and national levels led to proliferation of regional and sub-regional organizations (Bailes and Cottey, 2006). These regional organizations undertake security dialogue and conflict management to maintain peace within their regions.

According to these authors, European, African and Latin American organizations all have explicit conflicts prevention and management instruments such as security committees that meet regularly, and as need arise to prevent and manage conflicts. The meetings are informed by increasing realization among the member countries that contemporary regional and transnational threats such as terrorism, drug trafficking, piracy, organized crimes and human trafficking transcend countries and regions and therefore the need for effective response to combat them (UN Security Council meeting practice, 2015).

Kenya is not an exception to these theoretical approaches of establishing safety and security apparatus to address security problems. There are national security organs and a security system that guarantees the national security of the country as envisaged in the Constitution of Kenya 2010 and the Vision 2030.

The security machinery is headed at the top by the President who is the commander-in-chief of the Kenya Defense Forces (KDF), chairs the National Security Council (NSC), and directs and coordinates the functions of ministries and government departments (Republic of Kenya, 2010a,b: Article 239 and Article 132(3)).

This Article 239 lists the national security organs as the KDF, the NPS and the NIS, all of which are subordinate to civilian authority (Article 239:5). The civilian authority here is symbolized by the President who is elected to power through popular vote by universal suffrage of all Kenyan citizens in a general election. The Presidency is represented in all parts of Kenya by the RPA whose mandate includes among other functions, management of security agents in the field and maintenance of law and order.

The national security organs conduct their business through the National Security Council (NSC) which

executes its mandate through security committees. The members of the committee are drawn from the respective national security organs and are chaired by the President. The NSC meets at least four times in every financial year, and as often as need arises but not more than four months shall elapse between the date of one meeting and the date of the next meeting (Republic of Kenya, 2012a: 6(1)). The NSC operations are further operationalized through the National Security Advisory Committee (NSAC) and the Kenya Security and Intelligence Machinery (KSIM).

According to the NSC Act (2012), the security committees are decentralized through structures aligned to the National administrative units established under section 14 of the National Government Coordination (NGC) Act, 2013. These include: the Region established under section 14 of the NGC Act, 2013, the County, Sub County and Ward (Division) established under the County Government Act (2011), the Location and Sub-Location established under section 15(2) of the NGC Act (2013) and the Maritime and Border units established under the NSC Act (2012) (Republic of Kenya, 2014c). Pursuant to Article 239 (5) of the constitution, overall coordination of the NSC's activities in all its devolved structures shall be undertaken by National Government Administration Officers (NGAOs) appointed under section 15(2) of the NGC Act (2013) , who shall chair the decentralized units at the respective levels (Republic of Kenya, 2014c).

In other words, the NGAOs are the RPA and the chairpersons of the security committees at all levels of administration. If this is the case therefore, one may ask whether any reorganization of the command structure of this security system could have effects on the work of security committees in regard to maintenance of law and order. Have restructuring the Provincial Administration to the RPA had administrative impact on the frequency of security committees meetings in Bomet County in 2010 to 2014? This is a valid question if the theory of causality is anything to go by.

According to Lukas (2016), the law of causality states that anything that happens has at least one cause, and also any cause has future consequences. This theory can allow establishment of a logical claim of causes to the frequency of security committees meetings as an aspect of maintenance of law and order.

The security committees are supposed to meet regularly and as often as security needs arise to among other things: assess security status in their respective jurisdictions; receive and analyze security reports and intelligence; fast track continual and sustained implementation of the decisions of the NSC, NSAC and other appropriate institutions; liaising with County government on matters of national security; coordinating And liaising with national government ministries, departments and agencies in the County on matters of national security, among other functions (Republic of Kenya, 2014c).

The Locational and Sub Locational peace and security committees are supposed to meet weekly and forward their minutes to the Divisional (Ward) security committees, then these forward to the Sub-County security committee, then to the County Security Committee in that order up to the NSAC and the NSC (Republic of Kenya, 2012b).

To ensure that the citizens are not alienated from public participation in providing security to themselves, their properties and the national interests, the government adopted a community policing strategy launched in April 2005 and succeeded in 2014 by Nyumba Kumi initiative (or neighborhood watch).

This strategy entrenches community participation by empowering the citizens in national security issues (Republic of Kenya, 2013a,b,c,d,e). As a proactive process, the object of the strategy was to enhance maintenance of law and order, social cohesion and respect for the rule of law. As a consequence, community policing committees were rolled out based on cluster areas and alongside the national security committees at all the national administrative units as outlined earlier.

Nevertheless, even with all these committees in place, crime in Kenya and in Bomet County increased at an enormous rate during 2010 to 2014 (Aronson, 2010; Bomet County Commissioner's office, 2015). According to Security Research and Information Center (SRIC) (2014), robbery remained most frequently committed crime in Kenya since 2011 through 2014, followed by thefts and defilement cases which were on the increase.

There has been a significant decrease in active policing and law enforcement in Kenya while criminal behavior was steadily increasing, meaning there was little likelihood for a decline in crime rates in Kenya and East Africa anytime in the near future due to porous borders and extensive coastline (Aronson, 2010).

Yet, security committees are in place and meet regularly and as often as security needs arise to address national security issues. Does it mean restructuring the Provincial Administration to the RPA has had administrative impact on the maintenance of law and order to an extent that the frequency of security committees meetings was affected?

In Bomet County, the frequency of security committee meetings before 2006 to 2010 shows that most meetings were held on monthly and need basis. In 2007/08 for instance, there were more security meetings on need basis than ordinarily (Bomet County Commissioner's office, 2013). This was run-up to the 2007 general elections and the subsequent Post-Election Violence that erupted in 2007/08 after the disputed presidential results were announced. According to Aronson (2010), the extraordinary security meetings and operations was a common phenomenon across the country, especially in Rift Valley region where the ethnic violence was more pronounced, Bomet County not an exception.

The crimes statistics in Bomet County in 2010 to 2014

showed an increasing trend: in 2009/2010 were 1520 cases; in 2010/2011 were 1120; in 2011/2012 were 1164; in 2012 alone were 973; in 2012/2013 were 1252; and 2013/2014 were 1370. This crimes trend occurred despite the establishment of security committees at all levels of the administrative units. When analyzed against similar period before the RPA in 2006 to 2010, the crimes statistics were on increasing trend (Bomet CID reports, 2014; Bomet Law Courts, 2015). There were the two Bomet and Sotik Sub-Counties Security and Intelligence Committees and subsequent ones in all the 7 Divisions, 37 Locations and 100 Sub Locations at the time of writing this thesis (Bomet County Commissioner's office, 2015).

According to the Bomet County Security and Intelligence Committee (2015), the following were listed as major security concerns in 2010 to 2014 slightly more than was the case before in 2006 to 2010: illicit brews menace, robberies and thefts, assaults, defilement, rapes, highway robberies and traffic accidents, cattle thefts, land issues, domestic violence and political wrangles. However, despite the above security committees being in place in Bomet and Sotik Sub-Counties to analyze crime reports and sanction operations in 2010 to 2014, crime incidences continued to increase. What then could have been the administrative impact of the RPA on the frequency of security committees meetings and what informed them in 2010 to 2014?

Research setting

This research was conducted in Bomet and Sotik Sub-Counties in Bomet County, South Rift Valley region and one of the 47 Counties in Kenya. The two Sub-Counties have a total area of 1056.5 square Km, 37 locations and 100 sub-locations, with a total population of 421,014 people (49.6% males and 50.3% females) according to national population census of 2009 (KNBS, 2013). They have a high agricultural potential with crop and livestock production being the leading sources of livelihood for the residents.

In addition, they have good road infrastructure especially the Southern Corridor trunk road namely Narok-Bomet-Sotik Highway, which traverses both Sub-Counties and links the County to South Nyanza region. Bomet County borders the following Counties: Nakuru to the East, Kericho to the North-East, Nyamira to the West and Narok to the South East.

The predominant community is the indigenous Kipsigis tribe of the Kalenjin community with a population density of 437 persons per square kilometer compared to the national 78 persons per square kilometer and a population growth rate of 2.3% compared to the national population growth rate of 2.8% (Republic of Kenya, County Profile, 2013).

The aforementioned factors are sufficient conditions for

commission of crimes and the fact that the structure of public administration is the same in the country informed the choice of Bomet County for the study of the administrative impact of the RPA on selected aspects of maintenance of law and order in 2010 to 2014.

In addition, the political context of devolution whereby the County hosted the first Chairman of Council of Governors for two years (2013 to 2015), made the case study a unique one as the County Government was indifferent to the RPA and the operations of the security agencies under the new constitutional dispensation. These factors had ramifications on maintenance of law and order in the County in 2010-2014 (Bomet County Commissioner's office, 2015) and (Makiche, 2013).

In addition, analysis of crime trends before RPA in 2009/2010; 2010/2011; 2011/2012; 2012/2013 and 2013/2014 in Bomet County showed increasing trends of assaults, robberies, domestic violence, thefts, offences involving illicit brews, land and domestic disputes compared to similar period before the RPA in 2006 to 2010 (Bomet CID records, 2014; Bomet Law Courts, 2015).

This is despite restructuring the Provincial Administration to the RPA /or National Administration and the County having four sub counties , 13 divisions, 66 locations and 175 sub locations, all complete with security apparatus to ensure maintenance of law and order. In addition, there were 17 security installations, 855 *Nyumba Kumi* clusters, 259 peace committees and community policing committees established in all administrative units at the time of writing this thesis (Bomet County Commissioners office, 2015). Therefore, what have been the administrative impacts of the RPA on the selected aspects of maintenance of law and order in Bomet County in 2010 to 2014?

DATA COLLECTION AND METHODS

The research design for this study was descriptive survey because information was collected from a sample of respondents using structured closed and open-ended questionnaire. Additional data was sought from secondary sources through analysis of books, government reports and circulars, internet sources, journals and newspapers.

Analysis of the results therefore was based on the opinions of the respondents from the questionnaire. The research targeted 223 security officials from Bomet and Sotik Sub Counties comprising of four security agencies namely the National Administration (84), the Administration Police Service (91), the Kenya Police Service (43) and the National Intelligence Service (5). The study purposively identified this population based on their formations. The calculation of the sample size used Israel (1992) Simplified Formula for Proportions, giving a sample of 143 that is:

$$(NA=54; KPS=28; APS=58 \text{ and } NIS=3)$$

However, Kothari and Garg (2014) argue that the larger the sample size, the lesser the sampling error and the more representative the sample is. The study further purposively chose the final respondents in each service based on this formula because of the

need to identify those who had been in service for more than eight years (four years before the RPA in 2006 to 2010 and four years in 2010 to 2014). This would enable the researcher to establish the administrative impact of the RPA on the selected aspects of maintenance of law and order in the period under study.

The questionnaires were distributed through the heads of departments of the four security services who acted as research assistants namely: two Officers Commanding Police Divisions (OCPDs), two Sub-County Administration Police Commanders (DAPCs), one County Intelligence Coordinator and two Deputy County Commissioners in Bomet and Sotik Sub-Counties. The researcher personally administered the questionnaire to the County Security and Intelligence Committee members (these are: the County Commissioner, the County Police Commander, the County Administration Police Commander and the County Director of Criminal Investigations).

The questionnaire was divided into five sections namely: section one on demographic information and four sections according to the objectives of the research. These were the nature and causes of crimes committed in Bomet County before 2006 to 2010) and in 2010 to 2014, the frequency of joint security operations on illicit brews and reasons for not conducting them, the duration of response to scenes of crimes and why and the frequency of security committees meetings and what informed them.

Before commencing the research, ethical considerations were made. The researcher produced official introductory letters from the University, the National Commission for Science, Innovation and Technology, and the local administration to the respondents. Also, a pilot study was done to ensure validity and reliability of the tool. Secondary information was collected through critical analysis of books, government reports and circulars, policy and legislative papers, internet sources, journals and newspapers, to give in-depth of the variables being studied. Data collection took place from December 2015 to February 2016.

The study analysis was based on the data collected from 104 questionnaires out of 123 or 73% which were returned and correctly filled. The data was sorted out, coded and fed into the Statistical Package for Social Sciences (SPSS) computer program. Data was analyzed using descriptive statistics namely frequencies and percentages. The results were then presented using graphs and charts which were developed using MS Excel package. Discussion and interpretation of the findings were derived from the results.

Israel (1992) method used to calculate the sample size had 95% confidence level and a precision of 0.05%. Likewise, as it is with most surveys, 95% or 0.95% significance level of statistical tests being true while 5% or 0.05% of the tests being false.

RESULTS

The analysis focused on the general information of the respondents and the administrative impact of the RPA on the selected aspects of maintenance of law and order. The analysis was based on the opinions of the respondents as derived from the questionnaire since it is a descriptive survey research.

General information of the respondents

Gender

The respondents comprised of 81% females. Thus, males were more than the females in the targeted security

services. It is important to know the gender distribution in the security services.

Age

From the analysis of the data, 44% of the respondents were the majority aged between 46 to 55 years, 33% of the respondents were aged between 36 to 45 years, and 18% of the respondents were aged between 26 to 35 years while 5% of the respondents were aged over 55 years. Cumulatively, 49% of the respondents were aged above 46 years (with 5% of them tending to retire from the service). Because the objectives of the study were measured over a period of 8 years before the RPA in 2006 to 2010 and in 2010 to 2014, the age factor is critical in determining the administrative impact of the RPA on the selected aspects of maintenance of law and order from the opinions of the respondents.

Education level

The analyzed data shown that 63.4% of the respondents had Secondary education and were the majority, followed by 14.4% of respondents who had Diploma, 11.5% of them had a degree, 6.7% of the respondents had masters, and 3.8% of them had Primary level of education. The education level of the respondents is a critical element in the analysis of the data because it determines the extent to which the respondents understood and answered the questionnaire which was the instrument of data collection. Also, the education level reflects the extent to which the respondents understood the RPA and the selected aspects of maintenance of law and order which were the main questions in the questionnaire, hence the validity of the results.

Length in service

From the analysis of the data collected, 35% of the respondents had served for between 11 to 20 years and were the majority, 31% of them had served for between 6 to 10 years, 24% of the respondents had served for between 21 to 30 years and 9% of them had served for over 31 years. Cumulatively, those who had served for between 11 and over 31 years were 68%, a significant number in this analysis. It is imperative to note that experience in the Provincial Administration and maintenance of law and order is the most important component of this research since the main objective of the study was to establish the administrative impact of the RPA on the selected aspects of maintenance of law and order measured over a period of 8 years, four years before the RPA in 2006 to 2010 and four years in 2010 to 2014. Given the aforementioned analysis of the data of the respondents' length in service therefore, the results of the study can be interpreted as having a high degree of

validity and correctness.

Administrative impact of the RPA on the nature and causes of crimes committed in Bomet County before RPA in 2006 to 2010 and during 2010 to 2014

From the analysis of the data, 37.0% of the respondents observed that personal crimes were more during the RPA in 2010-2014 as compared to 31.3% of the respondents before the RPA in 2006 to 2010, 27.8% of the respondents opined that property crimes were more during the RPA in 2010 to 2014 compared to 20.7% of the respondents before the RPA in 2006 to 2010, while 25.7% were of the opinion that statutory crimes were more during the RPA in 2010 to 2014 as compared to 23.3% of the respondents before the RPA in 2006 to 2010.

According to the means of these opinions therefore, all the three categories of crimes were on increase during the RPA in 2010-2014. It shows that the RPA had administrative impact on the nature of crimes committed in Bomet County leading to increase of personal, property and statutory crimes during 2010 to 2014 as compared to the Bomet County crime statistics before the RPA in 2006 to 2010.

However, 9.5% of the respondents observed that other crimes categorized as political violence, inter-ethnic conflicts, cattle rustling, terror attacks and cybercrimes were on decrease in 2010 to 2014 as compared to the opinion of 24.7% before the RPA in 2006 to 2010. In this category, although terror attacks and cybercrimes were frequent in other parts of the country, in Bomet County there was never a terror attack during the period under study. These findings can be linked to March and Olsen (2008) theoretical argument that most institutional designs and reforms have limited capacity for achieving intended effects of reorganization. The changed command structure in the RPA and establishment of independent security services have not achieved improved fight against crimes as Hughes (2012) anticipates of any reform process.

Other researchers such as the KNCHR (2014) had established that Kenya witnessed a sharp increase in the number of crimes and insecurity in 2010-2014 including terror attacks, inter-ethnic conflicts and deaths of security officers; SRIC (2014) had established that robbery and murder cases were on increase by 5% in 2014 as compared to the previous years in the country; and Republic of Kenya, (2015) had established that illicit brews were the leading causes of alcohol related deaths in Kenya and the most popular alcoholic drinks.

Main causes of crimes

On what caused crimes in Bomet County, 32.7% of the respondents indicated that illicit brews prevalence was

the main cause of crimes in 2010 to 2014 as compared to 29.0% before the RPA in 2006 to 2010. According to this research, 3.7% more respondents felt that illicit brews were the main causes of crimes in the period under study as compared to the period before in 2006 to 2010.

Domestic and land issues were also cited as causes of crimes with 7.9% of the respondents indicating that they were responsible for the crimes committed in 2010 to 2014 as compared to 7.1% before RPA in 2006 to 2010. This shows that perceptions of the respondents on the domestic and land issues as the main causes of crimes in Bomet County had not changed a lot in the two periods before RPA in 2006 to 2010 and 2010 to 2014. However, according to a survey by GJLOS (2006) on service delivery by the Provincial Administration, domestic and land disputes were less before RPA in 2006 to 2010.

In addition, technological advancement was cited as a cause of crimes in the County, with 11.5% of the respondents indicating that it was responsible for the crimes committed in 2010 to 2014 as compared to 2.1% before RPA in 2006 to 2010. This shows a significant margin of opinion of the respondents on the technological advancement as a cause of crimes in the two periods under study.

However, 24.9% of the respondents were of the opinion that poverty and unemployment were causes of crimes in 2010 to 2014 as compared to 27.9% of the respondents before the RPA in 2006 to 2010. This shows that perception of poverty and unemployment as causes of crimes in Bomet County reduced from 27.9% in the period before in 2006 to 2010 to 24.9% in 2010 to 2014.

Likewise, 2.4% of the respondents were of the opinion that illiteracy and low levels of education caused crimes in 2010 to 2014 as compared to 7.1% of the respondents before the RPA in 2006 to 2010. This shows that the two variables were less contributing factors to the crimes committed in 2010-2014 than before the RPA in 2006 to 2010.

Overall, the RPA had negative administrative impact on the nature and causes of crimes committed in Bomet County in 2010 to 2014 because personal, property and statutory crimes increased during the period under study mainly caused by illicit brews prevalence, domestic and land issues and technological advancement. Previous researchers such as Republic of Kenya, (2015), SRIC (2014) and Republic of Kenya (2013, 2014) had indicated that illicit brews consumption had significantly contributed to occurrence of crimes in Kenya in 2010-2014.

Administrative impact of the RPA on the frequency of joint security operations on illicit brews and reasons for not conducting them in Bomet County before RPA in 2006 to 2010 and during 2010 to 2014

From the analysis of the data, 58% of the respondents observed that the frequency of joint security operations on illicit brews was high on weekly basis before the RPA in 2006 to 2010 as compared to 31% of the respondents

in 2010 to 2014, while 39.9% of the respondents opined that it was high on monthly basis in 2010 to 2014 as compared to 16.3% of the respondents before the RPA in 2006 to 2010. In addition, 33% of the respondents observed that the frequency was high on need basis as compared to and 20% of the respondents before the RPA in 2006 to 2010. Also from the analysis, 5% of the respondents felt that the frequency was minimally higher on daily basis before the RPA in 2006 to 2010 as compared to 1.5% of the respondents in 2010 to 2014. This means that the frequency of joint security operations on illicit brews dropped from weekly before the RPA in 2006 to 2010 to monthly and need basis in 2010 to 2014. It was also minimally higher on daily basis before the RPA in 2006 to 2010 than in 2010 to 2014.

This study therefore, argues that the RPA had negative administrative impact on the frequency of joint security operations on illicit brews since it dropped from daily and weekly basis before the RPA in 2006 to 2010 to monthly and need basis in 2010 to 2014. This is corroborated by the analysis that 58.7% of the respondents indicated that illicit brews prevalence had increased during 2010 to 2014 as compared to 40.4% of the respondents before the RPA in 2006 to 2010. This means that illicit brews prevalence in Bomet County was lower before the RPA in 2006 to 2010 but increased during 2010 to 2014. This result is supported by the existing crime statistics in the County (Bomet Law Courts, 2015 and Bomet CID Report, 2014).

Furthermore, 49.0% of the respondents indicated that illicit brews prevalence contributed to the crimes committed in Bomet County to a larger extent in 2010 to 2014 as compared to 39.4% of the respondents before the RPA in 2006 to 2010. From this analysis, it is argued that the frequency of joint security operations on illicit brews in Bomet County dropped in 2010 to 2014 as compared to the period before the RPA in 2006 to 2010, leading to increased prevalence of the illicit brews which in turn contributed to the crimes committed to a larger extent. This means that the RPA had negative administrative impact on the frequency of joint security operations on illicit brews in 2010 to 2014.

These research findings link to the theoretical argument by Hughes (2012) that reform is undertaken with the aim of improvement, but there has been so much change, so much reform that management capacity has not improved very much. It is therefore argued that restructuring the pillars of national security by changing the command structure and establishing independent security services negatively affected joint operations on illicit brews.

Reasons for not conducting joint security operations on illicit brews in Bomet County

From the analysis, 51.9% of the respondents indicated that joint operations on illicit brews were not conducted in

2010 to 2014 compared to 48.1% of the respondents before the RPA in 2006 to 2010. This means that lesser joint security operations on illicit brews can be attributed to the consequences of the RPA on the operations. What then were the reasons for lesser joint security operations on illicit brews in Bomet County in 2010 to 2014? From the analysis of the data collected, the respondents revealed the following reasons: 16% of the respondents cited inadequate resources; 15% of them cited mistrust among security agencies; 14% of the respondents cited lack of cooperation; while 13% of them shown County government confusion; 13% of the respondents indicated lack of sharing security information; 12% of them cited overlapping chain of command and 12% of the respondents cited corruption. This research finding conform to other researchers such as Republic of Kenya, (2015), that established that illicit brews are on high demand in Kenya and responsible for over 6000 deaths annually due to alcohol related problems. Also KNCHR (2014) established that there was lack of sharing security information and overlapping chain of command among the security agencies, leading to lack of congruence in their operations in 2010 to 2014.

Administrative impact of the RPA on the duration of response to scenes of crimes and why by security agencies in Bomet County before the RPA in (2006 to 2010) and during 2010 to 2014

From the analysis of the data, 47.1% of the respondents observed that it took minutes to respond to scenes of crimes before the RPA in 2006 to 2010 as compared to 43.3% of the respondents in 2010 to 2014, while 46.2% of the respondents observed that it took hours before the RPA in 2006 to 2010 as compared to 53.8% of the respondents in 2010 to 2014. This means that the duration of response to scenes of crimes was longer in 2010 to 2014 than before the RPA in 2006 to 2010. While there is no baseline literature on systematic recording of response time to scenes of crimes in Bomet County and in Kenya in general, it is a security practice taken seriously in the developed world. For example, in the New York City in the USA, response time is an important measure of police performance and an indicator of whether neighborhoods are being vigorously patrolled (The New York Times, September, 2012). However, this duration of response to scenes of crimes in Bomet County in 2010 to 2014 was far too long compared to that taken in developed countries. For example, in New York in the USA, it took 7 min for general crimes and 5 minutes for critical crimes scenes (The New York Times, September, 2012), while in Manchester and Sussex police in the UK took 15 min for all types of crimes (British Investigative Journalism, 2013). The previous researchers such as KNCHR (2014) had established that there was poor response of security activities and there existed lapses in security operations deployment among

the security agents in 2010 to 2014.

Why it took that duration of response

From the analyzed data, 38.5% of the respondents cited poor coordination of response to scenes of crimes in 2010 to 2014 as compared to 5.8% of the respondents before the RPA in 2006 to 2010. This means that coordination as an administrative function was negatively affected under the RPA than before and therefore contributed to longer duration of response to scenes of crimes in 2010 to 2014.

Unclear, complex and confusing chain of command was cited by 24.9% of the respondents, 27.9% of the respondents and 33.7% of the respondents respectively in 2010-2014 as compared to 14.4% of the respondents, 4.8% of the respondents and 4.8% of the respondents respectively before the RPA in 2006-2010. This means that the RPA had resulted to complex, unclear and confusing chain of command leading to poor response to scenes of crimes in Bomet County in 2010-2014. This finding confirms KNCHR (2014) report that the chain of command in the police services was unclear and confusing, resulting to lack of congruence in their operations.

In addition, 12.0% of the respondents cited lack of teamwork in 2010 to 2014 as compared to 10.1% of the respondents before the RPA in 2006 to 2010, 14% of the respondents indicated independent security operations in 2010 to 2014 as compared to 0.8% of the respondents before the RPA in 2006 to 2010 while 19.9% of the respondents cited lack of sharing security information in 2010 to 2014 as compared to 10.1% of the respondents before the RPA in 2006 to 2010. This means that all the above reasons were more prevalent in 2010 to 2014 except for inadequate resources, and contributed to longer duration of response to scenes of crimes than before the RPA in 2006 to 2010. The RPA thus had negative administrative impact on the duration of response to scenes of crimes in the period under study.

The other researchers such as Omeje and Githigaro (2010) highlight some of these factors as challenges to state policing in Kenya, KNCHR (2014) indicate that poor coordination of security operations exists among the security agents leading to lack of sharing information, lack of action on security intelligence leading to increase in crimes in Kenya in 2010 to 2010.

Administrative impact of the RPA on the frequency of security committees meetings and what informed them in Bomet County before the RPA in 2006 to 2010 and during 2010-2014

From the analysis of the data, 24% of the respondents were of the opinion that the frequency of security committees meetings was weekly in 2010 to 2014

compared to 15.1% of the respondents before the RPA in 2006 to 2010, 34% of the respondents indicated it was monthly in 2010 to 2014 compared to 42% of the respondents before the RPA in 2006 to 2010, and 35% of the respondents observed that it was on need basis in 2010 to 2014 compared to 26% of the respondents before the RPA in 2006 to 2010. This means that the frequency of security committees meetings was monthly and on need basis before the RPA in 2006 to 2010, but increased to weekly and on need basis in 2010 to 2014. From these findings therefore, it can be interpreted that there were more security meetings on weekly and need basis in 2010 to 2014 than before the RPA in 2006 to 2010. This implies that there were more frequent security issues and responsibilities under the RPA than it was before that needed the attention of the security committees. It can be argued thus, the RPA resulted to emergent security issues that had negative administrative impact on the frequency of the security meetings because it increased from monthly to weekly and on need basis in 2010 to 2014.

What informed the security committees meetings

From the analyzed data, 29.4% of the respondents observed that the security committees meetings were informed by increased crime incidences in 2010 to 2014 compared to 26.4% of the respondents before the RPA in 2006 to 2010, 23.2% of the respondents indicated increased illicit brews prevalence in 2010 to 2014 compared 21.1% of the respondents before the RPA in 2006 to 2010, 16.8% of the respondents cited disjointed security agencies operations in 2010 to 2014 compared to 4.1% of the respondents before the RPA in 2006 to 2010, 19% of the respondents cited routine in 2010 to 2014 compared to 23.2% of the respondents before the RPA in 2006 to 2010 and 12% of the respondents observed other reasons in 2010 to 2014 compared to 25.2% of the respondents before the RPA in 2006-2010.

From this analysis, the perceptions of the respondents on what informed the security committees meetings had increased by 3% for the increased crimes incidences and 2.1% for illicit brews prevalence in the two periods under study. However, whereas the difference in these opinions seems to be marginally close to one another, it was higher for the disjointed security operations by 12.7%. Also, from the results security committees meetings not a routine administrative practice in 2010 to 2014 as compared to the opinion of the respondents before the RPA in 2006 to 2010.

From these findings therefore, this study argues that the security meetings in Bomet County were more informed by increased crimes incidences, increased illicit brews prevalence and disjointed security operations in 2010 to 2014 than before the RPA in 2006 to 2010 and less informed by routine and other reasons. The frequency of the security committees meetings is outlined

by the Republic of Kenya (2012) and the Republic of Kenya (2013) from national level to the lowest levels of the administrative units, to occur as routine practice and as security needs occur at every level.

All the aforementioned percentages were means of the opinions of the sampled respondents as derived from the questionnaire for the two periods. They were derived from the cross tabulation of the data on each variable using the statistical package for social science (SPSS) computer program. From the significance level tests, 70% of the mean difference tests of these percentages between the two periods had significance level of less than 0.05% while 30% had significance level of more than 0.05%. Therefore, 70% of the variables researched had statistical significance in the new knowledge.

Conclusion

The study established that the changed command structure and establishment of independent security institutions in the RPA negatively impacted on the fight against crimes in Bomet County, resulting in the increase of personal, property and statutory crimes in 2010 to 2014. The new structure resulted in lack of effective enforcement and coordination due to overlapping chain of command, lack of cooperation and sharing security information among the four security agencies leading to increase in these three categories of crimes.

The frequency of joint security operations on illicit brews in Bomet County dropped from weekly and need basis before the RPA in 2006 to 2010 to monthly and need basis in 2010 to 2014. The study therefore concludes that the drop is attributed to overlapping chain of command that affected effective enforcement, disjointed operations due to establishment of independent security services, lack of cooperation among the four security services, persistent inadequacy of resources and entry of the County government in liquor management.

The duration of response to scenes of crimes in Bomet County increased from minutes before the RPA in 2006 to 2010 to hours in 2010 to 2014. The study concludes that the RPA introduced unclear, complex and confusing command system that resulted in poor coordination and implementation of responses to scenes of crimes, especially at the lower levels where the Chiefs largely rely on the Administration Police officers to enforce law and order.

Therefore, the confusing command system and persistent inadequacy of resources among the four security agencies had negative ramifications on the duration of response to scenes of crimes in 2010-2014. Furthermore, the study established that there was no systematic structure of recording response time to scenes of crimes by the four security agencies in Bomet County and in Kenya in the period under study. It is

therefore recommended that more research on this area be done, since response time to scenes of crimes is a key strategy in the maintenance of law and order.

The study established that the frequency of security committees meetings in Bomet County increased to weekly and need basis in 2010 to 2014 from monthly and need basis before the RPA in 2006 to 2010. It concludes that there were more emerging security and administrative issues during the RPA in 2010-2014 than before. Some of these issues the study established were overlapping chain of command, disjointed operations and lack of cooperation among the four security services. The resultant effect was increased crimes incidences, hence the need for frequent security meetings to address them.

Overall, the RPA had negative administrative impact on the four selected aspects of maintenance of law and order in Bomet County in 2010 to 2014. The research has contributed to new knowledge on restructuring the Provincial Administration in Kenya and its consequences on maintenance of law and order. As the theory of neo-institutionalism stipulates, in restructuring organizations, there are intended effects of reorganization. While it is largely expected by the neo-institutionalism perspective that restructuring results to positive effects, for this study the RPA had negative administrative consequences on the four selected aspects of maintenance of law and order.

The study findings would be of significance to the law enforcement agencies in enhancing their delivery of the selected aspects of the maintenance of law and order and in streamlining their operations, especially during this time when Kenya witnessed several incidences of insecurity and lawlessness. The study findings would also be useful to other civil servants in appreciating the RPA in the new constitutional dispensation, hence foster inter-linkages in regard to the maintenance of law and order.

The local community and the general public would benefit from the study findings in understanding and appreciating the new role of the RPA in the delivery of the maintenance of law and order under the new constitution. The study findings may also be useful to the government and the policy makers in reviewing laws and policies regarding the management of security services in Kenya, with a view to developing new strategies to combat emerging administrative and security challenges. Finally, the study findings would form a basis for further research in this new institution of the Restructured Provincial Administration.

The government should consider re-restructuring the command system among the four security agencies (the RPA, the KPS, the APS and the NIS) to promote teamwork and enhance effective enforcement and management of maintenance of law and order, establish a clear law and policy on liquor that is universal to all the Counties to streamline joint operations on illicit brews, avail adequate resources to enhance effective and efficient response to scenes of crimes, and empower the

security committees especially at the lower levels through operationalization of Article 239 (5) of the Constitution of Kenya 2010. These are indispensable strategies in the realization of improved enforcement of law and order as envisaged in the Vision 2030.

CONFLICT OF INTERESTS

The authors have not declared any conflict of interests.

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Full Length Research Paper

Designing innovative pro-poor healthcare financing system in sub-Saharan Africa: The case of Eritrea

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This study attempts to develop a pro-poor health care financing system for Eritrea. The study seeks to answer the following question: can the rich and healthy subsidize the poor and sick in Eritrea? This question is directly related to issues of social insurance and universal coverage. This study was conducted in 2016 in six months period from February to August. In this study, both primary and secondary data sources were used. Interviews were conducted with 35 key health officials and stakeholders. In this study, it is found that lack of purchasing power and financial resources; insufficient knowledge of health insurance schemes and high transaction costs; and lack of supply and information about care possibilities are the main problems for the development of a viable healthcare financing system in Eritrea. As the Ministry of Health is embarking on new pricing and cost recovery strategies, a closer look of its effects on consumers is required, particularly on the poor and vulnerable groups. Significant increases in revenues from user fees increases may not be realistic, given the country's high poverty rate. The health care financing policy needs to be assessed in light of current and projected health sector needs.

Key words: Eritrea, health care financing, Sub-Saharan Africa, health policy, health insurance.

INTRODUCTION

Eritrea is a country located in the Horn of Africa region bordered by the Red Sea to the east, Djibouti to the southeast, Ethiopia to the south, and the Sudan to the north and west. Eritrea gained independence from Ethiopia in 1993 after 30 years of armed struggle. With a population of about four million people, Eritrea has an area of 124,320 Sq Km.

The country's economy is largely dominated by subsistence agriculture. About 80% of the Eritrean people depend on farming and herding for its livelihood and almost 70% of the people live in countryside. The population density ranges from 36.3 to 40.6 people per sq. km (World Bank, 2002). Eritrea is a low income country; for the year 2010 the gross domestic product

(GDP) for Eritrea was estimated at US\$3.625 billion together with a per capita estimate of US\$681 (Desta, 2013). Despite its income, Eritrea has registered significant progress in child and maternal health. Eritrea is one of the few African countries that have achieved the Millennium Development Goals of 4, 5, 6 and 7¹.

Health is an integral part of the national development program in Eritrea. In its poverty reduction strategy

¹Millennium Development Goals targets achieved by Eritrea:

Goal 4: Reduction of child mortality;

Goal 5: Improvement of maternal health;

Goal 6: Combating HIV/AIDS, malaria and other diseases; and

Goal 7: Ensuring environmental sustainability

(2001 to 2002) and macro-policy (1994), the Government of the State of Eritrea (GoSE) clearly stated that health is the key input for national development. The country has six health regions (Anseba, Debub, Southern Red Sea, Gash Barka, Maekel and Northern Red Sea) and 54 health districts (Kirigia et al., 2012).

The health infrastructure comprises 369 health facilities, including 13 tertiary hospitals, 13 secondary hospitals and 343 primary level facilities (health centres, health stations, Maternal and Child Health units and Clinics, clinics and health posts) (GoSE, 2010a).

Health services are provided in Eritrea in three hierarchical levels: primary, secondary and tertiary. On the top there are teaching and national referral hospitals, in the middle regional referral and district hospitals and at the bottom primary health care facilities. Primary health services are very broad and comprehensive, and the facilities provide many community health services such as immunization, mother and childcare, health promotion (information, education and communication) and other preventive and curative services.

Primary health care facilities serve also as an entry points for curative services. There are also 292 licensed private pharmaceutical institutions, including 33 pharmacies, 31 drug shops and 228 rural drug vendors (GoSE, 2010b). The secondary and tertiary levels provide mainly curative services. Secondary level health care facilities encompass zone and sub-zone referral and first contact hospitals respectively. The national referral hospitals constitute the tertiary level health care facilities. The health infrastructure is operated by 215 physicians, 2505 nursing and midwifery personnel, 16 dentistry personnel, 107 pharmaceutical personnel, and 88 environment and public health workers (WHO, 2011).

The GoSE is in the process of forming national health policy rather than reforming as many countries are doing. For Eritrea the establishment of a comprehensive national health system, which is equitable, accessible and affordable for the poor, is a top priority.

This study, therefore, attempts to develop a pro-poor health care financing system for Eritrea that ensures contributions to the costs of healthcare are in proportion to different household's ability to pay, and protects the poor from the financial shocks associated with severe illness by enhancing accessibility and quality of services. The main concern in health care financing system in Eritrea is that "can the rich and healthy subsidize the poor and sick"? This question is directly related to issues of social insurance and universal coverage, which is quite challenging for developing

countries like Eritrea. Hence, the study adopts a deductive approach to explaining the healthcare financing systems in Sub-Saharan Africa.

Review of health care financing system in Sub-Saharan Africa

The reality in many Sub-Saharan Africa (SSA) countries is that health service systems are not providing cost-effective services in ways that would have the greatest impact on the major causes of illness and death. One of the problems in the public health system is that health service providers rarely receive incentives and there are no stipulations for service quality and quantity; no measurement of effectiveness and productivity.

Chronic shortage of drugs, infrequent equipment maintenance, inadequate logistical support, and weak supervision further contribute to inefficiency in health service (World Bank, 1994a). The rising costs, limited funding and increasing inefficiency have greatly weakened the ability of SSA countries public health systems to provide effective care and universal coverage (Shaw and Martha, 1995).

Consequently, many SSA countries rely on donor's finance. In 1990, for example, Burkina Faso covered 71% of its health expenditure by aid, and Sierra Leon and Tanzania covered 50 and 51% of their health expenditure respectively. In Lesotho, donor financing covered about 80% of the Ministry of Health capital budget between 1987 and 1992 and in Uganda donors financed 87% of total public development expenditures on health in 1988 to 1989 (World Bank 1994a: 152). Foreign aid covers 20% of the total health expenditure in SSA.

With the decline of donors financing and sharp fall in tax revenues many countries in SSA introduced private out-of-pocket payments. Out-of-pocket payments include user fees at public sector facilities as well as direct payments to private providers, ranging from doctors working in private practice to informal drug sellers and traditional healers. In many countries user fees cover about 43% of the total healthcare expenditure (World Bank, 1994a).

Private-for-profit and private voluntary clinics, including church/missions charge fees for their service to recover costs and to sustain their services. Since 1991, the Central African Republic, for example, has adopted four different user fee schemes: a charge for services rendered; a flat charge for each episode of illness; a flat fee per visit; and prepayment for a year of service (ECA,

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2003). A study conducted in Zaire, in the Bwananda District, further showed that, between 1986 and 1988, user fees accounted for 109 to 111 per cent of the operating costs of the health centers (World Bank, 1996).

In Bwamanda hospital, between 1986 and 1988, about 30% of the operating expenses were covered by user fees. The user fees were then supplemented by insurance payments and employer billings, which accounted for 22 to 33% and 13 to 22% of operating costs, respectively. At tertiary level, healthcare facilities revenues generated from cost-sharing ranged between 59 and 75% of total operating costs between 1986 and 1988 (World Bank, 1996). Four mission hospitals, in Uganda, recovered 78 to 95% of their operating costs, and nine of eighteen non-governmental dispensaries, in Tanzania, recovered 100% of their operating costs from user fees, and seven of twenty-one NGO hospitals recovered more than 75% of their operating costs (Shaw and Martha, 1995).

User fees are a stimulus to self-financing health insurance schemes. Shaw and Martha (1995) contended that SSA countries should impose user fees first in government healthcare facilities, especially at hospitals, before jumping into self-financing health insurance schemes. The reason is simply that when public health services are provided for free or at low cost, people are less likely to pay for insurance premiums to cover unexpected health hazards. The argument is that user fees can enhance more efficient, equitable and sustainable use of health care services. By charging fees for curative/personal healthcare services at tertiary level healthcare facilities, governments can free up and reallocate budgets to public health services (for example, community health services, immunizations, and control of infectious diseases).

Matji et al. (1995) however, warn that charging for health care without improving the quality of service is disappointing, as it has been seeing in the Democratic Republic of Congo. Clients must feel that they are getting value for services that are no longer provided for free. The issue of quality must be addressed before the implementation of user fees. User fee should also be accompanied by appropriate waiver mechanisms. There are growing international evidence that user fees can push households down into poverty if appropriate waiver mechanisms are not in place (Whitehead et al., 2001).

The world health organization (WHO) has estimated that 100 million people become impoverished by paying for health care each year and that a further 150 million face severe financial hardship from health care costs (WHO, 2005). Direct cost sharing through user fees does limit access, especially by those who are most prone to the consequence of ill health and those in low-income groups (Stewart, 1999). The introduction or increase of user fees in the public health system may create inequalities in access to services, particularly where

compulsory exemption systems do not exist or provide inadequate safety nets for the poor (Segall et al., 2000; Ensor, 1995; Wilkinson 1999; World Bank 1999).

Even exemption mechanisms are in operation, inequalities may be exacerbated also by ineffective targeting, as well as significant administrative, economic and informational barriers to their implementation (Russell and Gilson, 1997). In low-income countries, the demand reduction effect of user fees is the source of much concern than the demand diversion effect of user fees. After the imposition of user fees, in most SSA countries, the demand for government healthcare facilities diverted to non-government facilities including a shift to informal medical care and home remedies.

Sauerborn et al. (1996) noted that one of the first strategies of coping with the costs of illness is to try to avoid these costs altogether by modifying illness perception or ignoring disease. The poor often delay seeking care until an illness is severe, which may ultimately lead to higher costs of treatment. Patients consult traditional healers or use traditional medicines available at home, or purchased from a drug seller at a relatively lower cost than at public facilities, are another frequent strategy for avoiding or at least minimizing costs (McIntyre et al., 2005; Save the Children, 2005).

To cover rising healthcare cost, households use also coping strategies such as reducing consumption, selling assets and borrowing (McIntyre et al., 2005). Russell and Abdella (2002) in their study in Ethiopia found that households used available cash to pay for health care and sale assets such as livestock and land, which are essential to their future livelihood.

In many SSA countries, there are complaints that the improvement in quality is below expectation when it is compared with corresponding increase in user fees. Moreover, very little attention has been paid to the design and implementation of effective exemption mechanisms.

Few countries in Sub-Sahara Africa (SSA) have a viable health insurance system; existing social insurance schemes, in most SSA countries, cover a negligible portion of the population. Griffin and Shaw (1995) noted that the total population insured in SSA countries ranged from .0.01% in Ethiopia to a high 11.4% in Kenya. A survey conducted by the World Bank further reveals that in 39 SSA countries it was found that 14 countries have formal insurance systems in place and another 4 countries have some kind of employer provided program, 18 have no formal system (Nolan and Turbant, 1993). Vogel (1990) characterized the prevailing government health insurance arrangements in Sub-Saharan Africa as follows:

1. Health care is financed, for all citizens, out of national revenue and provided for free at point of use, as in Tanzania;
2. Health care is financed both by general tax fund and

through cost recovery mechanisms and provided by government, as in Ghana;

3. Health care is financed through the enforcement of compulsory Social Security system for the entire formal labour market, as in Senegal;
4. A special health insurance fund for government employees, as in Sudan;
5. A discount at health care facilities for government employees; as in Ethiopia;
6. Government employees are entitled to private medical care as fringe benefits, as in Kenya; and
7. Employers are mandated to cover the health care costs of their employees, as in Democratic Republic of Congo.

In most SSA countries, public health centers and hospitals tends to be funded, by the government, based on historic budgets due to this in most public health facilities there are little accountability and built-in incentive systems for health workers and managers to boost efficiency gains in health service production (Bitran and Winnie 1998). Furthermore, in most public health facilities healthcare is provided free of charge, to improve equity and access, partly limiting the right of patients to demand timely and good quality healthcare service. Hence, in SSA countries free care and the associated inability to collect revenue from patients, has limited the ability of health workers' and managers to improve output levels, quality and input mix.

LITERATURE REVIEW

Many countries in African are undergoing public service reforms. These reforms were initiated by the quest for efficient and effective public service provision influenced by structural adjustment programs and new public management movements of the 1980's.

Most of the reforms involve restructuring of government institutions, the creation of new systems, procedures, and functions that are expected to promote efficiency and responsiveness. Similarly, the reforms in healthcare revolve around four health care provision and financing mechanisms (Table 1). These are: public provision and public financing (Cell 1); private financing and public provision (Cell 2); public financing and private provision (Cell 3); and private provision and private financing (Cell 4).

Cell 1 is a pure model of the welfare state where the state directly provides as well as finances (through taxes and other public funds) health care services free at the point of use. In this system financing and provision of health services are government responsibility (e.g. Nordic countries traditionally). The public sector has generally taken on responsibility for the delivery of services and frequently used civil service bureaucracies as the

Table1. A model of health care provision and financing.

Variable	Financing		
	Public	Private	
Provision	Public	1	2
	Private	3	4

instrument. The state owns all the relevant assets, and resources are allocated through instructions given to agents through a managerial hierarchy. Classic examples are, of course, the systems of economic organization that characterized the Soviet Union and Eastern European countries before the fall of the Berlin wall. Le Grand (1999) described the system as "command and control" or "hierarchical" system. At best, this system supplies good quality care at reasonable cost according to clinical need. However, usually there are waiting lists and it seems to encourage an impersonal style of service. At worst, it results in crowded and low quality services, supplied by ill-motivated staff in shabby premises. Patients often corrupt the professionals by private "under the table" payments (Soeters, 1997).

In cell 1 health workers receive salaries and patient has no choice of provider. This means that the incentives for providers are perverse. Efficient providers may receive as 'reward' more work but not more resources and the 'reward' for the inefficient providers may be quite life and idle resource (ibid.). In a broader way, cell 1 can be used for pure public goods such as security, street lighting, refuse collection, ground and road maintenance, local economic development in residential areas, and infectious disease control.

Tax-based financing was the principal form of health care financing in most of SSA, South Asia and former Soviet Union and much of Eastern Europe countries. There are four solid arguments for tax based public provision and public financing of healthcare services:

1. In mature economies, tax-based systems tends to be progressive, that is, households with higher incomes pay a higher proportion of their income in tax)
2. The poor are protected from large healthcare costs
3. Pure tax-based financing systems have high financial accessibility because they do not involve user fees at point of use; and
4. In low income countries, the revenue generating potential of user fees is low, due to this the scope for improving the quality and accessibility of rural primary care services is limited.

These arguments, however, challenged particularly in the situation of low and middle income countries on five grounds:

1. Tax financing system shifts the locus of decision-

making from the consumers to the government, limits consumers choice and sovereignty

2. Tax-financed healthcare services are skewed towards subsidizing urban hospital services at the expense of the rural poor and primary healthcare services
3. Tax-financed healthcare services cannot be truly accessible, particularly to the poor, due to significant time and transport costs
4. In tax-financed healthcare services, even though there are no formal charges, healthcare services cannot be widely accessible to the poor due to the prevalence of informal charges; and
5. In many developing countries, transitional economies tax-based financing systems are constrained by limited tax bases, because of that a small share of the total government budget is allocated to health services.

In cell 2, healthcare services are financed by user-fees and other sources of private finance but now they are provided by the state. Cell 2 is potentially unstable if user-fees are completely financing health care costs and payments are indeed voluntary. In this case there is less justification for the provision of health care services by the public sector. In such situation economists recommend privatization, which will result a shift from cell 2 to cell 4. Activities will only remain in cell 2 if healthcare is in joint supply with other activities in cell 1 and if their separation is technically not possible or incurs extremely high cost or a decision is taken by the public sector provider to continue to make public supply available beside private sector provision.

The impact of user fees on the poor has been subject to more argument and discussion than any of the other financing mechanisms discussed here. Albeit these arguments, the introduction of user fees in a tax financed healthcare systems has been proposed to be pro-poor for two main reasons:

1. The introduction of user fees in urban hospital services would channel subsidies to the rural poor; and
2. User fees increase resources available for healthcare and would allow governments to expand or upgrade their network of rural, primary healthcare services to make them accessible to the rural poor.

In cell 3, public financing is combined with a private delivery of services. This system is common in Canada, Japan, parts of French and Germany (Donaldson et al., 1993).

Health services are contracted out to private healthcare service providers. In this system horizontal integration of the population is achieved through universal coverage of public financing. Compared to cell 1, in this system the population has more options for the choice of providers. There are also more opportunities for autonomy, and competition among providers. In this system there is a

global public budget, just like in the public system (cell 1).

In cell 3, the role of the state is changed to more of a regulator rather than universal provider and it can be referred to two cases. First, the state makes transfer payments to individuals by means of which they can get health care services from private providers. Second, health care services are contracted out to private providers. The first essentially improves allocative efficiency since purchases reflect individual wants and willingness to pay. The second, however, does not improve allocative efficiency since decisions regarding the quantity and quality of healthcare services remain within the public domain. In this case consumers are not sovereign.

In cell 4, healthcare is financed and provided by the private sector. It is a mandating welfare state whereby the state passes legislation for mandatory health insurance coverage. This system is applied in USA where citizens are entitled to have their own health insurance coverage from private health insurance markets but there are exceptions in the case of Medicare and Medicaid, both programs are funded by the state under social insurance.

In USA, healthcare services are provided by both public and private sector, and the system is characterized by pluralism, free choice and competition. Rich countries, like USA, have changed the organization of the healthcare financing system from bilateral exchange between consumers and providers, where the consumer pay the provider fully and directly for services to trilateral exchange by introducing a formal financing organization to pool the financial risks.

Cell 4 is hardly successful in low income countries. In these countries, private insurance market tends to be limited. It is confined to politicized groups and elites, majority of the people do not have the ability to pay for private health insurance even with the existence of liberal regulatory environment. But there are some important exceptions in micro-insurance schemes, which were recently implemented in Burkina Faso, Benin, Ghana, Cameroon, Mali, Côte d'Ivoire, Guinea, Nigeria, Tanzania, Senegal, Togo, and Uganda (Denis and Johannes, 2005).

In countries such as Zimbabwe and South Africa, there are gross disparities between income groups, higher income groups tend to depend upon private health insurance. Consequently, a move to cell 4 would be progressively self-reinforcing. The political voice for more spending within the public sector can be weakened if more people are making their own insured provision of private health care. The result could be that private sector provision of the service becomes more attractive, making public sector provision residualized. In such a case the shift from welfarism to post-welfarism increases, the so called overspill model of privatization.

Post-welfarism contains elements of cell 2, 3 and 4, whereas welfare is represented only by cell 1. Consumer

sovereignty would be facilitated more by a cell ¾ hybrids, user-charges being imposed at less than full cost hence publicly financed, partial subsidies continue in conjunction with competition for consumers between alternative providers.

The shift from welfarism to post-welfarism has several threads, and it can be thought as a continuum rather than as distinct categorical shift. The query is whether the shift reaches a border short of complete post-welfarism. That depends upon the nature of individual services, particularly private healthcare service provision, whether it is complementary with or substitutes for public provision. For example, for the private sector healthcare provision, it can be argued that it would not be profitable to treat all medical conditions, particularly the chronically sick and terminally-ill, in this case the shift will reach a natural limit.

The shift from welfarism to post-wefarism can also be encouraged if the informal sector of the economy takes on a growing absolute and relative responsibility for such provision to ease restraints on government expenditure. For example, provision of residential care places by local government for the elderly can be limited by fiscal stress. Usually, this happens when there is a structural gap between revenue collection and expenditure pattern of the government; consequently, government would have difficulties to finance the rising costs of public service provision with available revenue. To fill this gap families and local community voluntary organizations will take on more responsibility for care of the elderly, to cope up with an aging demographic structure. Governments encourage such moves by tax reliefs and other fiscal incentives that would lead to a progressive shift from cell 1 (or cell 3) to cell 4 in Figure 1, as demonetization and/or re-domestication of service provision takes place.

METHODOLOGY

This study was conducted in 2016 during a six months period from February to August. In the data collection process, senior Public Administration students of the College of Business and Economics were involved. The students were advised to conduct research on health care financing in SSA with special emphasis on Eritrea, as part of their senior research project. In this study both survey and case study methodologies were used.

The case study and survey methods are not mutually exclusive; hence, one could have a case study within a survey or a survey complementing a case study (Hakim, 1987; Dancey and Reidy, 1999). The study adopted descriptive and explanatory case study methods in the analysis of health care financing in Eritrea.

The case study method has an advantage of using multiple sources and techniques in the data collection process, for example; documents, interviews and observations. Survey is the appropriate mode of enquiry for making inference about large groups of people based on the sample drawn, relatively small number of individuals, from that group (Marshal and Rossman, 1995). Further, surveys provide rapid and inexpensive means of determining facts about people's knowledge, attitudes, beliefs, expectations, behaviours,

etc.

Primary and secondary data were collected for the survey and case study design. Primary data was collected through interviews and observations. Interviews were conducted with 35 key government officials and development partners (10 MOH officials, 10 physicians, 5 officials from development partners (donors), and 10 local government officials). To check, the reliability of data and information gathering respondents were asked similar questions at different times.

Secondary data was collected from the archives of the MOH (documents, publications, and annual reports); reports of the World Bank, international monetary fund (IMF), WHO, United Nations Children's Fund (UNICEF), United Nations Development Programme (UNDP); and reports of Eritrea's Demographic and Health Surveys.

Thus, the secondary data was collected from various sources inter alias relevant books and journals, international and national health reports, published and unpublished documents. This study is the first of its kind in Eritrea. So far there is no much research on health care financing in Eritrea and in most SSA countries country specific studies are lacking.

This study, therefore, fills the gap and paves the way for further research on health care financing in developing countries.

RESULTS

Through an interview and observation, the study investigates the key challenges and opportunities, provider payment mechanisms and revenue collection systems of Eritrea's healthcare system. It reviews also the existing health care financing policy of the GoSE. The key challenges identified include shortage of skilled human and financial resources, non existence of insurance markets and insufficient knowledge of insurance scheme, and poor referral mechanisms.

The opportunities include high government commitment, community participation, existence of good health care infrastructure, introduction of cost sharing systems and willingness to pay for quality health care services. The provider payment mechanisms include line item budget, global budget, fee for service, case based payment, capitation, per diem, and salary. The study assesses also different revenue collection systems, such as tax funded national health system, user fees, tax funds plus social health insurance, cost sharing plus tax funded, community health insurance and private health insurance.

Review of existing healthcare financing policies of the GoSE

Eritrea's national health policy intends to ensure equity and accessibility to essential services at an affordable cost for majority of the population, in accordance with the Universal Health Coverage principle. Maternal and child health issues got high priority in the national health policy with an intension to meet MDG targets and beyond. Attention is also given to communicable and non-

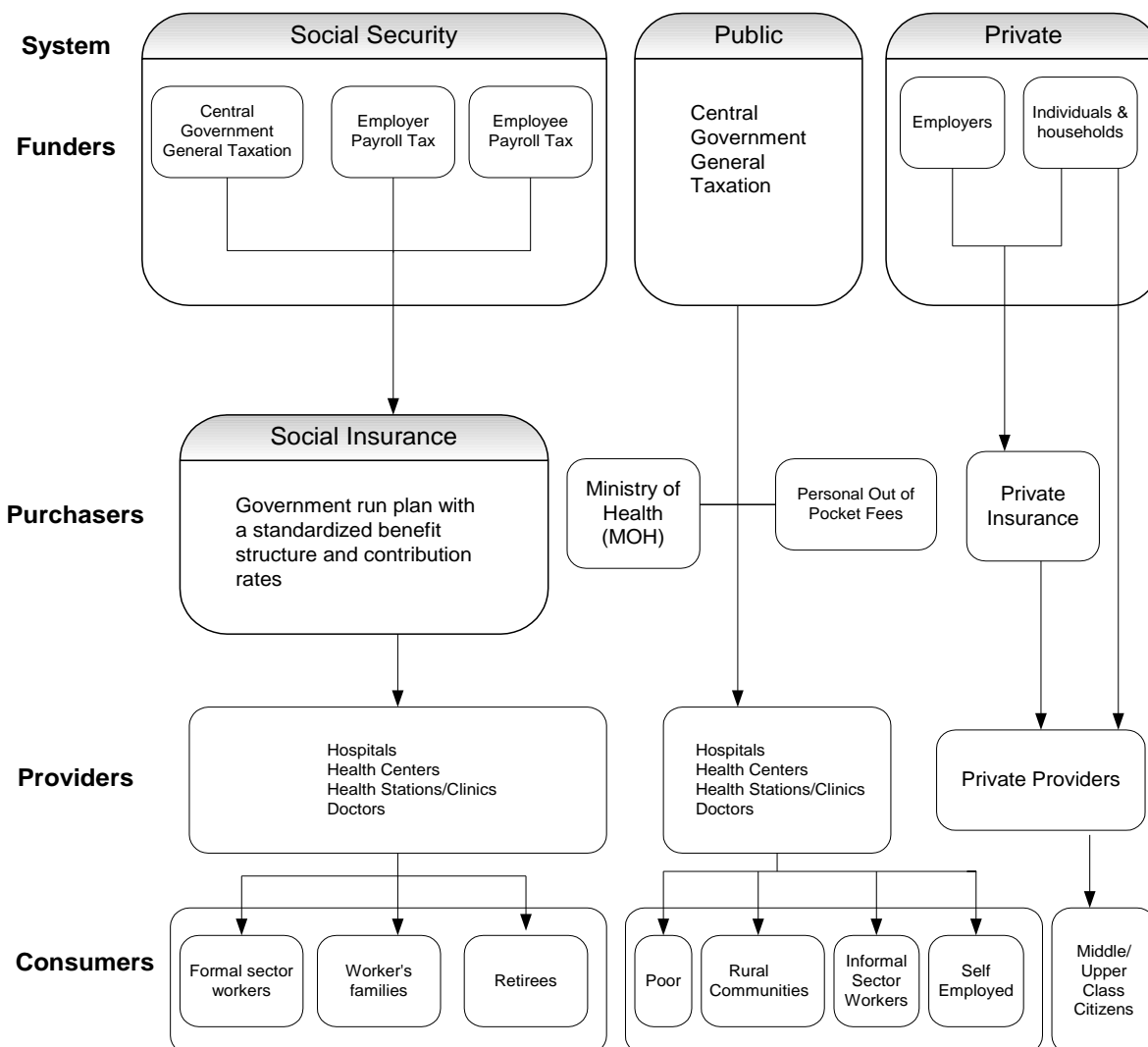


Figure 1. Proposed model of innovative health care financing system for Eritrea (Source: Based on Habtom (2006a)).

communicable diseases, as well as strengthening health system components. The health care financing policy of the GoSE, therefore, emphasizes on:

1. **Service specific exemption policy:** Service specific exemption to certain illnesses or services. These are antenatal services, well baby services, immunization, leprosy, tuberculosis, mental illness, sexual transmitted diseases (STDs), human immunodeficiency virus infection and acquired immune deficiency syndrome (HIV/AIDS), emergency cases for first 24 h, injuries from explosives and health education. In addition, those who can obtain a certificate of indigenes from the local MOLG office will receive free care. The cost of their care, however, will have to be paid by the local government, which issued the certificate.

2. **Non-discretionary exemption policy:** The GoSE uses none-discretionary exemption criteria such as gender, age, region, and type of service, as they are less likely to affect access of the poor to health services. The discretionary criteria, such as income and physical assets are difficult and costly to administer in Eritrea.

3. **Income specific exemption policy:** Waiving user fees for the poor, who possesses indigent certificates. Indigence certification has specific requirements:

a. An applicant for the indigence certificate should be a resident of the zone/sub-zone at least for the previous six months and should not earn a monthly income of approximately more than 500 Nakfa (at local exchange rate US\$ 33.33). In rural areas a person/household with no ox for farming would be considered eligible for

Table 2. Pro-poor health care policies in Eritrea.

Disease targeting	Geographical targeting	Cross-subsidies	Exempting the poor
Focus on the burden of diseases of the poor: malaria, tuberculosis, HIV/AIDS, diarrhea, respiratory infections, malnutrition, diabetics, hypertension and reproductive health.	Focus on rural areas; Larger subsidies to primary level health care facilities (health centers and health stations).	Higher mark-up and co-payments on diseases with lower levels of priority; High subsidies for maternity and child health services; Free immunization and oral dehydration therapy as well as promotion activities	Exemptions left to the discretion of local governments; Exempted categories include widows, orphans, elderly, disabled, and the destitute

Source: Habtom (2006a).

indigence certificate.

b. The applicant's claim of indigence has to be confirmed by a testimony of three individuals who are residents of the particular sub-zone (area administration).

c. Effective from the date of issuance, the waiver certificate is valid for three months.

Health officials stated that the MOH has nothing to do with the issuance of indigent certificates; it is the responsibility of the local government. In the new proposed health care financing policy, it is clearly stated that local governments are responsible for health care costs of all the patients who are duly certified by them as indigent.

4. Credit schemes: For non-indigent citizens (formal and informal sector employees) care is provided on credit basis. In patients pay a deposit of 500 Nakfa² when they are admitted into the hospital. On discharge from the hospital, they settle the bill. In cases of shortfall, they are made to pay the difference, and if the deposit is greater than the actual bill, they get a refund. For people obtaining care with a "sick report", the bill is sent to the respective employing organization. The employer deducts the fee from the salary of the individual and sends it directly to the central treasury. The hospital is notified of the payments made to the treasury office by a letter from the employer.

5. Pro-poor health care policies: A question was asked to public health officials, in the MOH, if other policy instruments are available to help the poor in Eritrea besides the waiver mechanisms. The director of public health service stated that there are many pro-poor primary health care programs in Eritrea; HAMSET project is one of them. HAMSET project focuses on the prevention of four diseases (HIV/AIDS, Malaria, Sexually Transmitted Diseases and Tuberculosis). There are also other programs like expanded programs of immunization, health education, and family planning. Pro-poor health care policies, in Eritrea, include cross-subsidization of basic health packages, selective intervention (disease

targeting), geographical targeting (focus on rural areas), and exemptions for the poor. Table 2 illustrates the pro-poor policies of the government of Eritrea. Cross-subsidization of basic health packages for the poor is an important health policy in Eritrea. In a situation of limited financial resources, it is important to base the allocation of public health funds to cost-effective programs. About 54% of the respondents replied that basic health packages for the poor are moderately subsidized, and 31% replied that they are highly subsidized. Officials in the MOH explained that basic health packages for mothers and children (for example, immunization, delivery, antenatal and postnatal care etc.), and for the poor and elderly are highly subsidized. This is in line to the World Bank argument that poor countries must target their resources to the poor so that they can obtain some meaningful health care (World Bank, 1994b).

6. Efforts towards universal health coverage: According to the universal public system, everybody should get all the care he/she need, when he/she need it, on equal terms and conditions, without financial barriers. But this is a statement of principle; in practice healthcare services are rationed according to relative need or according to ability to pay. In Eritrea, the drive for equity in healthcare provision calls for universal coverage, with care provided according to need rather than according to ability to pay. In principle, no one should be left out, no matter how poor or how far they are. In a situation where all cannot be served, those most in need should have priority. Here lies the "all" in the health for all mantra. In Eritrea, this is the basis for planning health services for defined populations, and for determining different needs in all administrative regions.

Assessment of revenue collection systems

The prevalence of a high burden of disease in Eritrea challenges the public health system both in financing and provision. The GoSE is looking for alternative sources of finance for health care. Free health care policy failed to warrant service quality and long-term sustainability.

In due course, the GoSE introduced user fees to support the strained public health facilities. Revenue

²Nakfa is Eritrea's national currency.

collection through user fees (cost-sharing) was supported by 30% of the respondents, tax funded national health services by 50%) and social health insurance by 20%. Most respondents argued that user fees rationalize the use of resource by freeing up highly expensive technology and personnel for more complex referred cases. The management of less costly services at health centers would make easy the task of combating preventable diseases and hospitals would not be squandered on easily detectable and treated illness. Equity could also be served by introducing progressive user fees. A combination of cost recovery systems (general taxation, social insurance, private health insurance and limited out of pocket user charges) may be preferred to ensure financial sustainability of the public health system in Eritrea. However, cost sharing would be successful only if it led to immediate and measurable improvements in access and quality of health services.

Currently, in Eritrea, at the level of health station and health center, the flat rate charges are inclusive of registration and consultation, treatment and where available, of laboratory services at the health center level. A one-time payment entitles the client to a free care for a month regardless of the episode of illness. The registration and consultation fees are lower at regional and sub-regional hospitals than at national referral hospitals (tertiary hospitals).

In hospitals, fees are levied for procedures (operation, delivery etc.), investigations (laboratory, X-ray etc.), and drugs besides to registration and consultation fees. Fees for laboratory and x-ray services did not include labour and capital costs (depreciation of equipment and building). The fees were set on the basis of costs of consumable items such as chemicals reagents, films etc. The way fees are set made a difference to their acceptability. In some contexts, people have shown that they are more prepared to pay for drugs and dressing than for 'registration fees'. Drugs and dressings account for a relatively high proportion of health expenditure in Eritrea (about 28% from 1994 expenditure data). They are thus an attractive basis for a cost recovery policy.

Health insurance (social and private) is another possible source of finance for the public health system in Eritrea. The plan for the introduction of national health insurance was clearly specified in the government's macro-policy, which was issued in 1994. Despite the government's policy 63% of the respondents stated that no bold action has yet been taken for the introduction of social insurance scheme whereas 37% replied that there are some government concerns for the introduction of social insurance some time in the future. Public health officials, in the MOH, underscored the importance of social insurance in the health sector and maintained that the government's intention is still towards that direction. As 70% of the Eritrean people live in rural areas and depend for their livelihood on subsistence agriculture

social insurance will be applied only to urban dwellers who are employed in formal sector jobs.

The development of efficient private health insurance system, in the short-run, is highly unlikely in Eritrea. The lack of supply and purchasing power are the main problems. Insurance cannot be created without a healthcare market. The private health sector is underdeveloped in Eritrea. Unlike in advanced economies private health insurance markets in Eritrea may face also problems of adverse selection and moral hazard. In private health sector neither the doctors nor patients may have any incentive to economize on treatment, and insurance companies may face difficulty in distinguishing between good and bad risk individuals.

Assessment of provider payment mechanisms

Although there is no single optimal method for paying providers, three provider payment mechanisms were selected by most respondents. These were line-item budgets (40%), global (lump sum) budget (70%) and retrospective fixed fees per case or per inpatient day (28%).

The method of payment of providers has an effect on access, efficiency and quality. For example, hospitals and physicians, under the fee-for service, have an incentive to deliver more units of service with little regard to medical need. If payment to hospital is based on actual number of beds occupied, they have an incentive for increasing the patients' length of stay per admission; to keep their beds fully occupied. Hence, all methods have some advantages as well as disadvantages, and the desirability of a specific approach depend upon the social, economic and institutional context of a particular setting.

Most respondents stated that mixed forms of provider payment mechanisms are superior to reliance on any single method because they are more practical and allow a tradeoff of administrative costs and desirable incentives. Different payment mechanisms can be combined to foster the provision of some form of treatment while providing other services in a more restrictive way (for example, fee-for-service plus basic salary for preventive and health promotion services).

The payment to hospitals can also be a combination of prospective budget, a fee for service, or a charge per day, per admission, or per diagnosis-related group. A fee for service, capitation, or salary system can be used to pay physicians in a combined or single form depending on the working conditions.

In low-income countries like Eritrea, complex fee-for-service or case-based reimbursement schemes are not appropriate (Barnum et al., 1993). Fee-for-service and case payments are not the best way to reimburse for the public health and primary services appropriate to the epidemiological environment (high rate of communicable

diseases, high fertility, and high infant mortality) in most poor countries (ibid.).

The schemes require also greater degree of resources and training. With proper quality monitoring, prepaid capitation schemes or straight global budget can have an important role in low-income countries. For middle income countries with more developed institutions that are partly through the epidemiological transition, the benefits of relatively simple service based or case-based reimbursement-especially in the institutional context of competitive provision of services--begin to outweigh the administrative costs of the systems.

Key challenges of Eritrea's healthcare system

Shortage of financial resource

About 70% of the respondents stated that shortage of financial resources is the major challenges of the Eritrean healthcare system. Most health facilities in Eritrea are reported to be experiencing a shortage of funds (World Bank, 2003). The user fees collected are not sufficient enough to recover recurrent costs, and none of the revenues collected are retained at the health facilities. The respondents further noted that there is uneven distribution of financial resources between preventive and curative health services. About two-third of the recurrent budget is consumed by hospitals, which provide mostly curative services. Primary level health care facilities have shortages of financial resources. In Eritrea about 90% of the recurrent health expenditure is spent on curative health services. The amount of funds allocated to community and preventive services was not adequate, which was 1.3 and 18%, respectively (Shaw, 1999). This was not in line to (primary health care) PHC policy, which advocates for private financing of tertiary health care services and public financing for public health and essential clinical service packages.

Shortage of skilled human resource

In Eritrea, there is huge gap between the demand for and supply of health personnel. The human resource gap, in the Eritrean health sector, can be explained by the following two factors:

1. Since independence, the GoSE rapidly expand health infrastructure to cater national health needs has led to a high demand for health personnel; and
2. The increase of non-communicable diseases combined with the burden of communicable diseases demand a higher level of skilled personnel to provide specialized services.

In essence, the current issue is not only numbers but

also competency and the right mix of the health professionals that are able to respond to current, emerging or re-emerging health conditions in Eritrea. About 75% of the respondents stated that shortage of qualified medical personnel, in the short-run, can be addressed by three ways:

1. Active recruitment of health personnel from urban to suburb/rural areas with adequate pay, benefits and other incentives.
2. Recruitment of expatriate staff from Far East or other developing countries; and
3. Staff substitution.

According to the MOH annual activity health report in 2002, about 27% of the physicians, 3.4% of the nurses and 5.9% of the associate nurses are working in administrative areas. Physicians in hospitals commonly perform management functions that could be more effectively and cheaply filled by trained managers who are not physicians.

High burden of disease

The prevalence of a high burden of disease in Eritrea challenges the public health system both in financing and provision. Preventable diseases are still responsible for about 70% of the burden of diseases in Eritrea. Communicable and nutritional deficiency diseases such as diarrhoea, acute respiratory infections, tuberculosis, malaria, HIV/AIDS, skin and parasitic infections are the major health problems facing the poor in Eritrea. In 2002, these diseases were responsible for 60% of outpatient, 40% of inpatient incidences and 56% of inpatient deaths. About 65% of the respondents stated that the free health care policy in Eritrea will not warrant service quality and long-term sustainability as long as there is high burden of diseases in the country. As documented by the WHO, developing countries bear 93% of the world's disease burden, yet merely account for 18% of world income and 11% of global health spending (Denis and Johannes, 2005).

Limited health insurance coverage

Health insurance in Eritrea is currently restricted to compulsory work-related accidents insurance for employees in companies of 100 or more, and a very small number of health cover supplements to private accidents and injury policies. The National Insurance Corporation's (NICE) mandate is a commercial one. Although the company is considering new products for private health cover, these are likely to appeal to a very small number of people. A social insurance mechanism, with premiums related to income and not to risk, and with

cost sharing between employer and employee, is outside the mandate of the NICE. With a formally employed workforce of about 33,000 and no pre-existing social welfare fund, substantial investments are needed to establish comprehensive social health insurance in Eritrea. This financing option should not be considered as a short-term proposition because comprehensive social health insurance is a new concept in Eritrea and it will take time for such schemes to gain acceptance.

Non-existence of insurance markets

Without healthcare, markets insurance cannot be created. In developing countries like Eritrea, insurance involves high transaction costs. In Eritrea, about 69% of the population live below the poverty line (UNCDF, 2001) and about 70% of the population live in rural areas and depend on subsistence agriculture for their livelihood. Eritrea's large rural and informal sector populations limit the expansion of formal insurance schemes. Health insurance schemes, which intend to cover the rural population and informal sector, will be confronted with low and irregular incomes and high transaction costs. Furthermore, infrastructure, communication and transport networks are minimal (or absent) in most rural and suburb areas in Eritrea. In rural areas there are no banks, no post office or mail services, no roads, and no telecommunication equipment. As a result, transaction costs are high, for example, to collect contributions, file and process claims, register and renew membership, keep members informed, and recruit new members. Griffin and Shaw (1995) identified five causes for high administrative and sales costs for insurance markets in rural areas and in the informal sector economy. These are:

1. Difficulties to identify and insure groups (as opposed to individuals) to minimize adverse selection
2. High transaction costs to collect premiums because lack of a regular income stream or banking system
3. The high cost of credit (which is typically rationed).
4. The high cost of controlling claims in a dispersed population and
5. The lack of reinsurance markets. Development of insurance in less developed countries, especially in rural areas militated by the aforementioned factors.

Insufficient knowledge of health insurance schemes

Many people in Eritrea simply do not understand the concept of health insurance. It takes time to explain the concepts of risk sharing and insurance. The idea of handing over money that will be used to pay for other peoples' health care is hard to explain-and to absorb.

Their main fears are about paying money for nothing, that is, if they are not ill, and paying for others, especially the very poor who are sick more frequently than the better off. Particularly for traditional rural communities, paying money in advance for health care means inviting diseases or bad luck for the family. In rural areas, there is a pervading culture of fatalism that resists cover as a result most rural communities are not used to taking personal responsibility for their health.

Large informal sector and rural populations

Eritrea's large informal sector and rural populations limit the taxation capacity of the government, which in turn delays the emergence of social insurance schemes with government subsidy. Preker et al. (2004) pointed out that to meet a target of 3% of GDP health expenditure through formal collective health care financing channels, it would take 30% of government revenue and this would be hard if a country's taxation capacity is below 10% of GDP.

In developing countries like Eritrea, public expenditure on health care is much lower than this, often not surpassing 10% of public expenditure, which means that less than 1% of GDP of public resources is available for the health sector (Preker et al., 2004; Weber, 2004; Diop et al., 1995).

Pooling of financial resources in low-income countries has typical problems. Pooling requires some transfers of resources from healthy to sick, rich to poor, and gainfully employed to inactive (Preker et al., 2004). In low-income countries there is problem of tax evasion, particularly by the rich and middle classes in the informal sector, higher income groups tend to avoid contributing their share to the overall revenue pool (ibid.). Without sharing of risks and pooling of revenues, low-income populations will be exposed to serious financial hardship at times of illness (Diop et al., 1995).

Poor referral systems

In Eritrea hospital entry is a matter of proximity, rather than the appropriateness of the classification, and that most inpatients in upper-level hospitals in most urban areas are admitted directly. Patients often bypass lower level health care facilities and continue to use more costly hospital services for common and mild illnesses. As long as patients believe that health service are better at higher level hospitals bypass fees would have little effect on maintaining the referral system. Many patients said that better services are available only in hospitals; lower level health care facilities do not have adequate staff and diagnostic equipment. A survey in 2005 shows that the main reason for patients bypass of primary level health

care facilities was related to service quality: 54% of the patients responded that diagnostic tests at lower level health care facilities are not available, 21% health workers at lower level facilities are incompetent, 15% drugs are not available at lower level facilities, and 10% other reasons (Habtom, 2006a). Overcrowding in referral hospitals and underutilization of lower level health facilities could be partly attributed to lack of adequate staff and services at lower level facilities (MOH, 2001).

Lack of information about care possibilities

The main problem in Eritrea is that even in the absence of user charges, access to healthcare services are not equal due to non-monetary factors such as distance, travel time and lack of information about the possibilities for professional healthcare services (Habtom, 2006a). Lack of resources not only inhibits demand but also people's awareness about health care services. About 80% of health officials stated that in most rural areas, when people are sick, they look to traditional medical practitioners and traditional recipes, not modern, professional health care institutions. Rural people look for modern healthcare services only as a last recourse. By then, illness is severe, and treatment costs are high.

Disease ignorance

Most of the poor people in Eritrea cope with the rising costs of healthcare services by modifying illness perception or ignoring disease. The poor often delay seeking care until the disease becomes severe, eventually it may lead to higher costs of treatment. Self-treatment using allopathic or traditional medicines available at home, or bought from a drug seller at a relatively cheaper price than at public facilities, are another common strategy for avoiding or at least reducing healthcare costs.

Existing local opportunities for healthcare financing system in Eritrea

Community participation

Community participation is the empowerment of the people to effectively involve themselves in designing policies and programs and creating the structure that serve the interests of all as well as to effectively contribute to the development process and share equitably in its benefits (Habtom, 2016b). One of the key success stories of Eritrea's development process is its ability to motivate and mobilize communities to participate in the planning, design and utilization of development

programs, including those related to health. Community participation is a credo of the GoSE development strategy.

High government commitment

The GoSE Health Sector Policy emphasizes on equitable provision of basic health services to all people, regardless how poor or far they are. The government gives high priority to the control of infectious diseases, especially Tuberculosis, Malaria, HIV/AIDS, and Sexually Transmitted Diseases (STDs), as well as the reduction of maternal mortality. The government focuses also on the improvement of the quality of health services through increased availability and accessibility of human and nonhuman resources.

Existence of good healthcare infrastructure

The GoSE adopted a stratified three-tier national health care delivery system. The system is well coordinated in a hierarchical structure and it is proven to be capable of meeting the needs of the Eritrean communities at all levels. At the bottom of the hierarchy there are primary level healthcare services, which provide basic health care package services. Primary healthcare consists of community-based health services with coverage of an estimated 2,000 to 3,000 people.

The key delivery agent is the community health worker led by the Village Health Committee. In addition health stations offer facility-based primary health care services to a catchment population of approximately 5,000-10,000. Through primary healthcare services the government empowers and mobilizes communities to tackle resources constraints.

At the middle of the hierarchy there are also Community Hospitals, which are the referral facility for the primary health care level of service delivery, serving a community of approximately 50,000-100,000 people. Community hospitals deliver obstetric and general surgical services with the aim of providing vital life-saving surgical, medical and other interventions, in addition to all the services available at lower level facilities,. At the top of the hierarchy there national referral hospitals (tertiary hospitals), which are the referral facility for all regional hospitals.

The MOH estimates that access to health service (within 10 km radius or 2 h walk) has improved from 46% in 1991 to 70% in 1999. Official reports of the MOH further indicated that more than half of the Eritrean population lives within 5 km from a health facility. In line with the expansion of health facilities the respondents were asked about the availability of basic drugs in public health facilities. About 64% of them stated that essential

drugs are available; only 36% explained some shortages.

Introduction of cost sharing system

The MOH has been aware at the outset that it could not provide free health service indefinitely. In February 1996, the MOH introduced user fees (registration fees, and daily hotel fees) at all public health facilities. The fees were introduced in order to: provide substantial subsidies for primary care; charge patients the full costs of care at tertiary facilities; and encourage patients to use the referral system appropriately. The user fees were designed in a sliding scale with the highest fee being paid at secondary and tertiary hospitals and lowest at health centers and health stations. Health centers and health stations charge only flat nominal registration fees, which serve for one month. Central and regional hospitals charge patients for investigation, procedures, registration and treatment at a rate close to nominal fee. The low socio-economic status of the population at independence plus the then existing devastated health infrastructure compelled the government to provide health services to the people at a nominal cost or free of charge (MOH, 2001). When health service is provided at free or nominal fees to everybody it typically leads to rationing of expensive services and restriction of choices.

Willingness to pay for quality healthcare services

Fees increase should correspond to quality improvements, which means that value for money. It is unfair to ask people to pay, or to pay more, for the same service, they use less of it. The rural poor are more sensitive to price increases than other groups. To keep utilization up to previous levels-or even to increase them- people has to see that their extra payment are being used to improve the service they are getting, for example, extension of opening hours, ensuring availability of basic drugs, medical equipment, etc. Many people will prepare to pay more for their health care if they think that they will get a better care. In the new proposed health care financing policy there are plans to improve the current quality, efficiency and equity levels by 50-60%. There are also plans to decrease clients bypass the referral system by 60%, so that clients will be encouraged to use the preventive health care services and discourage the use of expensive hospital care services for common and mild illnesses.

DISCUSSION

Designing innovative pro-poor health care financing system in Eritrea

In the developing world health care financing continues

to be a challenge despite tremendous government efforts to improve funding of public health services. Many low- and middle-income countries are still far from achieving universal health coverage. Eritrea is not an exception; the health care financing system in Eritrea is often inadequate leaving many poor people without access to the most basic health services.

In Eritrea, government taxation capacity is not strong, formal mechanism of social protection for vulnerable populations are not adequate, and government oversight of the informal health sector is lacking. Public services in rural and low-income urban areas are often plagued by understaffing, supply shortages, and low-quality care due to this the poor and majority of the rural populations frequently seek care from traditional medical practitioners .In most instances the need for collective arrangements and strong government action in health care financing is often confused with public production of services.

Eritrea's health care financing system is closely associated with the welfare ideology of the government. Health care financing remains the main responsibility of the government. There are no health insurance schemes in Eritrea that facilitate involvement of the private sector. In the absence of health insurance, the government has been striving to finance the health system by leaving resources from households (either in the form of general taxation or user fee).

As government funds are limited health care must compete for its share with many other worthy programs, such as economic development, roads and transportation, communications, and education. Alternative sources of revenue should be sought as the existing budgetary resources are not adequate to finance the public health system. With the existing user fee policy the MOH recovers only 10% of its current expenditure on health care. The fees charged are much lower than the actual cost (MOH, 2001).

The mismatch between current health expenditure and cost recovery, and the growing demand for health care creates a stress in the public health system. Most health facilities in Eritrea are reported to be experiencing a shortage of funds (World Bank, 2003). For example, the *Gash-Barka* zonal health team in 1997 reported that nearly 65% of the budget allocated for health is consumed by the three hospitals in the region, and even this amount is considered insufficient for efficiently running them.

In 2008, Eritrea's total per capita health expenditure was US\$10; compared to international standards it was very less. About 45% of total health expenditure come from government general expenditure and the remaining 55% coming from private expenditure in the form of household out-of-pocket payments (Kirigia et al., 2012). The external resources for health accounted for 61% of total expenditure on health in 2008; that is channelled through public and private sectors (WHO, 2011).

The degree of interaction between different financing mechanisms would determine the extent to which the financing system as a whole is pro-poor or not. For example, if a tax funded system for those outside of formal sector employment co-exists with a social health insurance system for those people employed in the formal sector, then the equity effects depend largely on how well funded the tax-based system is and whether it can deliver a similar package of benefits to the social health insurance system.

In a situation of limited financial resources, different criteria could be used to allocate investments in health. Policy makers, practitioners and health administrators frequently ration scarce financial resources on the basis of one criterion or another. The desirability of alternative financing mechanisms clearly depends upon many factors including ability to generate revenues, administrative efficiency and acceptability to the population. However, it is known that there is no single (or perfect) financing mechanism, either for raising revenue or in allocating expenditure. There are positive and negative to each method, which need to be balanced. In most of the cases a mix of finance is preferable, but the right mix is difficult. For middle-and higher income countries a combination of social insurance, general taxation, private health insurance, and limited out-of-pocket user fees can be the preferred health-financing instruments; where income is easily identifiable, taxes and premiums can also be collected at the source (Preker et al., 2004).

In the social insurance scheme, the public system may cover only certain groups of people, normally those who are in the formal sector jobs (see the proposed mode in Figure 1). Initially social insurance plans can be used to cover health care costs for citizens with regular payments such as civil servants and other salaried employees in formal sector jobs, and later can be extended to the poor and the elderly.

More than 70% of health service providers and almost all health policy makers emphasized the importance of social insurance. In the proposed model social insurance is designed to cover the formal sector workers and better be achieved by a compulsory means. The government-run social insurance scheme will collect premiums from three sources: payroll taxes on employees, payroll taxes on employers, and a contribution from general taxes. Furthermore, to prevent moral hazard and unnecessary treatments, fees will be charged to people with health insurance, which are known as co-payments or deductibles.

But it is obvious that when social insurance coverage is limited to formal sector employees and their families, the poor are going to be excluded because either they are unemployed or are in the informal system. The poor are also excluded if benefits are limited to inpatient care because most of them live in rural areas or periurban slums, far from the public hospitals that are dis-

proportionately used by the middle and upper classes. If coverage is universal and benefits are generous, rationing is normally achieved through waiting lists. Again, the poor are discriminated against, because upper-income groups are more effective in bypassing waiting lists. In the proposed model, however, it is assumed that a well developed private health sector in conjunction with public and private health insurance and/or user fees will attract the upper and middle income citizens and eventually public health facilities will be easily accessible to the poor.

As can be seen in Figure 1, public health facilities, which are run by the MOH, will provide health care services to the poor, rural communities, informal sector workers and self-employed people. Public health facilities will be financed through general taxation and user fees. At the same time the government has the responsibility to ensure that the poor is not denied health care; this is compatible with the argument that health care is a "basic fundamental right".

The main issue in the proposed model of health care financing system in Eritrea is that the government should reduce responsibility for paying for services that provide few benefits for society as a whole and to exempt the government from providing services for the rich. The typical problem with the Eritrean healthcare financing system is that it subsidizes the wealthy who could afford to pay for their own services, and thus leaves fewer government resources for the poor. The policy package for the proposed model of health care financing includes:

1. Introduction of user charges combined with measures to protect the poor from the adverse effects of these costs.
2. Promotion of health insurance schemes to cover cost of medical treatments for an increased proportion of the population. Compulsory coverage of all formal sector workers is proposed together with measures to ensure competition between insurers so that schemes are low cost.
3. Full utilization of non-government resources. Encouragement and incentives should be given to the non-government sector, including missions and non-profit making organization along with private practitioners to provide services for which consumers are willing to pay.
4. Decentralization of planning, budgeting and purchasing to counter internal inefficiency. Introducing market incentives; by allowing collection and retention of user fees at the point of service. Local units providing direct services to people should be given more responsibility in determining how collected funds and money from central government will be spent.

Most officials in the MOH supported the proposed policy package of health care financing system in Eritrea. Health officials in the MOH stated that the local

government should have a role in the finance of health care and should cover the health care costs of the poor with indigent medical certificate. About 68% of the respondents supported the idea that local government should retain a portion of the user fees to finance health care costs of the poor and other community health services.

User fees and private insurance schemes can be used to finance private health services. User fees may rationalize the use of resource by freeing up highly expensive technology and personnel for more complex referred cases. The management of less costly services at health centers would make easy the task of combating preventable diseases, and hospitals would not be squandered on easily detectable and treated illness. Equity could also be served by introducing progressive user fees. The introduction of user fees may shift many upper/middle income groups into the private sector and that will make government health facilities easily accessible to the poor at a reasonable cost. At the same time the MOH should enhance its regulatory capacity to make sure that health care service providers are maintaining acceptable quality standards and service procurers (financing organizations) are managing adverse-selection.

Conclusion

In Eritrea, health care services are mainly financed by the government. Social and private insurance systems are not developed in Eritrea. Underdevelopment of health insurance schemes constrains effective public-private mix in health care financing system in Eritrea.

Due to this in Eritrea, health spending overall, and public sector health spending, remains low by international standards. Most health facilities are reported to be experiencing a shortage of funds. The MOH should revise its cost recovery plans of 1996.

In the 1996 pricing policy, fees were designed to provide correct signals for the direction of the use of health care and health sector resources. One of the most commonly cited reasons for imposing user fees were to provide signals that discourage unwarranted use of services that have high cost but comparatively low benefits. However, in practice neither recurrent costs were sufficiently recovered nor patients were discouraged from bypassing primary level health care facilities. Several reports of the MOH indicated that the costs recovered through user fees are not more than 10% on the average. Reports of the MOH on bed occupancy rate showed also overcrowding in national referral hospitals, which is an indication of under utilization of lower level health care facilities.

To overcome the shortcomings of the 1996 health care financing policy, the MOH recently revised its health care

financing policy. A new health care financing policy was drafted in 1998, but it has not yet adopted because of the recent border war with Ethiopia. When the draft policy is ratified and becomes operational, the cost recovery of the recurrent expenditure is expected to increase by 40%.

Participation of communities in their own health care service is also expected to increase by 70%. In the proposed health care financing policy emergency cases for the first 24 h, hazardous and contagious disease, and patients with indigent certificates are entitled to get free medical care.

As the MOH is embarking on new pricing and cost recovery strategies, there is a need for a closer look of its effects on consumers, particularly on the poor and vulnerable groups. The health care financing policy should be assessed in light of current and projected health sector needs, together with estimated financing sources and the expected roles of the government, external partners and the private sector, within the context of the country's high poverty rate, in order to not to lead to a decrease in utilization of services by the poor.

Taking into account the current economic situation in Eritrea, the scope for increasing health fees be restricted to the higher income households. Significant increases in revenues from user fees increases may not be realistic, given the country's high poverty rate. From a poverty-related perspective, the most worrying aspect of current healthcare financing system in SSA countries is the large share of out-of-pocket payments. Concerns about the negative impact of user fees on equity have been growing throughout the 1990s.

In Eritrea, ways to increase efficiency need to be explored, and priorities in interventions and services assessed and established. To this end, Eritrea should develop a healthcare financing system that can sustain and improve health service delivery to the whole population regardless of patients' financial status. Hence, the GoSE should focus on:

1. Increasing healthcare financing system by mobilizing more resources into the sector.
2. Restructuring the National Health System in such away that it comprehends community based health insurance schemes to allow better coverage of the grass root population.
3. Developing mechanisms for financial protection, which ensures that all those who need health services are not denied access due to inability to pay and the livelihoods of households' should not be endangered due to the costs of accessing health care. This indicates that there is a need for the separation of health care financing contributions or payments from service utilization, which requires some form of pre-payment (health insurance or government taxes).
4. Designing progressive healthcare financing system, where those with greater ability-to-pay contribute a higher

proportion of their income than those with lower incomes.

5. Promoting cross-subsidies in the overall health system, that is, the healthy subsidizes the ill and the wealthy subsidizes the poor. To this end the government should reduce the fragmentation between and within individual financing mechanisms and develop a system to allow cross-subsidies across all financing mechanisms.

6. Developing a healthcare financing system that promotes universal access to health services. A system whereby all individuals are entitled to benefit from health services via existing financing mechanisms and value for money is guaranteed.

CONFLICT OF INTERESTS

The author has not declared any conflict of interests.

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