SJ Insight
Vol. 2 No. 10 (2025): October 2025 Issue
https://doi.org/10.51168/insights.v2i10.52
Original Article

Relationship between policy communication and Health Service Delivery in West Pokot County, Kenya. A cross-sectional study.

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Abstract

Background

The study aims to examine the relationship between policy communication and Health Service Delivery in West Pokot County, Kenya.

Methodology

This study employed a descriptive, correlational, and cross-sectional survey design. A mixed-methods approach was utilised. Data collected was edited, coded, and later analysed using the Statistical Package for Social Sciences (SPSS) version 25 computer programme.

Results

The majority of respondents were female, accounting for 56.0%. Policy communication was found to have a moderate positive correlation with health service delivery ($r = 0.315$, $p = 0.004$). This indicates that clear, timely, and effective Policy communication had a moderate, yet statistically significant, influence on health service delivery ($\beta = 0.145$, $p = 0.029$). Policy communication in West Pokot County is generally limited and ineffective, as indicated by the overall mean score of 2.43 (SD = 1.10). A majority of respondents disagreed that government policies are clearly communicated to local communities (Mean = 2.39, SD = 1.12). Community members reportedly lack adequate understanding of the objectives of newly introduced policies (Mean = 2.42, SD = 1.10). Local leaders do not effectively explain policy changes to the public (Mean = 2.44, SD = 1.14). Policy communication materials are rarely available in local languages (Mean = 2.38, SD = 1.08), further constraining accessibility, especially among residents with low literacy levels. The use of media channels such as radio, posters, and social media was also perceived as ineffective (Mean = 2.51, SD = 1.12).

Conclusions

Policy communication showed a moderate positive correlation with health service delivery. Clear, timely, and effective dissemination of policy information facilitates awareness, compliance, and community engagement.

Recommendations

The County Government should develop multi-channel communication strategies targeting both health workers and the community, utilizing radio, community meetings, social media, and printed materials.

Keywords: *Policy communication, Health Service Delivery, West Pokot County, Policy information, Kenya*
Submitted: *October 03, 2025* ***Accepted:*** *October 21, 2025* ***Published:*** *October 30, 2025*

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Background

The Health Policy Triangle Framework is a widely used tool to understand the complexities of health policy formulation and implementation. It provides a structured approach to analyzing how various factors interact to shape public health policy and its delivery. This framework is composed of four key components: context, content, process, and actors, which are integral in understanding how health policies are designed, executed, and evaluated (Gilson, 2012; Walt & Gilson, 1994). The context refers to the broader social, political, economic, and environmental factors that influence the design and implementation of health policies. The context shapes the challenges and opportunities that policymakers face. It encompasses the political climate, governance structures, and socio-economic conditions, all of which can either enable or constrain effective policy (Buse, Mays, & Walt, 2012). For example, in low-income or marginalized areas, such as West Pokot County in Kenya, the context of healthcare policy might be shaped by regional challenges like inadequate infrastructure, arid conditions, or limited healthcare professionals. This context impacts the feasibility of policy solutions, determining how easily health services can be delivered (Agyepong et al., 2017). The content refers to the substance of health policies, such as the specific goals, strategies, and interventions they propose. This component defines the aims of health policy and the

https://doi.org/10.51168/insights.v2i10.52

means by which those goals are to be achieved (Walt & Gilson, 1994). It involves decisions about which issues to prioritise, whether it is maternal health, child immunisation, or combating infectious diseases, and how to address these priorities effectively. For instance, if a health policy aims to improve access to maternal healthcare in underserved regions, its content would include strategies such as increasing the number of health facilities, improving infrastructure, and training more healthcare providers. The success of health service delivery largely depends on how well the policy content aligns with the needs of the population (Buse et al., 2012).

The process refers to the policy development and implementation stages. This includes the decision-making process, how policies are formulated, and the methods of implementation. It involves stakeholder involvement, consultations, and negotiations to shape the policy's direction (Lavis et al., 2002). A transparent and inclusive process is crucial for ensuring that policies are well-received and can be effectively executed on the ground. The implementation process also requires effective coordination between various stakeholders, including government agencies, healthcare providers, and local communities. Challenges in this phase may include inadequate funding, poor governance, or resistance to change (Buse et al., 2012). The Health Policy Triangle provides valuable insights into Policy Implementation. This stage is crucial for translating policy into action. It involves organizing resources, engaging stakeholders, and ensuring that the proposed policy is operationalized. Factors like political stability, the efficiency of healthcare systems, and the availability of skilled personnel significantly influence the success of policy implementation (Lavis et al., 2002). Poor governance or lack of infrastructure may lead to inadequate implementation, even if the policy content is strong. The study aims to examine the relationship between policy communication and Health Service Delivery in West Pokot County, Kenya.

METHODOLOGY

Research Design

This study employed a descriptive, correlational, and cross-sectional survey design. A mixed-methods approach was utilised, incorporating both qualitative and quantitative techniques to analyse the data and derive meaningful conclusions. The quantitative method facilitated a detailed numerical analysis of the research problem, examining the relationships between key variables. Meanwhile, the qualitative approach captured insights into attitudes and behaviours, providing a deeper understanding of the study elements.

Study Population

The target population of the study was 440 participants. These comprised the County Health Executive Officer, County Director of Public Health, 06 Doctors in County Hospital, 136 Nurses in public health centres, and 242 Community health workers and political leaders (County governor, 52 county assembly members, and the senator) (West Pokot County, 2025).

Sample Size

A sample size of 205 was selected from a population of 440 participants using Krejcie & Morgan's (1970) table for determining sample size, and the respondents within each category were proportionally selected as shown in Table 1

Table 1: Sample size, Sampling Techniques & Target Population

Participants	Population Target	Sample Size	Selection Technique
County Health Executive Officer	01	01	Purposive sampling
County Director of Public Health	01	01	Purposive sampling
Doctors in County Hospital	06	03	Purposive sampling
Nurses in public health centres	136	62	Simple random sampling
Community health workers	242	112	Simple random sampling
County governor	01	01	Purposive sampling
County Assembly Members	52	24	Simple random sampling
The senator	01	01	Purposive sampling
Total	440	205	

Source: West Pokot County Local Government (2024).

Sampling Techniques and Procedure

The study used a purposive sampling technique and a simple random sampling technique to arrive at the sample size. Purposive sampling was used to select the County Health Executive Officer, the County Director of Public Health, the County governor, the senator, and Doctors in the County Hospital as respondents for the study. The method was used in order to get information from key respondents with knowledge of public policy and health care service delivery. Additionally, simple random sampling was used to select nurses in public health centres, community health workers,

and County Assembly Members. The method was used to eliminate bias.

Data Sources

Data was selected from both primary and secondary sources. Primary data was obtained by use of questionnaires and scheduled interviews to look for information about the study directly from the field by the study.

Secondary data was obtained from Government Reports and Publications, Ministry of Health Reports (Kenya Health Sector Strategic and Investment Plan (KHSSIP), Academic Journals, Kenya Health Information Systems (KHIS), Demographic and Health Surveys (DHS), WHO and UNICEF Reports, Health Policy Documents, Newspapers, and Magazines.

Data Collection Instruments

Basically, three research instruments were used in conducting the study. The instruments were questionnaires, an interview guide, and a documentary review checklist.

The questionnaire was the main instrument, and the interview guide was used to gain an in-depth understanding of the subject and the interaction with the respondents. A documentary review checklist was used to collect secondary data for interpretation findings in order to arrive at realistic conclusions and recommendations.

Questionnaires

Questionnaires were sent to respondents to obtain primary data. This made it more convenient and easier to collect data from respondents with busy schedules as they answered the questions at leisure. Further, the instrument ensured a high response rate and elicited the required information on a wide range of issues on the study topic. Closed-ended questions using Likert scales were used to enhance simplicity for straightforward questions. Open-ended questions, on the other hand, were intended to permit a greater depth of response on specialised issues of the interview.

Interview Guides

An interview method was used to secure the in-depth information from the interviewees in the study. A probe with additional questions and gathering supplemental information enabled the study to cross-check the accuracy of the data collected. The interviews were conducted for about 10 minutes on average among the political leaders and some health workers within the county. They were mainly conducted using the face-to-face techniques, but where respondents were busy, the study used telephone calls to obtain clarity on certain issues.

Documentary Checklist

The study was conducted on a wide documentary review to help the study avoid unnecessary and unintentional duplication of studies and provided a framework within which the research findings were interpreted. Data was gathered using this method was basically secondary from a critical examination of public and private recorded information related to the issue under investigation. The documentary evidence method was used to get dependable data, as it was permanent and reliable information. The study reviewed reports, plans, newspaper articles, and literature from the library, together with other relevant written material on the study.

Data Quality Control

These were the steps and measures taken to ensure that the instruments used were good and clear enough to give the right findings of the study. To control the quality of the data, the study carried out validity and reliability tests of the instrument, as reflected below:

Validity of Instruments

The validity of the instruments (questionnaire) was determined using expert judgment and the Content Validity Index. An expert in research, particularly in health services, was contacted for judgment of the instruments. During this session, 18 questions out of 20 were correct, and the two questions with errors were corrected with his guidance to make the whole instrument accurate in collecting the intended data.

Content Validity Index was calculated using the formula below:

$$\text{Content Validity Index} = \frac{\text{Number of relevant questions}}{\text{Total number of items}}$$ (Jachi & Mandongwe)

The Content Validity Index of 0.9 (18/20) was obtained. Therefore, the instruments were accepted for data correction as the Content Validity Index was above 0.7, a benchmark.

Reliability of Instruments

Reliability is the measure of the degree to which a research instrument yields consistent results if administered on different occasions. The study administered the questionnaire to only the target group, and it was used for selective data, which was only relevant to the research objectives, to minimise errors and increase its reliability.

A pretest was done, whereby the research instruments used were tested with 3 respondents (outside the study but in the same community) in order to find out the consistency of the research instruments. The selected respondents were given a questionnaire, which they answered and kept by the study. After 1 week, the same people were given the same questionnaire. Answers from the first and the second tests were compared, and the relative values were fed into SPSS to determine the Cronbach alpha coefficient.

A Cronbach alpha coefficient of 0.86 was obtained. This was compared with 0.7 (Amin, 2009), and thus the instruments were consistent and reliable for collecting data for the study.

https://doi.org/10.51168/insights.v2i10.52

Data Collection Procedures

After obtaining an introductory letter, the study sought permission from the relevant parties within West Pokot County before starting to collect data. The study then physically delivered questionnaires to the respondents and collected them after 1 week.

Interviews were conducted to verify the data provided in the questionnaires. For procedures of obtaining secondary data, enquiries were made about the access and availability of the information. A critical analysis of documents was made to squeeze out the required data.

Measurements of Variables

The study used both nominal and ordinal scales to measure the variables. The nominal scale of measurement was mainly used to measure demographic data, which comprised items with the same set of characteristics, such as gender, age, and education levels.

The rest of the items in the questionnaire were measured using the ordinal scale, in which the five-point Likert scale, ranging from 5-strongly agree, 4-agree, 3-no sure, 2-disagree, and 1-strongly disagree, was used to measure both the independent and dependent variables against each other.

Data Analysis

Data collected was edited, coded, and later analysed using the Statistical Package for Social Sciences (SPSS) version 25 computer programme. Quantitative data were analysed using tables, correlation analysis to show the relationships, and regression analysis to show the influence of public policy implementation and health service delivery.

Pearson's correlation coefficients (r) and level of significance (p) were used to test the hypotheses at 95 confidence level in the correlation analysis. This involved running a correlation analysis, allowing it to find any significant relationship at a 2-tailed test. The adjusted R^2, t value, beta, and significance values were used to measure the influence of the independent variables on the dependent variable in the regression analysis.

Qualitative data were analysed using thematic analysis.

Ethical Considerations

The study sought an introductory letter from the School of Graduate Studies and Research of Team University that introduced her to the concerned authorities for permission to collect data for this study.

She also solicited permission through a written request to the concerned officials of the selected Departments and respondents of the study.

The study requested the respondents to sign the *Consent Form*.

The study acknowledged all the authors quoted in this study through citations and referencing.

Confidentiality: The study ensured confidentiality and anonymity of the information collected, and the information given was used for academic purposes.

Results

Response Rate

The response rate was determined using the formula;

$$\text{Response Rate}\,(\%) = \frac{\text{Interviews Conducted and Questionnaires Issued}}{\text{Interviews Scheduled and Questionnaires to be Issued}} \times 100$$

Table 2: Response Rate of the Study

Participants	Interviews Scheduled and Questionnaires to be Issued	Interviews Conducted and Questionnaires Issued	Response Rate (%)
County Health Executive Officer	01	01	100%
County Director of Public Health	01	01	100%
Doctors in County Hospital	03	03	100%
Nurses in Public Health Centers	62	60	96.8%
Community Health Workers	112	111	99.1%
County Governor	01	01	100%
County Assembly Members	24	22	91.7%
The Senator	01	01	100%
Total	**205**	**200**	**97.6%**

Source: Primary data (2025)

The study targeted a total of 205 respondents, comprising various stakeholders in the county's health sector. These included the County Health Executive Officer, County Director of Public Health, doctors, nurses, community health workers, the County Governor, County Assembly Members, and the Senator.

https://doi.org/10.51168/insights.v2i10.52

Out of the 205 interviews scheduled and questionnaires issued, 200 were completed and returned, representing a response rate of 97.6%. This is considered an excellent response rate for a social science study, indicating a high level of cooperation and engagement from the participants.

Specifically, all targeted senior officials, including the County Health Executive Officer, County Director of Public Health, County Governor, and the Senator, fully participated, recording a 100% response rate. The doctors in the county hospital also achieved a 100% response rate. Among nurses in public health centres, 60 out of 62 responded, giving a response rate of 96.8%, while 111 out of 112 community health workers responded, representing 99.1%. The County Assembly Members recorded a slightly lower response rate of 91.7%, with 22 out of 24 participating.

The overall response rate of 97.6% demonstrates that the study achieved a robust level of participation across all respondent categories. This enhances the reliability and validity of the findings, as it reflects a comprehensive representation of views from key health sector stakeholders in West Pokot County.

Socio-Demographic Characteristics of Respondents

Table 3: Demographic Characteristics of Respondents (n = 200)

Variable	Category	Frequency (f)	Percentage (%)
Gender	Male	88	44.0
	Female	112	56.0
Age (Years)	20–29	38	19.0
	30–39	62	31.0
	40–49	56	28.0
	50 and above	44	22.0
Marital Status	Single	46	23.0
	Married	138	69.0
	Widowed/Separated	16	8.0
Education Qualification	Certificate (e.g., Nursing/CHW)	54	27.0
	Diploma	78	39.0
	Bachelor's Degree	52	26.0
	Master's Degree and above	16	8.0
Length of Service	Less than 5 years	42	21.0
	5–9 years	68	34.0
	10–14 years	52	26.0
	15 years and above	38	19.0

Source: Primary data (2025)

The findings revealed that the majority of respondents were female, accounting for 56.0% (n=112), while male respondents constituted 44.0% (n=88). This distribution indicates that women play a dominant role in health service delivery in West Pokot County, particularly in nursing and community health work positions, which traditionally attract more female professionals. The relatively high female representation may also reflect national trends within Kenya's health workforce, where women form a significant proportion of frontline health service providers.

The age distribution of respondents showed that 19.0% were aged between 20–29 years, 31.0% were between 30–39 years, 28.0% were aged 40–49 years, while 22.0% were aged 50 years and above. The findings suggest that the majority of health personnel and policy implementers fall within the active working-age bracket of 30 to 49 years, representing 59.0% of the total respondents. This age composition implies that most respondents are mature, experienced, and capable of providing informed opinions regarding the implementation of public health policies and service delivery in the county.

Analysis of marital status indicated that 69.0% (n=138) of respondents were married, 23.0% (n=46) were single, while 8.0% (n=16) were widowed or separated. The predominance of married respondents may suggest a relatively stable social background, which could positively influence job commitment and responsibility in the delivery of health services. The diversity in marital status also reflects the broad social composition of the health workforce in the county.

The study further assessed the respondents' educational levels to understand their academic and professional preparedness for policy implementation and service delivery. The results indicated that 27.0% (n=54) of respondents held a Certificate (such as nursing or community health work qualifications), 39.0% (n=78) had a Diploma, 26.0% (n=52) possessed a Bachelor's Degree, while 8.0% (n=16) had attained a Master's Degree or higher.

https://doi.org/10.51168/insights.v2i10.52

This distribution demonstrates that the majority of respondents (66%) possess post-secondary qualifications at certificate or diploma levels, aligning with the human resource profile typical of Kenya's devolved county health systems. The relatively smaller proportion of degree and postgraduate holders reflects the hierarchical nature of the health workforce, where most operational and service delivery roles are performed by diploma and certificate holders.

Regarding work experience, 21.0% of respondents had served for less than 5 years, 34.0% had worked for 5–9 years, 26.0% had served for 10–14 years, and 19.0% had 15 years or more of experience. The results suggest that a majority of respondents (60%) have worked in the health sector for between 5 and 14 years, signifying a workforce with considerable institutional knowledge and practical experience. Such experience enhances the credibility of the responses, as participants are likely to have adequate exposure to public policy implementation processes and service delivery mechanisms within the county.

Policy Communication in West Pokot County

Descriptive Findings on Policy Communication in West Pokot County

The study sought to examine the effectiveness of policy communication mechanisms in West Pokot County. Respondents were asked to indicate their level of agreement with various statements related to the clarity, accessibility, timeliness, and inclusiveness of government policy communication using a five-point Likert scale, where 5 = Strongly Agree, 4 = Agree, 3 = Not Sure, 2 = Disagree, and 1 = Strongly Disagree. The findings are summarised in Table 4.

Table 4: Policy Communication in West-Pokot County

Statement	SA (5)	A (4)	N (3)	D (2)	SD (1)	**Mean**	Std. Dev.
Government policies are clearly communicated to local communities.	12	28	30	78	52	**2.39**	1.12
Community members understand the objectives of newly introduced policies.	10	34	26	80	50	**2.42**	1.10
Local leaders effectively explain policy changes to the public.	16	32	24	76	52	**2.44**	1.14
There are adequate forums for discussing government policies.	14	38	20	84	44	**2.47**	1.09
Policy communication materials are available in local languages.	10	30	28	82	50	**2.38**	1.08
Media are effectively used to communicate policies in the county.	18	36	22	80	44	**2.51**	1.12
There is timely communication of policies before implementation begins.	12	34	18	86	50	**2.38**	1.11
Government officials are available to answer questions about new policies.	14	40	20	84	42	**2.50**	1.10
There is two-way communication between policymakers and the community	10	32	24	88	46	**2.38**	1.07

Source: Primary *Data (2025).*

The results presented in Table 4 reveal that policy communication in West Pokot County is generally limited and ineffective, as indicated by the overall mean score of 2.43 (SD = 1.10). This mean falls below the neutral midpoint of 3.00, suggesting that most respondents disagreed with the statements asserting the effectiveness of policy communication processes within the county.

A majority of respondents disagreed that government policies are clearly communicated to local communities (Mean = 2.39, SD = 1.12). This indicates a significant gap between the formulation of public policies and their dissemination to intended beneficiaries. Consequently, community members reportedly lack adequate understanding of the objectives of newly introduced policies (Mean = 2.42, SD = 1.10). This lack of clarity may hinder proper interpretation, ownership, and compliance during the implementation stage.

The study further established that local leaders do not effectively explain policy changes to the public (Mean = 2.44, SD = 1.14). This points to weak involvement of sub-county and ward-level administrators in the communication chain, which limits the translation of national or county policies into actionable information for communities.

Similarly, respondents disagreed that there are adequate public forums such as barazas or community meetings for discussing government policies (Mean = 2.47, SD = 1.09). Public participation mechanisms appear to exist in principle, but are not effectively utilised to facilitate dialogue between citizens and policy implementers.

Findings also show that policy communication materials are rarely available in local languages (Mean = 2.38, SD =

1.08), further constraining accessibility, especially among residents with low literacy levels. The use of media channels such as radio, posters, and social media was also perceived as ineffective (Mean = 2.51, SD = 1.12), implying that information dissemination through modern and traditional media remains weak or irregular.

Moreover, the study found that timely communication before policy implementation is inadequate (Mean = 2.38, SD = 1.11). This suggests that stakeholders and community members are often informed of new policies only after implementation has begun, limiting opportunities for early engagement or feedback. Additionally, accessibility of government officials for policy-related inquiries was rated low (Mean = 2.50, SD = 1.10), reflecting bureaucratic barriers or limited outreach efforts.

Lastly, respondents disagreed that there exists two-way communication between policymakers and communities (Mean = 2.38, SD = 1.07). The lack of effective feedback mechanisms implies that community views and concerns are not systematically captured or integrated into the policy process.

Qualitative Findings on Policy Communication in West Pokot County

To complement the quantitative data, interviews were conducted with key county officials, including the County Health Executive Officer, County Director of Public Health, County Governor, selected County Assembly Members, and the Senator representing West Pokot County.

The purpose of these interviews was to gain deeper insights into policy communication processes, particularly regarding how health-related policies are disseminated and received by stakeholders at different administrative levels.

Response from the County Health Executive Officer

The County Health Executive Officer acknowledged that policy communication remains a major challenge in the county's health sector. He stated: *"While the county government has made efforts to inform the public about new health policies and programs, the communication channels are not always effective. Many times, policies are rolled out before the community fully understands their purpose or implementation process. We rely heavily on chiefs and health facility managers, but their reach is still limited, especially in remote areas."*

He further noted that logistical challenges and inadequate resources hinder the timely dissemination of policy information:

"We would like to translate policy documents into local languages and hold more public meetings, but funding and time constraints make it difficult. As a result, there is often a disconnect between the policymakers and the people who are supposed to benefit."

Response from the County Director of Public Health

The County Director of Public Health emphasised that although policy communication is part of the implementation framework, it is often overshadowed by operational pressures:

"In most cases, our focus tends to be on service delivery targets such as immunisation coverage or disease control, leaving less attention to structured communication. We do share information through circulars and meetings, but these rarely reach the community level in an understandable form."

He also pointed out language barriers and limited access to media as key obstacles:

"Most of our policy documents are written in English, which many community members may not comprehend. We have started using local radio stations to bridge this gap, but the approach is still in its early stages."

This supports the quantitative findings that policy communication materials are rarely available in local languages and media use remains ineffective.

Response from the County Governor

The County Governor acknowledged that the county administration recognises the importance of effective communication but admitted that implementation has been inconsistent:

"Our administration has made strides in developing policies that improve health services, but I must admit that the process of communicating these policies to the grassroots has not been as effective as we would want. We depend on sub-county and ward administrators, but sometimes information gets distorted or delayed."

He added that the county government is exploring ways to enhance community engagement:

"We are planning to strengthen the use of public barazas, health outreach programs, and digital platforms to ensure timely and inclusive communication. However, there is still much to be done to achieve consistent two-way communication."

His response reflects recognition of limited feedback and top-down communication, as observed in the survey results.

Response from County Assembly Members (Health Committee Representatives)

The County Assembly Members expressed concern that the communication of policy decisions to both the public and lower-level implementers is inadequate:

"We often pass motions and allocate budgets for health programs, but the feedback from the ground shows that communities are not always aware of these policies. The dissemination process is slow, and sometimes the information does not reach the people it is intended for."

They also highlighted a lack of coordination between the executive and legislative arms of the county government:

"There is a communication gap between departments. For example, while the Health Department may develop a policy, the Assembly might not receive sufficient follow-up information to sensitize the community. This weakens accountability and policy ownership."

This view corresponds with the low mean scores for two-way communication and accessibility of government officials.

Response from the Senator

https://doi.org/10.51168/insights.v2i10.52

The Senator for West Pokot County noted that the communication gap between policymakers and the community reflects a broader national challenge of policy dissemination:

"Most counties, including ours, struggle to translate policy documents into messages that ordinary citizens can relate to. Policies are discussed at high levels, but very little effort is made to simplify them for the public. As a result, people may view new health programs with suspicion or indifference."

He emphasized the need for participatory communication strategies:

"There must be deliberate efforts to involve communities in discussions before and during policy implementation. When people are part of the process, they become more supportive, and implementation becomes easier."

His remarks reinforce the quantitative finding that two-way communication and community feedback mechanisms are weak in West Pokot County.

Table 5: Thematic Analysis of Interview Findings on Policy Communication in West Pokot County

Main Theme	Sub-Themes	Summary of Findings	Illustrative Quotes
1. Ineffective Dissemination of Health Policies	• Limited communication channels • Late dissemination of information	Respondents indicated that policies are often introduced without prior community sensitization. The communication process is inconsistent and relies heavily on administrative officers who may lack adequate reach, especially in remote areas.	*"Many times, policies are rolled out before the community fully understands their purpose or implementation process."* - County Health Executive Officer.
2. Inadequate Public Engagement and Feedback	• Weak two-way communication • Lack of structured feedback mechanisms	The study revealed that policy communication is largely top-down, with minimal opportunities for communities to give feedback or participate in decision-making.	*"There must be deliberate efforts to involve communities in discussions before and during policy implementation."* - Senator.
3. Language and Accessibility Barriers	• Policies not translated into local languages • Low literacy levels in communities	Communication materials are rarely available in local languages, limiting comprehension and inclusivity, especially in rural areas.	*"Most of our policy documents are written in English, which many community members may not comprehend."* - County Director of Public Health.
4. Ineffective Use of Media and Communication Tools	• Underutilized local radio and posters • Limited digital outreach	Although media platforms exist, their use in communicating health policies remains inconsistent and ineffective.	*"We have started using local radio stations to bridge this gap, but the approach is still in its early stages."* - County Director of Public Health.
5. Inadequate Coordination Among Government Actors	• Weak inter-departmental communication • Poor link between executive and legislative arms	County departments operate in silos, leading to delays and inconsistencies in policy communication. The Assembly is often not adequately informed to support community sensitization.	*"There is a communication gap between departments. While the Health Department may develop a policy, the Assembly might not receive sufficient follow-up information."* - County Assembly Member.
6. Limited Public Forums for Policy Dialogue	• Few barazas and stakeholder meetings • Logistical and resource challenges	Respondents noted that the county lacks regular and well-structured forums for public discussion of new health policies. Barazas are infrequent and not well-publicised.	*"We would like to hold more public meetings, but funding and time constraints make it difficult."* - County Health Executive Officer.

Source: Primary data (2025).

The thematic analysis highlights several recurring issues across the interviews. The overarching theme is that policy communication in West Pokot County is limited, uncoordinated, and largely top-down. All respondents agreed that communication gaps exist at multiple levels, from the county executive to the community, resulting in poor understanding and participation among the public.

Specifically, inadequate translation of policy information, insufficient use of media, limited public participation forums, and poor interdepartmental coordination emerged as

https://doi.org/10.51168/insights.v2i10.52

key barriers. Nevertheless, there is a shared acknowledgement among county leaders of the need to adopt more participatory and inclusive communication mechanisms to enhance the success of health policy implementation and service delivery.

Health Service Delivery in West Pokot County

Descriptive Findings on Health Service Delivery in West Pokot County

This study assessed the perceptions of health service delivery in West Pokot County across key areas, including maternal and child health, reproductive health, HIV services, mental health, accessibility of health facilities, and referral systems. Respondents were asked to indicate their level of agreement with statements reflecting the quality, accessibility, and coverage of these services, with scores ranging from 1 (strongly disagree) to 5 (strongly agree).

Table 6: Health Service Delivery in West-Pokot County

Statement	SA	A	N	D	SD	Mean	Std
Most births are attended by skilled personnel	20	40	30	70	40	2.65	1.20
The majority of mothers make at least 4 antenatal care visits	15	35	40	70	40	2.55	1.18
Expectant mothers receive postnatal care (within 48 hours of delivery)	10	30	35	80	45	2.40	1.22
All children are immunized	25	40	30	60	45	2.80	1.25
Under-5 mortality rate is low (per 1,000 live births)	10	20	30	90	50	2.20	1.15
The maternal mortality ratio is low	10	25	25	85	55	2.25	1.18
Youth know the use of contraceptives	20	35	40	70	35	2.65	1.20
Women have access to modern family planning methods	15	30	35	80	40	2.50	1.19
The adolescent pregnancy rate is scanty	5	15	20	90	70	1.85	1.05
Most population has tested for HIV	20	30	35	80	35	2.55	1.18
Cases of mental illness have been reported	30	40	30	60	40	2.85	1.22
The population lives within 5 km of a health facility	25	35	30	70	40	2.70	1.20
Very ill patients are given referrals outside the county	20	30	35	75	40	2.60	1.18

Source: Primary Data (2025).

The analysis indicates that maternal health services are inadequately delivered, with most births not attended by skilled personnel (Mean = 2.65) and the majority of mothers failing to make at least four antenatal care visits (Mean = 2.55). Postnatal care within 48 hours of delivery is also insufficiently provided (Mean = 2.40), suggesting gaps in the continuum of maternal care.

Child health services show moderate coverage. While immunization services are somewhat available, not all children are fully immunized (Mean = 2.80), and under-5 mortality remains high (Mean = 2.20). Similarly, maternal mortality ratios remain a concern (Mean = 2.25), reflecting persistent challenges in ensuring safe childbirth and maternal care.

Reproductive health and family planning services are limited. Youth have some knowledge of contraceptive use (Mean = 2.65), but access to modern family planning methods for women remains constrained (Mean = 2.50). Adolescent pregnancy rates are high, indicating ineffective outreach and education programs (Mean = 1.85).

HIV testing and mental health services also show poor coverage. Only a small proportion of the population has been tested for HIV (Mean = 2.55), and mental health cases are recognized but inadequately managed (Mean = 2.85), pointing to gaps in both preventative and curative care.

Accessibility of health facilities remains a challenge. A significant proportion of the population lives beyond 5 km from the nearest health facility (Mean = 2.70), limiting timely access to care. Furthermore, very ill patients are often referred outside the county due to inadequate capacity in local facilities (Mean = 2.60), indicating weaknesses in the county's emergency and specialized care systems.

Qualitative Findings on Health Service Delivery in West Pokot County

The interviews were conducted with five key respondents: the County Health Executive Officer (CHEO), County Director of Public Health (CDPH), County Governor, County Assembly Members (CAMs), and the Senator. The aim was to gain in-depth insights into the quality, accessibility, and challenges of health service delivery in the county. The responses revealed systemic gaps in maternal, child, reproductive, and mental health services, as well as challenges in facility accessibility and emergency care.

County Health Executive Officer (CHEO) said, *"While we have established health facilities and personnel, in reality, the services often do not reach the communities as intended. Skilled attendance at birth is not universal; many women still deliver at home due to distance or cultural practices.*

https://doi.org/10.51168/insights.v2i10.52

Our antenatal and postnatal programs are designed to ensure regular follow-ups, but staffing shortages and logistical challenges often prevent consistent service delivery."

The County Director of Public Health (CDPH) is *"Immunization coverage and maternal health services are uneven across the county. Some facilities perform well, but many remote areas are underserved. Data collection happens, but we often struggle to convert reports into actionable interventions. Mental health and reproductive health services are particularly neglected, with very few trained personnel available to support the community."*

The County Governor said, *"We are aware of the poor health outcomes in some areas, including high maternal and under-five mortality rates. Our health facilities are not evenly distributed, and emergency referrals are often made to facilities outside the county. Budgetary limitations and logistical constraints mean we cannot fully operationalize all programs as planned, despite our policy intentions."*

County Assembly Members (CAMs) said, *"Oversight reveals that health service delivery is inconsistent. Some wards have functional clinics, while others are lacking even basic maternal and child health services. The population often travels long distances for care, and even then, staff shortages compromise the quality of services provided."*

Senator added, *"Reproductive health and adolescent services are particularly weak. Awareness of contraceptive methods is low among youth, and access to modern family planning is limited. Adolescent pregnancies remain high, which affects educational attainment and community well-being. HIV testing and mental health services also remain inadequate, reflecting a need for targeted interventions."*

Table 7: Thematic Analysis of Interview Findings on Health Service Delivery in West Pokot County.

Main Theme	Sub-Theme	Summary of Findings	Illustrative Quotes
Maternal Health Services	Skilled Birth Attendance	Many births occur at home due to distance, cultural practices, or limited staff.	CHEO: *"Skilled attendance at birth is not universal; many women still deliver at home due to distance or cultural practices."*
	Antenatal & Postnatal Care	Inconsistent follow-ups due to staffing shortages and logistical challenges.	CHEO: *"Our antenatal and postnatal programs are designed to ensure regular follow-ups, but staffing shortages often prevent consistent service delivery."*
Child Health Services	Immunization	Coverage uneven; remote areas underserved.	CDPH: *"Some facilities perform well, but many remote areas are underserved. Data collection happens, but interventions are slow."*
	Child Mortality	High under-5 mortality due to poor service coverage.	Governor: *"Our health facilities are not evenly distributed, and emergency referrals are often made outside the county."*
Reproductive Health & Family Planning	Contraceptive Awareness	Limited knowledge among youth; low access to services.	Senator: *"Awareness of contraceptive methods is low among youth, and access to modern family planning is limited."*
	Adolescent Pregnancy	High incidence due to inadequate services and education.	Senator: *"Adolescent pregnancies remain high, affecting education and community wellbeing."*
Mental Health Services	Availability & Coverage	Services are largely neglected; few trained personnel.	CDPH: *"Mental health services are particularly neglected, with very few trained personnel available to support the community."*
Access & Infrastructure	Facility Distribution	Many populations live far from health facilities.	CAMs: *"Some wards have functional clinics, while others are lacking even basic maternal and child health services."*
	Emergency Referrals	Local facilities are unable to handle severe cases; patients are referred outside the county.	Governor: *"Emergency referrals are often made to facilities outside the county due to inadequate capacity locally."*

Source: Primary data (2025)

https://doi.org/10.51168/insights.v2i10.52
Original Article

Documentary Findings on Health Service Delivery in West Pokot County

A comprehensive review of documentary sources, including county health reports, policy briefs, Ministry of Health statistical data, and previous research studies, was undertaken to complement survey and interview data on health service delivery in West Pokot County. The documentary evidence corroborates the empirical findings and highlights systemic challenges affecting the quality, accessibility, and coverage of health services.

County health records indicate that skilled birth attendance remains low, with less than 50% of deliveries occurring in health facilities in rural wards. Reports from the County Health Department (2022) show that only 48% of pregnant women complete the recommended four antenatal care visits, while postnatal care coverage within 48 hours of delivery stands at just 35%. Immunization coverage for children under five is inconsistent, with some remote sub-counties reporting below 60% full immunization, resulting in sustained high under-five mortality rates (41 per 1,000 live births) and maternal mortality ratios above the national average.

Documented evidence highlights limited access to modern family planning services. The County Integrated Development Plan (CIDP, 2021) reports that contraceptive uptake among women of reproductive age is below 40%, and adolescent pregnancy rates remain above 25% in certain regions. County sexual and reproductive health reports further reveal that youth-targeted interventions are minimal and that awareness campaigns are sporadic and poorly funded.

Documentary sources, including the Kenya Health Sector Strategic and Investment Plan (KHSSIP, 2020), show that HIV testing coverage in West Pokot County is below the national average, with only 45% of the population reported to have been tested at least once. Prevention and treatment services are limited by inadequate staffing, stock-outs of test kits, and logistical constraints, especially in remote areas.

County health reports indicate that mental health services are significantly underdeveloped. Only two functional mental health units exist within the county hospital system, and there is a critical shortage of trained mental health professionals. Cases of depression, substance abuse, and other psychiatric disorders are often untreated, contributing to unmet community health needs.

Review of geographic health data shows that a large proportion of the population resides more than 5 km from the nearest health facility, limiting access to essential care. Referral systems for critically ill patients are weak, with most severe cases being transferred outside the county due to inadequate local capacity. The CIDP (2021) also notes that health facility staffing levels are below recommended standards, with some dispensaries operating with only one nurse or clinical officer.

County budget reports and audit documents reveal insufficient allocation of financial resources for health service delivery, with frequent delays in disbursement and inequitable distribution across wards. Resource limitations affect procurement of essential drugs, medical equipment, and the maintenance of health infrastructure, exacerbating service delivery challenges.

Correlation Findings of the Study

Table 8: Correlation between policy communication, policy resource mobilization, policy implementation monitoring, and Health Service Delivery in West Pokot County, Kenya.

Variable	Pearson Correlation with Health Service Delivery	Sig. (2-tailed)	N
Policy communication	0.315 *	0.004	200

**Correlation is significant at the 0.01 level (2-tailed).*
Source: Primary Data (2025).

Policy communication was found to have a moderate positive correlation with health service delivery ($r = 0.315$, $p = 0.004$). This indicates that clear, timely, and effective communication of policies to both health workers and the community is positively associated with service delivery.

Regression Analysis of Public Policy Implementation and Health Service Delivery

Table 9: Regression Coefficients

Predictor Variable	B (Unstandardized)	Std. Error	Beta (Standardized)	t	Sig.
Constant	0.412	0.105	-	3.92	0.000*
Policy Communication	0.137	0.062	0.145	2.21	0.029*

Source: Primary Data (2025)

Policy communication had a moderate, yet statistically significant, influence on health service delivery ($\beta = 0.145$, $p = 0.029$). Effective communication of policies to health personnel and community members facilitates awareness, adherence, and engagement. However, its relative influence is smaller compared to resource mobilisation and

monitoring. This suggests that while communication is necessary to inform stakeholders and promote understanding of health programs, it cannot independently drive significant improvements in service delivery without sufficient resources and robust monitoring mechanisms. The limited forums, inconsistent use of local languages, and scant media engagement highlighted in survey findings explain the modest effect of communication on health service delivery.

Discussions

The study revealed a moderate positive correlation between policy communication and health service delivery ($r = 0.315$, $p = 0.004$), suggesting that effective dissemination of policies positively influences service outcomes, albeit to a lesser degree compared to resource mobilisation. This finding aligns with the literature emphasising the centrality of communication in decentralised governance. Empirical studies from other low- and middle-income countries reinforce this point. However, the relatively weaker correlation observed in this study suggests that while policy communication facilitates awareness and compliance, it may not independently drive substantial improvements in service delivery without adequate resources and robust monitoring. Therefore, policy communication serves as an enabler of service delivery but requires complementary mechanisms to produce significant health outcomes.

Conclusions

Policy communication showed a moderate positive correlation with health service delivery ($r = 0.315$, $p = 0.004$). This suggests that clear, timely, and effective dissemination of policy information facilitates awareness, compliance, and community engagement, though its impact is weaker compared to resources and monitoring. Effective communication alone is insufficient to significantly improve health services without adequate resources and monitoring mechanisms.

Recommendations

The County Government should develop multi-channel communication strategies targeting both health workers and the community, utilizing radio, community meetings, social media, and printed materials.

The County Government should ensure that communication is clear, timely, and accompanied by feedback mechanisms to facilitate understanding and compliance.

The County Government should train health managers and frontline staff in effective communication and public engagement practices to enhance policy adherence and service responsiveness.

ACKNOWLEDGEMENT

First and foremost, I give all glory and honour to the Almighty God for His abundant grace, wisdom, and strength that have guided me throughout this research journey. Without His divine guidance and provision, this work would not have been possible.

My deepest appreciation goes to my research supervisor, whose guidance, insightful feedback, and unwavering support have been invaluable in shaping this study. Your mentorship has greatly enriched my academic experience and personal growth.

Special thanks to my loving husband for his constant encouragement, patience, and understanding. Your support has been my anchor and motivation through every stage of this research.

I also extend my sincere gratitude to the management of Team University for providing a conducive learning environment and the necessary academic support that made this research possible.

Finally, I thank all those who, in one way or another, contributed to the successful completion of this work. Your assistance and goodwill will always be remembered with deep appreciation.

Limang'ura Dinah

LIST OF ABBREVIATIONS

DHS – Demographic and Health Survey
WHO – World Health Organisation

Source of funding

The study was not funded

Conflict of interest

The author did not declare any conflict of interest

Data availability

Data is available upon request

Author contribution

Dinah Limang'ura collected data and drafted the manuscript of the study
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