STRATEGIC LEADERSHIP ROLES OF HOSPITAL LEADERS ON

DELIVERING HIGH-QUALITY SICKLE CELL DISEASE AND

HEMOPHILIA CARE IN KENYA

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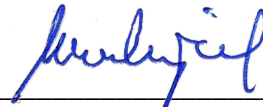
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DEDICATION

I dedicate this proposal to the almighty God whose grace enabled me to pursue this course, and to my family, especially my Mother Mary Mbunya, Father Hudson Mbunya, my 7 siblings and my 2 children Aaliyah Nyaboke and Mateó Nyanguru, for their continued love and support.

Secondly, I would like to appreciate my colleagues from the Innovative Hematology/Indiana Hemophilia and Thrombosis Center, specifically Dr. Anne Greist and Chris Roberson for believing in me and providing the necessary time and resources towards completing my DBA journey) AMPATH Kenya (Dr. Festus Njuguna – Principal Investigator), the Sickle Cell Disease and Hemophilia Community and the entire Ministry of Health, Kenya (especially Dr. Gladwell Gathecha – NCD division head) in ensuring that I access data and networks to the entire healthcare system.

I hope that this research be a testament on the current gaps in the healthcare system and that it will highlight the need of intervention towards achieving optimum care for patients living with the two blood disorders. The sickle cell disease warriors and Hemophilia heros deserve a better life and this research highlights the need for the hospital leadership to step up and work efficiently and diligently to maximize the input towards better service delivery.

As the blood disorder community continues to receive support from the global community in Kenya, the research will further increase the output of the current programs and existing systematical procedures and improve outcome of the patients who need it the most.

ABSTRACT

STRATEGIC LEADERSHIP ROLES OF HOSPITAL LEADERS ON
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Background

Challenges have been identified in the Kenyan healthcare system, especially on the service delivery of care in general and specifically to the people living with Sickle Cell Disease and Hemophilia. This study determines the strategic roles of hospitals leadership toward delivering high-quality sickle cell disease and hemophilia care, by determining the effect of strategic leadership practices and to developing an effective strategic leadership model in the provision of high-quality sickle cell disease and hemophilia care in Kenya.

Methods

The study targeted 558 hospitals that of public, private, and faith-based hospitals registered and categorized as level 4, level 5 and level 6. The study stratified the sampled 233 hospitals into 3 levels of hospitals (4, 5 and 6). Purposive sampling from the non-probability sampling technique was used to purposively pick 3 management officials (Head of department, supervisors and one medical staff and one client (sickle cell disease and hemophilia patients) seeking care from the hospital), giving a total sample of 928 respondents. This study used both closed-ended and open-ended data collection instruments. Pilot's study was conducted to identify any likely faults in the research tool by evaluating its validity and reliability. Face validity was attained when the questionnaire was critiqued by supervisors and experts and necessary adjustments done. Further, to

accomplish construct validity, convergent and discriminant validity was tested using factor analysis. To check the reliability of the survey instrument, the study used Cronbach's Alpha. Data was analyzed using descriptive statistics and structural equation modeling with aid of Analysis of Moment of Structure (AMOS 21) in SPSS version 26.

Results

The study underscores the substantial influence of strategic leadership on the provision of High-Quality Sickle Cell Disease and Hemophilia Care, revealing a clear positive correlation between strategic leadership and service delivery. Notable strengths observed include a dedicated focus on employee training and the adeptness in adapting organizational structures to leverage emerging opportunities. Additionally, moderately practiced aspects encompass the ability to adjust plans in response to evolving circumstances, implement disciplinary measures for communication gaps, and foster collaboration among departments. However, shortcomings in ensuring employee comprehension of institutional priorities and evaluating performance were identified as areas in need of improvement.

Discussion and Conclusion

In conclusion, the study emphasizes the pivotal role of strategic leadership in optimizing healthcare services for High-Quality Sickle Cell Disease and Hemophilia Care, urging targeted efforts to tackle identified challenges. Therefore, it recommends bolstering existing strengths, particularly through enhanced employee training and communication

strategies, while advocating for continual refinement of strategic leadership practices to elevate the delivery standards for such specialized care.

LIST OF ABBREVIATIONS

SCD	Sickle cell disease
DC	Dynamic Capability
DMS	Deputy Superintendents
MS	Medical Superintendents
CEOs	Chief Nurse Executives
PCSMs	Primary Care Staff Members
RNs	Registered Nurses
IT	Information Technology
HIS	health information systems
AMPATH	Academic Model Providing Access to Healthcare ()
UK	United Kingdom
US	United State
MCAR	Missing Completely at Random
SEM	Structural Equation Modelling
CEOs	chief nurse executives\
RN	registered nurses
HIS	health information systems
HIV	Human immunodeficiency virus
HOD	Head of department
SPSS	Statistical Package for Social Sciences
AMOS	Analysis of Moment of Structure
CFA	Confirmatory Factor Analysis

PCA   Principle Components Analysis

KMO   Kaiser-Meyer-Olkin

CR   Composite Reliability

AVE   Average Variance Extracted

TLI   Tucker-Lewis index

RMSEA   Root Mean Square Error of Approximation

GFI   Goodness-Of-Fit Index

CFI   Comparative Fit Index

NFI   Normed Fit Index

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CHAPTER I: INTRODUCTION

1.1   Introduction

Recently, there has been a global health challenge and if a hospital has to survive in increasingly health care competition, they will require leaders with ability, expertise, strategy, and skills that improves performance of medical employees (Asbari, 2020). Thus, to attain and improve performance of medical employees it is paramount for management to consider strategic leadership (Madlabana, 2020). Strategic leadership has the role of improving employee development and growth through motivation strategies (Alvi, Haider, & Akram, 2021), enhanced through deliberate and strategic choices (Gu, Wang, & Xie, 2016). Effective leaders with a strategic mindset inspire and guide those under their leadership to see it that they have the confidence, are recognized and rewarded thereby propelled towards achievement of individual and overall performance (Caro, (2016).

Further, strategic leadership has turned into the dominant discussion globally in strategic management, making it one of the most effective instruments for enhancing employees' performance (Peterlin, Pearse, & Dimovski, 2015). A Strategic leader is tasked with making vital decisions of facilitating information sharing and resource utilization towards improving performance of employees in attainment of organizational goals and objectives(Simsek, Heavey & Fox, 2018).Strategic leadership practices are critical for enhancing organization competitiveness and survival ensuring that employees optimally utilize the existing resources towards achieving its mission and goals. In support, Sibghatullah and Raza (2020) and Pitelis and Wagner (2019) pointed that strategic leadership improves the ability of employee to be innovating with new ideas and adaptive to sudden changes. Thus, strategic leader has ability to lead well

is essential in navigating and resolving crisis situations within a company such as Covid 19 Pandemic experienced worldwide. Indeed, strategic leaders analyze and understand disruption and uncertainty in the business environment and rationally and proactively respond to them (Collier & Evans, 2020; Obeidat and Thani, 2020; Sayed & Theeb, 2019)

In the modern uncertain business environment, strategic management literature recognizes strategic leadership as one of the vital concepts (Samimi, Cortes, Andres, Anderson, Marc & Herrmann, Pol., 2020). Strategic leadership has its roots in military doctrine, but it has quickly developed into modern management ideas (Wright, Mainzer, Masiero, Grav, Cutri & Bauer, 2018). Some people associate strategic leadership with the capacity to clearly explain and execute the organization's strategic vision, motivate employees and ability to make followers comprehend and believe in it. Hence, strategic leadership can be described as the capacity to anticipate and maintain flexibility.

Strategic leadership is defined as an experienced leader's knowledge and vision in strategic decision - making in an uncertain and complicated strategic environment. To put it another way, strategic leadership is the practice of making decisions in order to attain the most relevant, accepted and desired plans for the business and its partners (Banzato & Sierra, 2016). According to Fibuch and Arif (2016), strategic leadership comprises reducing imperfection through mental strength, the urge to pursue excellence, and building a high-productivity culture among personnel. According to Mulyono et al., (2020), strategic leadership is a leader's ability to share and communicate a potential strategy through strategic communication, thinking,

orientation, alignment, and directions in motivating and persuading employees to implement firm strategies and achieve firm goals.

As stated by Dubrin (2013), strategic leadership entails engaging staff in realizing strategic goals through initiating changes in the workplace and effectively addressing both external and internal factors. Strategic leadership refer to the ability of the leader in visualizing and foreseeing the future, thinking strategically, maintaining flexibility and proactively responding to sudden changes that develops competitiveness for the future of the company (Lear, 2012). In conceptualizing strategic leadership, Tutar, Altınöz, Mehmet Çakıroğlu and Demet (2011), define strategic leadership in an organization as the ability to create strategies by analyzing external and internal business environment, implementing strategies effectively within the timeline and evaluating and adapting behavior in responding to the future business environment appropriately.

According to Simsek, Jansen, Minichilli and Escriba-Esteve (2015), strategic leaders comprise of chief executive officers (CEO), senior managers, directors, frontline managers and entire workforce in the organizations that delivers stakeholder value (O'Shannassy, 2016). Four elements of strategic leadership are provided by Alzawahrah and Alkhaffaf (2021), including organizational culture, strategic direction, examining strategic capabilities, and human capital. Samimi et al., (2020) identifies eight functions of a strategic leader which are stakeholders' engagement, human capital development, inspiring and motivating, management of information through strategic decisions and thinking, operations and administration supervisions; managing conflicting demands and managing social and ethical issues. This study followed Gupta (2018) aspect of strategic leadership which have the ability to improve employee

performance and includes making strategic decisions (strategic direction), communicate strategic intent (strategic communications, and ethical practice that enable adaptation (strategic agility) and alignment to external changes (strategic alignment).

Globally, Sickle cell disease (SCD) which is an inherited blood disorder has caused major health problems such as infections, stroke and kidney failure which eventually might lead to death, many of which can reduce life expectancy. In Kenya, Sickle cell disease (SCD) is the most common hemoglobinopathy with over 4.5% of children born with SCD, and 18% of children born with sickle cell trait (Wanjiku et al., 2019). However, most of these children do not survive into adulthood due to poor access to quality health care. Provisions of quality health care depend on performance of medical employees who are valuable in maintaining the hospital's reputation and overall performance (Labrague and de los Santos, 2021). The accomplishment of medical employees task highly depends on the kind of strategic leadership available in maintaining the quality of hospital services. Recently, there has been a global health challenge and if a hospital must survive in increasingly health care competition, they will require leaders with ability, expertise, strategy, and skills that improves performance of medical employees (Asbari, 2020). Thus, to attain and improve provisions of quality service by medical employees, it is paramount for management to consider strategic leadership (Madlabana, 2020). This study provided a framework that highlights strategic roles of hospitals leadership toward delivering high-quality sickle cell disease and hemophilia care in Kenya.

1.2   Research Problem

The Government of Kenya and other stakeholders have shown interest in SCD by coming up with numerous interventions aimed at enhancing the delivery of high-quality care for SCD and hemophilia. However, hospitals responsible for providing this care still face significant challenges. These challenges include inadequate funding, healthcare providers lacking proper training, limited availability of diagnostic tools, and insufficient treatment options. . This brings in the question that, despite most of hospitals in Kenya receiving large funding from donors, governments among others for provision of quality care to SCD and Hemophilia patients, why do most of the patients with SCD and Hemophilia still complain of poor services (Kenya Haemophilia Association, 2021), and why is it that most of the children with SCD and Hemophilia do not survive into adulthood and those who survive end up living with multiple deformities and complications?. Based on the above discussions, is there a gap on strategies laid out to ensure delivering high-quality sickle cell disease and hemophilia care in Kenya, and what are the strategies stipulated by hospitals leaders in ensuring sickle cell disease and hemophilia patients receive quality care. Therefore, the study intends to investigate the strategic roles of hospital leaders in ensuring sickle cell disease and hemophilia in receiving quality care in Kenya. In accordance with it, main research objective of the present study is to investigate effect strategic roles of hospital leaders on delivering high-quality sickle cell disease and hemophilia care in Kenya.

In the context of main research objectives, the study stated several research questions:

i. What aspects of strategic leadership are practiced by leaders of hospitals providing sickle cell disease and hemophilia care in Kenya?

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ii. What is the effect of practiced strategic leadership aspects on delivery of high-quality sickle cell disease and hemophilia care in Kenya?

iii. Are there any challenges of strategic leadership in hospitals providing sickle cell disease and hemophilia care in Kenya?

1.3   Purpose of Research

The main purpose of this study is to empirically develop a strategic leadership framework applicable towards enhancing quality healthcare. This study followed Gupta (2018) model of strategic leadership which characterize strategic leadership strategic decisions, communicate strategic intent (strategic communications), and ethical practice that enable adaptation (strategic agility) and alignment to external changes (strategic alignment). The study objective was to determine the strategic roles of hospital leaders and their effect on delivery of high-quality sickle cell disease and hemophilia care in Kenya.

1.4   Significance of the Study

The findings of this study are crucial for patients, as they highlight the importance of strategic leadership in delivering high-quality care. Improved leadership practices can lead to better patient care, more accurate diagnoses, timely treatment, and enhanced patient satisfaction. Ultimately, this can improve the quality of life for patients suffering from these conditions.

Medical practitioners will benefit from this study by gaining a deeper understanding of how leadership influences clinical practices and patient care outcomes. The insights provided can foster better collaboration between medical staff and hospital leaders,

leading to a more supportive work environment and better care delivery for patients with sickle cell disease and hemophilia.

For policymakers and government officials, this study offers valuable information on the critical role of hospital leadership in healthcare delivery. The results can inform policy development and implementation, ensuring that leadership standards and practices are aligned with the goal of providing high-quality care. This can lead to the establishment of frameworks and regulations that support effective hospital management and patient care.

Scholars will find this study significant as it contributes to the body of knowledge on healthcare leadership and its impact on care delivery. The research provides a foundation for further studies on strategic leadership in healthcare, offering new perspectives and data that can be used to explore related topics and advance academic discourse in the field.

1.5   Research Purpose and Questions

The study aims to achieve its primary objective, which is to determine the strategic roles of hospital leaders and their impact on the delivery of high-quality care for sickle cell disease and hemophilia in Kenya. In pursuit of this goal, the study intends to address the following research questions.

i.What are the aspects of strategic leadership practiced by leaders of hospitals providing sickle cell disease and hemophilia care in Kenya?

ii.Do strategic leadership practices improve delivery of high-quality sickle cell disease and hemophilia care in Kenya?

iii.What are the challenges of strategic leadership in hospitals providing sickle cell

disease and hemophilia care in Kenya?

CHAPTER II: LITERATURE REVIEW

2.1   Theoretical Framework

2.1.1   Theory of Dynamic Capability

Teece & Shuen (1997) founded the principle on three key tenets namely seizing, sensing, and reconfiguring are necessary for successful adaptation strategies (or transformation). According to Teece (2017), dynamic capabilities refer to a company's capability to construct, expand, or modify its collection of resources in order to outperform its competitors in terms of financial benefit. Furthermore, dynamic capabilities transform resources into higher performance. In regimes of rapid (technological) changes, Teece (2017) claims that dynamic capabilities boost competitive advantage. In a highly dynamic environment, these capabilities are component competencies that are required to sustain exceptional service quality.

According to Day and Schoemaker (2016), In order to respond to fluctuating markets, rivals, and technological breakthroughs, it is crucial to recognize opportunities and threats. Leaders ought to generate fresh concepts when identifying the requirement for transformation during the perception stage of undertaking (Cyfert & Krzakiewicz, 2016). A workforce that is capable of recognizing change, is in better position to react and adapt to it.

The theory of dynamic capabilities can be utilized by corporate leaders to respond to alterations in the commercial setting. When it comes to building dynamic capabilities, management plays a key role, especially when it comes to altering or reorganizing company's resource pool (Liang & Zhang, 2019). The essence of dynamic capabilities, according to Wojcik (2015), is modifying how resources, processes, and talents are

allocated and merged in order to boost productivity. According to Teece (2017), Leaders in organizations which are dynamic have incredible forces of nature that allow them to seize, reconfigure, sense and modify their institutions.

In relation to DC theory, Cai, Liu, Huang and Wang (2018) defined agility as the capability of a strategic leader to swiftly and effectively respond to and adjust to change for the betterment of the institutions. A leader with strategic agility is capable of not just reacting to and adapting to change quickly and correctly, but also the ability to bring about changes (Festing & Harsch, 2019). According to Carvalho, Rebentisch, Sampaio, and Saraiva (2017), a leader's agility serves as a facilitator for organizational competitive advantage.

When business executives improve workforce agility through suitable initiatives, they have the potential to reap numerous advantages. Quality enhancement, improved customer service, and accelerated learning curves are all benefits of strategic leader's agility, according to Sohrabi, Hammad & Nia, 2014). Snyder and Brewer (2019), posit besides speed, reactivity, and adaptability, strategic leaders' flexibility enables businesses to thrive in a cutthroat, uncertain, and continually changing world. Due to its emphasis on identifying and exploiting opportunities and changes in the environment through resource alignment, and modifying resources to address risks, the dynamic capabilities theory is a suitable perspective for examining the methods of leader agility in this study (L'Hermitte, Bowles, Tatham, & Brooks, 2015).

This theory was the most pertinent to this study as dynamic capabilities and can be used by leaders to promote change adaptation and implementation, resulting in improved employee performance. According Pitelis and Wagner (2019) dynamic capability theory is used in interacting strategic leaders with employee performance and

understanding managers/leader capabilities in building dynamic capabilities variables. Strategic agility, according to Sherehiy and Karwowski (2014), produces a flexible work environment capable of adjusting to sudden and rapid developments in the business context. However, the DC theory has drawn criticism for its key notions' absence of empirical clarification and for the difficulties in defining initial circumstances (Hallberg & Felin, 2020).

2.2.2 Contingency Theory of Leadership

The contingency theory of leadership, also known as "A Contingency Model of Leadership Effectiveness," was created by Fred Edward Fiedler in 1964 and posits the efficiency of a leader. According this theory, strategy is a contingent component that must be fit into its context, both internal and external in order to improve employee performance (Shala, Prebreza & Ramosaj, 2021). The alignment of company characteristics to contingencies which depict the institution's circumstances, according to contingency theory, results in performance improvement (Cyfert, 2021). This point of view asserts that firms seek to improve the alignment and fit of the current set of situational variables with the altering its external surroundings. In hectic workplaces, this fit technique is seen as a dynamic, continual activity (Mahmud, Soetanto & Jack, 2021).

Contingency Theory of leadership practice believes that there is no universal organizational system that can fit every organization. Rather, the circumstances will decide the most effective leadership style (Suharyanto and Lestari, 2020). The contingency theory in strategic management is where the concept of strategic alignment comes in as fundamental idea that the balance between personnel performance and

strategic alignment has a substantial impact. This context can be found in the organization's external as well as internal environments (Abedalsttar, 2022).

As a result, by integrating synergies in strategy such as processes, organizational resources, and technical skills, institutions, whether private and public, function in a certain environment. Additionally, corporate strategy should indeed be interwoven with the goals, missions and plans of an organization (Chi, Huang & George, 2020). McClements and Young (2019) argue that strategic alignment is a contingency strategy that is dynamic throughout time. The study anchors influence of strategic alignment on employees' performance on this theory, because due to uncertain and constant changes, strategic alignment is needed in adapting to environmental change and uncertainty (Price, 2016). The study's alignment tactics, which are tied to organizational characteristics that will ultimately have an impact on employees' performance, make the theory of contingency pertinent (Luftman, 2014)

2.2.1 Goal-Setting Theory

Goal-setting theory was developed by Edwin Locke in 1960. The theory principle is that goal setting is effectively connected to employee performance. According to Locke and Latham (2002), defined goals, strategies, and plans should be established to understand what an organization wants to achieve and how it wants to achieve it (Locke & Latham, 2002). In goal-setting theory, firms with goals perform better because they focus efforts and resources on tackling key challenges and employees understand the organization's priorities (Jung and Lee, 2013).

Similarly, in goal-setting theory, firms with goals perform better because they focus efforts and resources on tackling key challenges and employees understand the

organization's priorities (Jung &Lee, 2013; Locke & Latham, 2002). Strategizing has always resulted in concrete strategies, goals, and plans aimed at overcoming strategic challenges (Bryson 2011). It incorporates elements of goal-setting theory to strategy development by stating clearly what the organization's goals are priorities are and how they were addressed to the organization's stakeholders.

Goal-setting theory emphases on definition of goals, strategies, and plans in order to understand what an organization intends to do and how it will accomplish it (Locke & Latham, 2002). In theory, strategic direction is a method of strategy formation that includes procedures, tools, and behaviors targeted at merging these theoretical explanations during strategy formulation—though it should be highlighted that how companies "act" strategic direction varies significantly (Bryson, Edwards, and Van Slyke 2018; Ferlie and Ongaro 2015). The popularity of strategic direction appears to support the notion that it improves employee performance.

In relation to goal seating theory, effectiveness of employee is an enhanced version of employee performance that results in an increased output (Locke, Shaw, Saari & Latham, 1981). Therefore, goal setting theory is significant to the current study because employee effeteness was enhanced by goal settings. This argument supports findings that individuals without specified goals may work ineffectively without direction or awareness of how they are performing or bringing value to the organization experiments.

2.2 Empirical Review

The organizational crises that have been experienced globally, have led to the recognition of strategic leaders as vital drivers in improving employee performance. For instance, Alvi, Haider and Akram (2021) linked the high performance of employees in Higher Education Commission headquarters in Islamabad with strategic leadership. In Pakistan, Raza, Ali & Moueed, (2017) showed strategic leadership enhancing employee performance, the study proved the benefits of strategic leadership, when managers consider the physical factors when conducting an environmental analysis in order to compete with their competitors. Due to their firm's usage of the production approach, strategic leaders place less emphasis on developing relationships with their workforce.

2.2.1 Global perspective

Globally, In the United Kingdom, Andrews, Higgins, Waring & Lalor (2012) indicated due to critical role played by strategic leadership in implementation of strategies, most larger firms are engaging in effective leadership that enhances employee performance. In India, Zia, Aqib, Bin, Bilah & Raza (2017) associated the performance of employees in Indian firms with strategic leadership. In the Kurdistan Region of Iraq, Ali and Anwar (2021), observed that strategic leaders in small and medium-sized companies (SMEs) improves employees' motivation, workplace coordination and employees' productivity. In University of Guilan, Akbari, Dustar, Esmailzadeh, Hosseini (2019) found that the higher the strategic leadership skills, the more the employees' effective commitment, empowerment and work performance.

In Pakistan Health sector, Baloch and Siddiq looked at how strategic leadership affected Peshawar, Pakistan's market-competitive healthcare services. Their study concentrated on the senior management of hospitals in the public and private sectors. The goal of the study was to investigate the conventional methods and strategies of strategic leadership in the provision of healthcare services. The study used a sample of 300 people in top management roles in both public and commercial institutions for its research. Male and female participants with titles including directors, deputy superintendents (DMS), chairmen, chief executives and medical superintendents (MS), were included in the sample. The researchers examined the data by using regression analysis. The findings showed that there were differences in the two sectors of Peshawar's strategic leadership, notably in two areas: the leaders' capacity to display personal attributes and their competence to carry out plan. The participants felt that, in comparison to their counterparts in the private sector, top management in the public sector had a higher level of personal traits. On the other hand, top managers in the private sector showed a higher capacity to implement strategy while adhering to the recommended leadership structure. however, despite the study indicating importance of strategic service in health services, it was conducted in Pakistan and did not focus on delivery high-quality sickle cell disease and hemophilia care.

Smith (2019) performed a survey to examine the effect of leadership techniques on healthcare in American hospitals, concentrating in particular on the difficulties faced by hospital administrators in providing top-notch medical care to people of varied racial and ethnic backgrounds. Phenomenology was used in this study as a qualitative research methodology. In-depth interviews were used to acquire data while surveying healthcare leaders. Constant comparative analysis was used throughout the data analysis process to compare one data segment to another and find similarities and differences. Using

methods including taking notes, data entry and storage, and coding, the researcher transcribing and analyzing the interview data. Personal participant observations and interview responses, which occasionally called for follow-up inquiries, were both noted. Healthcare executives who have been in their current positions for at least two years were included in the study. According to the results, 33% of the participants mentioned communication as a tactic for utilizing their leadership qualities. Technology significantly contributed to the promotion of a team approach by improving communication throughout the healthcare spectrum. The participants also discussed how direct access and communication between healthcare professionals were improved by electronic health records, which helped to promote patient-centered care. The study did not narrow to strategic leadership strategies but focuses on general leadership. Further the study provided focuses on healthcare outcome but not quality of health care.

Conner-Boyd (2019) looked at roles played by strategic leadership in profitability of healthcare how Georgia health sector. Using 'in-depth approach to collect data from five senior healthcare executives who had 15 years experienced in health care and 10 years in leadership positions using semi –structured interview schedule which had open ended open-ended questions, the study sought to answer role played by strategic leadership in hospitals, which strategic leadership strategies were successful implemented and increased hospital profitability, how effective was strategic leadership strategies in improvising hospital hospitality and key challenges faced in implementing strategic leadership . The resource-based perspective, which placed emphasis on the value of strategic leadership abilities, served as the focal point for the discussion on increasing healthcare profitability. The data were analyzed using thematic analysis. Seven themes emerged as a result of the analysis: human capital growth, leadership element, adaptability, market expansion, efficient financial resource management,

customer happiness, and standardization. These findings may benefit senior Z healthcare profitability in the United States, stimulating a growth in employment, and creating employment opportunities. the study majored more of how strategic leadership profitability of health care with specific the health and there was no link between strategic leadership and quality of health care

Huebner and Flessa (2022) used review of literature in discussing strategic management in health care and call for strategic thinking in an Uncertain System. The study reviewed four strategic leadership strategies namely; strategic apex, strategic thinking, uncertainty and complexity in healthcare sector. The review's conclusions showed that, in comparison to earlier centuries, the rapid acceleration of interconnections and the complexity of societies require a higher level of strategic thought in pandemic response. In addition to technical forecasts, effective management of COVID-19 highlights the critical importance of inspiration, communication. and motivation. The study was theoretical and focused more on general leadership hence; there was no empirical evidence strategic leadership and quality health care high relevance of leadership in dealing with the COVID-19 pandemic.

Sritoomma and Wongkhomthong (2021) established what entails strategic leadership competencies of chief nurse executives (CEOs) in private hospitals in Thailand. Using factor analysis in a qualitative approach data was gathered from a sample of 234 nurse executives from 65 private hospitals using open and close-ended questionnaire. Items measuring elements of strategic leadership competencies had Crobanch alpha coefficient of .91, while content validity test indicated a score of 0.91, and the reliability was at 0.91. Confirmation factor analysis was used to verify competencies derived from content analysis. After factor analysis 7 components of strategic leadership (strategic-

innovative thinking and planning, building futuristic leaders, strategic partnership, relating the parts to the whole, strategic direction, corporate spirit and making it happen which after confirmatory factor analysis indicated loadings of 0.89, 0.89, 0.82, 0.78, 0.78, 0.73 and 0.66 respectively. However, there was no link between strategic leadership competencies and delivery of quality health care.

Morténius, Hildingh and Fridlund (2016) employed longitudinal design in assessing how innovation (long-term interest in research and development for 12 years period in Swedish primary care area. Data was collected using in prospective intervention from primary care staff members (PCSMs) in general and registered nurses (RNs). Results revealed after 7 years of intervention of strategic leadership, 99.5% of registered nurses were aware of research and development compared to 95% of the remaining PCSMs (p = .004). Those who were not interested in research and development increased their interest in employing strategic innovative thinking. Thus, the results concluded that strategic thinking increase innovative thinking and research and development. Nevertheless, there was no demonstration on how strategic thinking is linked with provisions of sickle cell disease and hemophilia health care.

2.2.2   Regional perspective

In Africa, despite strategic leadership being adopted and implemented in most organizations, statistically, less than 10% of leaders possess strategic skills hence the need in most current organizations (Dampson & Edwards, 2019). Adeoye, Egwakhe and Adefulu (2019) indicated that strategic leadership dimensions: - decision making, risk taking, strategic practices (ethical practices) and communication, improves employee performance. From their viewpoint, Obiwuru, Okwu, Nwankewere and Akpa (2011) emphasized that strategic leaders bring together their subordinate employees

around the firm's objectives and goals with the aim of facilitating their attainment. These thoughts are shared by Dimitrios, Vlachos and Sakas (2013), who identify strategic leadership as an essential driving factor due to its capacity to favorably effect success of a firm. Folarin (2013) found that strategic leaders execute strategies aimed at enhancing employee innovation, attitude and information technology (IT) capability and this eventually increases performance of the institutions. However, lack of visionary leaders as one aspect of strategic leadership is one of the major challenges being faced by organizational management in Sub-Saharan Africa.

In Eastern Ethiopia, Jemal, et al., (2021) sought to factors associated with determine strategic communication between nurses and physicians in providing patients in Public Hospitals of Harari Regional State and Dire-Dawa City Administration. The level of communication was measured using dummy measures of "poor outcome" and "good outcome". The study reviewed related literature to visualize factors associated with level of strategic communication between nurses and physicians into organizational factors, socio-demographic factors and individual-related factor. Through phenomenological qualitative and a quantitative cross-sectional, self-administered questionnaire was employed in data collection from 440 nurses and physicians sampled using simple random sampling technique. Data was analyzed with aid of Epi-Data version 3.1 and STATA software (version SE 14). Quantitative data was analyzed using Descriptive statistics and Multivariable logistic regression analysis, while Qualitative data was analyzed with aid of Open Code (version 4.2) using thematic analysis method. Based on the findings, the study established that there was 53.2% level of nurse–physician communication in patient care. Based on the Multivariable logistic model, it was discovered that the poor degree of nurse-physician communication in patient care was independently related with various characteristics. Age group, marital status, level

of professional experience, wage bracket, greater ratings for organizational-related aspects, and higher ratings for work-related attitude behaviors were some of these variables. According to the qualitative research, poor working conditions and unfavorable attitudes among professionals served as obstacles to nurse-physician communication during patient care. The amount of nurse-physician contact in patient care cannot be causally linked to the analyzed variables because this study is cross-sectional in nature. It is crucial to remember that this study's conclusions could be impacted by some biases. It's possible that respondents had conversations with their coworkers that contributed to social desirability bias. Furthermore, respondents may have displayed recollection bias.

Odit, Rwashana, and Kituyi's study from 2014 concentrated on the factors and dynamics impacting the strategic alignment of Uganda's health information systems (HIS). The objective was to successfully address the intricate design problems with information systems. 296 people in all, who were purposefully chosen from 39 healthcare facilities across the nation, participated in the poll. Descriptive statistics were used to analyze the data that was gathered. According to the study's conclusions, Ugandan health units lacked the structures, standards, and policies required for the strategic alignment of HIS, and there was not enough money to support such projects. It is essential to engage in careful planning and train healthcare professionals on the value of strategic alignment in HIS in order to improve the alignment of HIS. Additionally, there is a need to promote the use of electronic information systems in healthcare facilities because they can increase productivity and effectiveness.

2.2.3 Local perspective

Locally, according to a study by Kabetu and Iravo (2018), it was found that fewer than 10% of leaders displayed the strategic leadership abilities necessary to guide organizations to reach their goals. As noted by Ng'ang'a (2018), some of the critical duties of strategic leaders within companies are setting the strategic direction for the firm, fostering and preserving a productive organizational culture; skillfully procuring, distributing, and administering company resources, providing employees with the required skills, establishing internal control systems and implementing best practices. Tek, and Deya, (2020) identifies four strategic leadership approaches namely strategic direction, strategic intent, strategic alignment and strategic communication, as key drivers of successfully implementing strategies that favors improved employee performance. Miriti (2021) indicated that strategic leadership components like human capital focus, strategic direction and strategic control were related with organizational performance positively.

In Kenya, Cherop, Wachira, Korir and Bagire (2022) studied attributes of strategic leaders in Academic Model Providing Access to Healthcare (AMPATH) clinic, at Moi Teaching and Referral Hospital in Eldoret, Kenya. A sample of 22 clinical officers (clinical officers, social workers, nurses, retention officers, counselors and, pharmacists) who are in HIV healthcare system who were purposively responded to open ended question in a semi-structured interview schedule in-depth interviews carried between September 2019 to May 2020. Four domains containing characteristics of strategic clinical leaders were identified after the data was evaluated using a thematic method. These areas included management attributes, personality traits, interpersonal skills, and training and expertise. Clinical expertise, knowledge, team leadership skills,

loyalty, honesty, and integrity were among the criteria listed under each area. Other qualities included being quick and adaptable, unbiased, and serving as a mentor. Additionally, qualities like approachability, encouraging positive relationships and interactions, being an excellent listener and understander, a problem-solver, having good communication skills, exhibiting respect, being a good planner, being accountable, disciplined, innovative, organized, dedicated and hardworking, and vocal were also identified.

2.3 Summary

Strategic leadership's impact on employee performance has been widely studied, as shown by Andrews et al. (2012) in the UK and Zia et al. (2017) in India. However, these studies do not specifically address healthcare. Ali and Anwar (2021) in Iraq's SME sector, and Akbari et al. (2015) at the University of Guilan, emphasize the benefits of strategic leadership on motivation and productivity but lack a focus on healthcare quality. In Pakistan, Baloch and Siddiq highlighted differences in leadership effectiveness between public and private hospitals but did not focus on high-quality care for specific diseases. Smith (2019) and Conner-Boyd (2019) in the US explored general leadership and profitability in healthcare without addressing strategic leadership's role in quality care for sickle cell disease and hemophilia.

In Africa, Adeoye et al. (2019) and Jemal et al. (2021) focused on general organizational contexts and communication factors affecting healthcare delivery but did not address strategic leadership in delivering quality care. Odit et al. (2014) in Uganda highlighted the need for strategic alignment in health information systems but did not directly relate to strategic leadership or specific healthcare quality issues. These

regional studies, while relevant, do not bridge the gap between strategic leadership and high-quality care for sickle cell disease and hemophilia.

In Kenya, Kabetu and Iravo (2018) identified a lack of strategic leadership skills among leaders, focusing on general organizational leadership rather than healthcare. Cherop et al. (2022) studied strategic leadership attributes in HIV care at the AMPATH clinic but did not address sickle cell disease and hemophilia care. The literature reveals a significant gap in research linking strategic leadership to the delivery of high-quality care for these specific conditions in Kenya, emphasizing the need for targeted studies in this area.

CHAPTER III: METHODOLOGY

3.1 Overview of the Research Problem

The Government of Kenya and other stakeholders have shown interest in addressing sickle cell disease (SCD) and hemophilia by implementing numerous interventions aimed at enhancing the delivery of high-quality care. However, hospitals responsible for providing this care continue to face significant challenges such as inadequate funding, lack of proper training for healthcare providers, limited diagnostic tools, and insufficient treatment options. Despite substantial funding from donors and the government, many patients with SCD and hemophilia still report poor service quality, and a majority of children with these conditions do not survive into adulthood, or if they do, they live with multiple deformities and complications. This raises critical questions about the effectiveness of current strategies in delivering high-quality care. Consequently, this study aims to investigate the strategic roles of hospital leaders in ensuring that patients with SCD and hemophilia receive quality care in Kenya. The main objective is to assess how strategic leadership impacts the delivery of high-quality care, with specific research questions focusing on the aspects of strategic leadership practiced, their effects on care delivery, and the challenges faced by hospital leaders in this context.

3.2   Operationalization of Theoretical Constructs

Strategic leadership encompasses a leader's ability to articulate and communicate a strategic vision, motivate employees, and implement strategies to achieve organizational goals. Scholars such as Mulyono et al. (2020) emphasize strategic communication, thinking, and direction, while Alzawahrah and Alkhaffaf (2021) highlight articulating vision, inspiring confidence, and promoting human capital and

technology. Davies and Davies (2012) link strategic leadership to operational planning, focusing on vision, organizational change, and strategic thinking. Syafitri, Ahadiat, and Hayati (2021) add foresight, flexibility, and team cooperation to the concept. Alyileili (2020) underscores competitive edge through organizational learning and modern technologies, and Al Thani and Obeidat (2020) stress vision molding, inspiration, and strategic discussions. For this study, strategic leadership is operationalized using indicators such as strategic direction, technological innovation, employee involvement, and strategic thinking to investigate the roles of hospital leaders in enhancing care for sickle cell disease and hemophilia in Kenya.

3.3   Research Purpose and Questions

The study aims to achieve its primary objective, which is to determine the strategic roles of hospital leaders and their impact on the delivery of high-quality care for sickle cell disease and hemophilia in Kenya. In pursuit of this goal, the study intends to address the following research questions.

iv.   What are the aspects of strategic leadership practiced by leaders of hospitals providing sickle cell disease and hemophilia care in Kenya?

v.   Do strategic leadership practices improve delivery of high-quality sickle cell disease and hemophilia care in Kenya?

vi.   What are the challenges of strategic leadership in hospitals providing sickle cell disease and hemophilia care in Kenya?

3.4   Research Design

Guided by the work of Creswell (2014), this study leaned towards the positivism paradigm given that quantitative data was collected to generate knowledge through testing the theories that grounds the study. Therefore, descriptive and explanatory research design was used to descriptive aspect of strategic leadership practiced in hospitals and their effect on delivery of high-quality sickle cell disease and hemophilia care in Kenya. In Explanatory research design, the researcher identifies the key variables that have a causal effect relationship with a given phenomenon (Gratton & Jones, 2010). In Explanatory research design, Coefficient of regression analysis as a statistical parameter explains the degree and the nature of casual-effect relationship between two variables. A positive change in the value of one variable may cause a similar and a positive change in another variable (Cooper and Schindler (2014). These two variables tend to be perfectly positively correlated. If the mentioned variables decreased whenever the other one was decreased, then such variables are said to be perfectly negatively correlated (Fraenkel, Wallen and Hyun, 2011). Similarly, if a change in one variable does not trigger any effect on the other variable, then the two variables are said not to be correlated.

3.5 Population and Sample

3.5.1 Target Population

The research will focus on 558 hospitals located throughout the country, including public, private, and faith-based institutions. These hospitals are registered and categorized as level 4, level 5 and level 6, which indicates their ability to provide care for sickle cell disease and hemophilia. The main subjects of observation in the study were three senior management officers and one client/patient who is receiving services

at each hospital. It is assumed that the senior management officers possess relevant information about the study's concepts due to their managerial responsibilities in the hospitals, while the clients/patients hold valuable insights as recipients of services. Lower-level facilities will not be included in the study due to their high patient volume and limited capacity to provide comprehensive care and services.

Table 3.2: Target Population

	Hospitals
Level 6	8
Level 5	56
Level 4	494
Total	**558**

Source: Ministry of Health, (2023)

3.5.2 Sample Size

For this study, Slovin's formula (2018) also developed by Yamane (1967), was used to calculate the sample size of 233

$$n = \frac{N}{1 + N(e)^2}$$

$$n = \frac{558}{1 + 558(0.05)^2}$$

$$n = 233$$

Where n is the sample size, precisions level is 95% confidence level thus giving a e of 0.05, N = population of 558 which when integrated in the Slovin's formula, generate a sample size of 233 as outlined above. For the selection of the sample, the study will adopt the stratified, random and purposive sampling technique.

3.6 Participant Selection

This research will employ probability sampling methodologies. Stratified sampling and simple random sample from the probability sampling approach was used in this study. In the first phase, stratified sampling was used to stratify the 233 sampled hospitals into 3 levels of hospitals (4, 5 and 6). The strata were formed based on area of specialization, mandate, and similar characteristics, which account for the sample not being homogenous. Using proportionate method, the calculated sample was proportionately apportioned to each stratum (Kothari, 2015). Proportionate method was used in order to get equal representation, where the study will compute each stratum's sample by dividing the stratum's population with the total population and multiplying the result with the sample so as to get a proportionate representative sample from each stratum as shown in Table 3.2. This will ensure that equity in representation of respondents and data is maintained.

The next stage of probability sampling technique process will involve employing simple random sampling to select the final sample of hospitals from each stratum. This method will hence be preferred because it is good in attaining high level of representativeness from the population and reducing bias. In this study, a total study sample of 233 will randomly be selected.

Further, purposive sampling from the non-probability sampling technique was used to purposively pick 3 management officials (Head of department, supervisors and one medical staff) and one client (a sickle cell disease and hemophilia patients seeking care from the hospital) giving a total sample 928. Purposive identification of these managers was based on their unique experiences and expertise in management issues in their institutions.

Table 3.2:   Sample Size Distribution

	Hospitals	Sample Of Hospitals	HOD	Supervisors	Medical Staff	Clients	Sample Of Respondents
Level 6	8	3	3	3	3	3	12
Level 5	56	23	23	23	23	23	92
Level 4	494	206	206	206	206	206	824
Total	558	233	232	232	232	232	928

Source: Researcher (2023)

3.7 Instrumentation

This study used both closed-ended and open-ended data collection instruments. Structured or closed-ended questionnaires was used to collect quantitative data from management and patients. Close-ended questionnaire was under five-point Likert scale. Closed-ended questionnaires focus on collecting numeric data with the use of specific questions (Creswell and Creswell, 2018). The rationale is that all respondents are asked the same series of questions that effectively collect answers from a large sample before the analysis is performed (Saunders, Lewis & Thornbill, 2015).

Pilot's study was conducted to identify any likely faults in the research tool by evaluating its validity and reliability.   Face validity was attained when the questionnaire is critiqued by supervisors and experts and necessary adjustments done. Face validity was in the early stages of developing a questionnaire. Further, to accomplish construct validity, convergent and discriminant validity was tested using factor analysis as postulated by Straub et al. (2004). To check the reliability of the survey instrument, the study will produce a Cronbach's Alpha. A Cronbach's Alpha coefficient of 0.7 or higher was taken into account. Hair *et al.* (2010) recommends that composite reliability values should be larger than .70 above as sufficient for data collection to proceed.

3.8 Data Collection Procedures

The data collection procedure began with the researcher or an appointed assistant formally introducing themselves at the designated data collection sites, using letters of authorization from the university and the principal secretary. Following this, HR managers or departmental heads at the sites sought approval from relevant research and ethics committees to ensure compliance with ethical standards. Only after receiving official approval letters from these committees did the actual data collection process commence.

3.9 Data Analysis

Data was collected, cleaned, coded, and analysed using the Statistical Package for Social Sciences (SPSS) version 26 and Analysis of Moment of Structure (AMOS 21) software using both descriptive and inferential statistics. Data cleaning was done to ensure that missing values using Littles test for (Missing Completely at Random) MCAR and use of Expectation Maximation if MCAR to avoid distorting results in Structural Equation Modelling (SEM)), outliers was tested using scatter plot to ensure no extreme cases affect data thus normality. The normality of distribution using kurtosis and skewness was done to measure peakedness and symmetry respectively. Descriptive statistics was used to describe and summarize the data to enable the meaningful description of the distribution of the scores or measurements and data was presented using mean, standard deviation, and variance. Data was also subjected to inferential statistics using Structural Equation Modelling (SEM) to test the relationships between exogenous and endogenous variables.

3.9 Research Design Limitations

The study was limited to hospitals registered and categorized as level 4, level 5, and level 6, which are designated as having the capability to provide care for sickle cell

disease and hemophilia. Additionally, the research relied solely on quantitative data collected through the use of closed-ended questionnaires. This approach may have restricted the depth of insights into the nuanced experiences and perspectives of healthcare providers and patients, potentially overlooking qualitative aspects that could provide a more comprehensive understanding of the challenges and effectiveness of care strategies in these hospitals.

The study presents significant findings regarding the aspects of strategic leadership practiced in hospitals providing care for Sickle Cell Disease and Hemophilia in Kenya, along with the impact of these practiced aspects on the delivery of high-quality care, and the challenges faced in strategic leadership within these healthcare settings. However, the study has several limitations. Firstly, it focused exclusively on hospitals offering care for Sickle Cell Disease and Hemophilia in Kenya, utilizing the conceptualization of strategic leadership items as outlined by Simsek, Jansen, Minichilli, and Escriba-Esteve (2015), supplemented by insights from O'Shannassy (2016), Alzawahrah and Alkhaffaf (2021), and Gupta (2018). Additionally, the study was constrained in its ability to precisely identify how each specific dimension of strategic leadership influences the delivery of high-quality care for these conditions. Furthermore, the study relied on quantitative data, which may introduce subjectivity in measurement

CHAPTER IV: RESULTS

4.1   Introductions

This chapter indicates results of data and answers research questions done to investigate how strategic leadership affects delivery of high-quality sickle cell disease and hemophilia care in Kenya. The chapter is organized into five sections, each focusing on a specific aspect of the research. The first section outlines the demographics of the participants, providing an essential context for understanding the sample population. The second section delves into factor analysis, exploring the underlying dimensions of the data that contribute to the overall results. In the third section, a descriptive examination of the study variables is conducted, allowing for an in-depth understanding of their distribution and relationships. Lastly, the fourth section presents outcomes of research questions.

4.2   Response Rate

The participants were presented in terms of medical employees (clinical officer, dentist, doctor, lab technician, medical officer, nurse, orthopedic technician, paramedic, pediatrician, pharmacist, physiotherapist, radiographer, radiologist, and surgeon) categories from where the respondents were drawn. The response rate was analyzed as per questionnaire order.

Table 4.1:

Response Rate

	Hospitals	Questionnaire distributed to medical staff	Total Questionnaire Retuned	Response rate as per hospitals	Response rate (%)
Level 6	3	9	9	3	100.0
Level 5	23	69	47	16	69.6
Level 4	206	618	561	187	90.8
Total	233	696	617	206	88.4

Source: Field Data (2023)

Based on Table 4.1, out of a total of 696 questionnaires distributed to medical employees (3 questionnaires in each of the 233 hospitals, distributed to 1 Head of Department, 1 Supervisor, and 1 Medical Subordinate Staff), 617 questionnaires were returned from 206 hospitals (Note: the 3 questionnaires in each hospital were averaged to get one consolidated response), yielding an 88.4% response rate. This impressive outcome was achieved after meticulous data screening and cleaning, which involved checking for missing data and outliers. The success in obtaining such a high response rate can be attributed to the consistent presence of the researcher and assistant at the research sites. They patiently awaited respondents to complete the questionnaires on-site, conducted personal reminder calls and visits, and allowed those not immediately available to use the drop-and-pick-later method. Mugenda & Mugenda (2013) established that response rates above 50% are acceptable, rates surpassing 60% are considered good, and those exceeding 70% are very good. Cooper and Schindler (2014) suggested that research can proceed with a response rate of more than 60%. In the context of this study, a response rate of 88.4% was deemed more than sufficient for conducting a thorough analysis and presenting the results.

4.3 The Data Preparation, Screening and Cleaning

Data gathering, cleaning, and organization are all steps in the process of preparing data for analysis (Desimone et al., 2019). It was confirmed that the data satisfied the prerequisites for quantitative as well as qualitative evaluation before it was made ready for analysis. This included visually inspecting questionnaires to identify outliers, any missing values, incomplete sections or wrongly filled in.

4.3.1 Checking for Missing Value and Treatment

The completed questionnaires were examined to verify that they were accurately filled out and did not contain any missing information or values. Hair et al., (2010) recommends that researchers may exclude cases with missing data, while Tabachnick & Fidell (2018) note that observations with over 50% missing values can significantly impact the remaining data. Consequently, the research disregarded 2 cases that had more than 50% missing values.

Apart from eliminating the mentioned cases, the research also dealt with cases that had missing values of less than 50%. To treat these instances, Pallant's (2011) technique of mean substitution was utilized in the study. With this technique, the missing values are filled in by computing the mean value of the relevant variables. Hair (2010) highlights several benefits of this approach, including fewer convergence issues, unbiased factor loading estimates, and ease of implementation with any statistical software.

4.3.2 Outliers

Data points that appear anomalous or fall outside the anticipated value range are referred to as outliers, which may signify errors or information unrelated to the main data set (Zhang, Meratnia & Havinga, 2010). To identify and address multivariate outliers, this study employed the Mahalanobis D2 measure, as suggested by Tabachnick

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and Fidell (2018). It is worth noting that managing multivariate outliers would also handle univariate outliers; however, addressing univariate outliers does not guarantee the same for multiple outliers.

Table 4.2:

Mahalanobis D2 for Outlier Test

case	D2	P value
15	41.2	0.0001
33	46.18	0.000
38	291.17	0.000
71	101.88	0.000
113	216.01	0.000

Source :(Field Data, 2023)

The Mahalanobis D2 values were calculated using SPSS's linear regression algorithms, followed by the calculation of a Chi-square value. Upon careful examination, it was observed that 5 of the cases examined, contained outliers which may would have influenced the overall statistical analysis and interpretation of the results. According to Tabachnick and Fidell (2018), four of the five selected variables represent the degrees of freedom in the chi-square table and have a p-value of less than 0.001. As a result, every case that qualifies as a multivariate outlier and requires removal has a Mahalanobis D2 value probability that is less than 0.001. Five of these instances, each with a value below 0.001, were thus excluded from the study to allow for additional research.

4.4 Demographic Characteristics

Demographic data plays a crucial role in providing insights about research participants and ensuring that the study's sample accurately represents the target population (Salkind, 2010). Cooper and Schindler (2014) highlight the significance of

demographics in fostering a positive relationship between the researcher and the respondent, which further encourages the respondent to provide the necessary information. This background information enables the researcher to collect accurate data from the appropriate respondents and ensures their ability to address the research questions. Munyao (2020) asserts that an organization's employee performance largely depends on its capacity to address the needs related to its workforce's demographic characteristics. The findings are presented in Tables 4.2 through 4.8.

4.4.1 Medical Staff Respondents

The study aimed to identify the participants' organizational cadres in Table 4.3

Table 4.3:

Cadre

	Frequency	Percent
Clinical officer	27	13.1
Dentist	4	1.9
Doctor	36	17.5
Lab technician	6	2.9
Medical officer	2	1
Nurse	113	54.9
Orthopedic technician	1	0.5
Pediatrician	1	0.5
Pharmacist	2	1
Physiotherapist	3	1.5
Radiographer	1	0.5
Radiologist	4	1.9
Surgeon	6	2.9
Total	**206**	**100**

Source: Field Data (2023)

The findings table 4.3 reveals a diverse distribution of medical professionals in the survey, with nurses comprising the majority at 54.9%, emphasizing their pivotal role in healthcare. Doctors and clinical officers also constitute significant portions at 17.5%

and 13.1%, respectively, showcasing the diversity of medical expertise. Other specialties, such as dentists, lab technicians, and surgeons, contribute to the overall representation, albeit in smaller percentages. The prevalence of various medical roles underscores the multidisciplinary nature of the healthcare workforce, with each category playing a crucial part in the delivery of healthcare services. Understanding these proportions is essential for tailoring interventions and policies to the distinct needs and perspectives of different medical professionals.

4.4.2 Job Group/Grade

The study also identified Job Group/Grade as a crucial characteristic of the respondents, as illustrated in Table 4.4.

Table 4.4:

Job Group/Grade

	Frequency	Percent
M	104	50.5
N	3	1.5
P	1	0.5
K2	29	14.1
K4	21	10.2
K5	3	1.5
K6	24	11.7
K7	3	1.5
J	18	8.7
Total	**206**	**100**

Source: Field Data (2023)

The table 4.4 provides insights into the distribution of respondents based on their Job Group/Grade. Notably, Job Group 'M' stands out as the most prevalent, representing 50.5% of the total respondents, indicating a substantial presence within this specific grade. Additionally, the combined representation of 'K2,' 'K4,' and 'K6' accounts for 35.9%, highlighting a noteworthy diversity across middle-ranking grades. Job Group 'J'

contributes 8.7% to the distribution, emphasizing a significant but smaller presence. The remaining Job Groups - 'N,' 'P,' 'K5,' and 'K7' - collectively form 4.5% of the respondents, showcasing additional diversity within the surveyed population. Understanding the distribution across these Job Groups/Grades is crucial for developing targeted strategies and interventions that cater to the unique characteristics and requirements associated with each category in the workforce.

4.4.3 Distribution of Respondents by Gender

The gender of the respondents was also deemed an important characteristic for assessment, as depicted in Table 4.5.

Table 4.5:

Respondents' Gender

	Frequency	Percent
Male	101	49
Female	105	51
Total	**206**	**100**

Source: Field Data (2023)

Table 4.5 on gender biodata revealed that there was relatively balanced representation of both males and females. Although there was slight dominance of female employees, constituting 51% of the total respondents, the male employees were well represented at 49%. This marginally higher representation of female medical employees could be attributed to the increasing trend of women pursuing careers in the medical field in the region. The findings also implied that the public health sector offers equal employment opportunities to either gender. Owino (2019) points out that a study should reflect the two-thirds gender rule in its participant representation. Similarly, gender representation

in the study aligns with the views of Creswell & Creswell (2018), who advocate for including both genders in a study to ensure diverse responses.

4.4.4 Distribution of Respondents by Age

The following section presents an analysis of the distribution of respondents based on age, with specific details provided in Table 4.6.

Table 4.6

Age of the Respondents

	Frequency	Percent
30 years and below	27	13.1
31-40 years	75	36.4
41-50 years	63	30.6
51-60 years	41	19.9
Total	206	100

Source: Field Data (2023)

The researcher was interested in age dynamics because it is significant in determining the level of employee commitment to performance. According to Muchemi (2013), perception, thinking, experience and performance vary depending on age. From Table 4.8, the majority of respondents 36.4%) fell within the 31-40 years of age category. In addition, 30.6% of respondents were between the ages of 41 and 50, while just 13.1% of respondents were aged 30 or younger. This demographic distribution indicated that the respondents were relatively young employees in the medical field, with the majority being within their first five years of employment. Although the largest group of respondents was middle-aged, the inclusion of all age groups guaranteed a diversity of perspectives, eliminating any negative impact from age-related bias. According to Creswell & Creswell (2018), having a well-distributed age range in research contributes to diversified responses. Chanzi (2017) supports this stance by arguing that age can significantly affect a respondent's understanding and opinion on a specific social issue.

4.4.5 Distribution of Respondents by Years Worked in the Hospital

The researcher was interested in years worked in the hospital sector; because expertise is important in the acquisition of knowledge and skills, which can be used in understanding the research tool and subject under study, hence presenting informed and valid responses.

Table 4.7:

Worked years in the Public Service

	Frequency	Percent
0-5 years	58	28.2
6-10 years	79	38.3
11-15 years	33	16
16-20 years	13	6.3
Over 21 years	23	11.2
Total	**206**	**100**

Source: Field Data (2023)

Majority of employees (38.3%) had worked in hospital sector for 6-10 years. A considerable percentage (28.2%) had 0-5 years of experience in the hospital sector, while only 14.9% had worked between 11-15 years. The percentage of employees working for long periods significantly reduced, with only 6.3% having 16-20 years and 11.2% having over 21 years of experience. Evidently, the hospitals had predominantly younger workforce in hospital sector, with a gradual decrease in representation as the years of experience increased, possibly indicating a high turnover rate or limited long-term career growth opportunities for medical employees in the healthcare sector.

4.4.6 Distribution of Respondents by Period worked in the Current Station

The research further sought to determine respondents' years worked in the current station.

Table 4.8:

Years Worked in the Current Station

	Frequency	Percent
0-5 years	117	56.8
6-10 years	60	29.1
11-15 years	22	10.7
16-20 years	3	1.5
Over 21 years	4	1.9
Total	**206**	**100**

Source: Field Data (2023)

Table 4.8 presents the respondents' years worked in their current stations. As shown in the Table, it is observed that the majority of the participants (58%) had worked for duration of 0-5 years at their stations. This indicated that most medical employees were relatively new to their respective workstations. In comparison, a substantial percentage (27.9%) had 6-10 years of experience at their stations, 10.4% had 11-15 years, 1.5% had 16-20 years, and a minority (2.2%) had been working in the same location for over 21 years. The data demonstrated a skewed distribution towards recently employed medical staff, with a smaller percentage of employees possessing long-term experience in their stations. This demographic information proved valuable when considering how strategic leadership influences medical employees output with varying levels of experience and tenure in their workstations.

4.4.7 Patients Demographic Characteristics

Table 4.9 delves into the patients' demographic characteristics, offering a comprehensive overview of key aspects such as medical conditions, gender distribution, duration of hospital visits, and the duration since the onset of sickle cell disease and hemophilia. This table serves as a valuable resource for understanding the composition of the patient population under study, shedding light on the prevalence of

specific medical conditions, the gender distribution, and the temporal aspects related to hospital visits and the duration of illness.

Table 4.9:

Patients Demographic Characteristics

		Frequency	Percent
condition	Hemophilia A	58	28.2
	Hemophilia B	4	1.9
	Sickle cell disease	144	69.9
	Total	**206**	**100**
Gender	Female	94	45.6
	Male	112	54.4
	Total	**206**	**100**
Years have you visited this hospital	1-10 yrs	114	55.3
	11-20 yrs	41	19.9
	21-30 yrs	25	12.1
	above 30 yrs	26	12.6
	Total	**206**	**100**
Years have you had sickle cell disease and hemophilia	1-10 yrs	24	11.7
	11-20 yrs	64	31.1
	21-30 yrs	29	14.1
	above 30 yrs	89	43.2
	Total	**206**	**100**

The table reveals that among the patients surveyed, 28.2% are diagnosed with Hemophilia A, 1.9% with Hemophilia B, and a significant majority of 69.9% with Sickle Cell Disease. This highlights the prominence of sickle cell disease within the patient population. In terms of gender, the data shows a relatively balanced representation, with 45.6% female patients and 54.4% male patients. This balanced gender distribution is crucial for understanding potential variations in healthcare needs and outcomes. Regarding the duration of hospital visits, the majority of patients (55.3%) have been visiting the hospital for 1-10 years. This information provides insights into the long-term healthcare needs and relationships between patients and healthcare facilities. The data on the duration of sickle cell disease and hemophilia

reveals that a substantial portion of patients (43.2%) have been dealing with these conditions for above 30 years. This underscores the chronic nature of these illnesses and the potential challenges faced by patients over extended periods.

The findings from Table 4.9 underscore the diverse and chronic nature of the patients' medical conditions. The prevalence of sickle cell disease is notably high, emphasizing the need for targeted healthcare interventions and support systems. The balanced gender distribution suggests the importance of considering gender-specific healthcare requirements. Additionally, insights into the duration of hospital visits and the longstanding nature of sickle cell disease and hemophilia contribute to a more nuanced understanding of the patient population, aiding healthcare providers in tailoring effective and personalized care strategies.

4.5 Aspects of Strategic Leadership Are Practiced by Leaders Of Hospitals Providing Sickle Cell Disease And Hemophilia Care In Kenya

The study aimed to assess the practice of various aspects of strategic leadership by leaders in hospitals providing care for sickle cell disease and hemophilia in Kenya. This objective is crucial in understanding the leadership dynamics within healthcare institutions and their alignment with strategic goals. The mean and standard deviation were utilized as analytical tools to gauge the extent to which specific aspects of strategic leadership are practiced.

Table 4.10:

*Aspects of Strategic Leadership are Practiced by Leaders of Hospitals Providing
Sickle Cell Disease and Hemophilia Care in Kenya*

	Mean	Std. Deviation
The hospital leadership ensure all employees are trained in implementation of strategic plan	3.85	1.31
The hospital leadership is capable of shifting its structure quickly to address new opportunities	3.83	1.10
If there is change of circumstances, the hospital management can adjust its current plans effortlessly	3.78	1.12
The failure to respond to official communications attracts disciplinary action.	3.69	0.95
The hospital leadership provide linkages between business units or departments so that the employees can cooperate with each other coherently	3.63	1.16
The hospital top leadership integrate technologies such as mobile phones, Video, Conferencing, social media etc. in its communication	3.62	1.04
The hospital leadership ensure there are no collaboration barriers between departments.	3.61	1.11
The hospital top leadership provides timely feedback efficiently.	3.53	1.00
The hospital leadership encourages autonomy among employees	3.51	1.19
Top management embraces and encourages innovative idea from employees by offering rewards	3.49	1.13
The hospital leadership has implemented continuous learning approach	3.47	1.15
The hospital leadership encourages and develops employees to work as a team.	3.35	1.12
The hospital leadership strives to continuously align operational functions in all departments	3.34	1.23
The hospital top leadership embraces more clarity of ideas/strategy before communicating	3.33	1.11
The hospital leadership have effectively aligned IT with operation functions in all departments	3.31	1.15
The hospital leadership ensure all stakeholders are involved in developing a strategic plan	3.31	1.34
The hospital top leadership has vertical communication channel for employees' inputs	3.30	1.02
The hospital leadership has successfully implemented fundamental long-term strategic plan.	3.29	1.14
The hospital leadership shares strategic goals with all employees	3.26	1.31
The hospital leadership directs all its activities to meet the needs of the customers.	3.26	1.14
The hospital leadership ensures to provide a large variety of services without adversely affecting their quality	3.26	1.21
The hospital leadership allows staff from all departments raise their opinions on organizational policy and work condition	3.22	1.22
The hospital leadership consult widely before coming with a strategic plan	3.19	1.17
The hospital leadership have directed the hospitals' resources for the achievement of all goals	3.17	1.09
The hospital leadership regularly evaluates the implemented of strategic plan	3.12	1.24
The hospital leadership ensures employees clearly understand institution's work priorities.	2.91	1.19
The hospital leadership analyses on why its employees succeeded or failed.	2.81	1.38

The analysis of various aspects of strategic leadership within hospitals providing care for sickle cell disease and hemophilia in Kenya reveals a diverse landscape with elements perceived positively, moderately, and areas in need of improvement. Aspects with mean scores of 3.5 or higher are collectively regarded as well-agreed upon and positively practiced by the respondents. Specifically, the leadership's commitment to ensuring employees are trained in the strategic plan and the ability to swiftly shift structures to address new opportunities are noteworthy strengths. This positive perception suggests a commitment to strategic development and adaptability in the face of evolving circumstances.

In the category of moderately practiced aspects ($2.5 \leq$ Mean < 3.5), several dimensions showcase a mixed level of satisfaction among respondents. Notable elements include the ability to adjust plans effortlessly in response to changing circumstances, disciplinary actions for failing to respond to official communications, and providing linkages between business units or departments for coherent cooperation. While these aspects exhibit a moderate level of perceived effectiveness, there is room for improvement and targeted interventions to enhance strategic leadership practices in these areas.

Conversely, two aspects fall into the category of poorly practiced dimensions with mean scores below 2.5. These are related to ensuring employees' understanding of the institution's work priorities and the analysis of why employees succeeded or failed. The lower mean scores for these aspects indicate significant challenges and a clear need for focused attention. Effective communication of work priorities and comprehensive analysis of employee successes and failures are critical for fostering a conducive work environment and optimizing organizational performance.

In conclusion, these findings provide a comprehensive understanding of the strategic leadership landscape within healthcare institutions providing care for sickle cell disease and hemophilia in Kenya. The categorized aspects offer clear guidance for hospital leadership to prioritize interventions, leveraging existing strengths, and addressing specific areas for improvement. This targeted approach can contribute to the overall enhancement of strategic leadership practices, ultimately benefiting the quality of healthcare services in this specialized domain.

4.6 Effect of practiced strategic leadership aspects on delivery of high-quality sickle cell disease and hemophilia care in Kenya.

In exploring the impact of practiced strategic leadership aspects on the delivery of high-quality care for sickle cell disease and hemophilia in Kenya, structural equation modelling (SEM) emerges as a crucial analytical tool. SEM serves as a comprehensive framework that allows for the examination of complex relationships among latent and observed variables. Its significance lies in its ability to integrate multiple stages of analysis, offering a systematic approach to assessing the interplay between various factors influencing the healthcare delivery process. Within the SEM methodology employed in this study, a series of essential procedures were undertaken to discern latent and observed exogenous and endogenous variables. This included an initial factor analysis to identify underlying constructs, followed by Confirmatory Factor Analysis (CFA), and assessments of reliability, convergent validity, and discriminant validity. The culmination of these procedures culminated in the development and evaluation of the SEM model, providing a robust foundation for understanding the intricate dynamics between strategic leadership practices and the delivery of high-quality care for these specialized medical conditions.

The application of SEM allows for a nuanced examination of how distinct strategic leadership practices impact the overall quality of healthcare services for sickle cell disease and hemophilia in Kenya. By undergoing factor analysis, the study aimed to distill key latent variables that capture the essence of strategic leadership aspects. The subsequent CFA further validated these latent constructs, ensuring that the identified factors align with the observed data. The reliability assessment gauged the consistency of measurement tools, while convergent and discriminant validity analyses tested the coherence and distinctiveness of the identified constructs. These methodological steps collectively contribute to the robustness of the SEM model, enabling a comprehensive exploration of the relationships and interactions shaping the delivery of care for these medical conditions.

In the SEM model developed in this study, the intricate relationships between strategic leadership practices and the quality of healthcare provision were systematically analyzed. The multifaceted nature of SEM allowed for a thorough investigation, capturing not only direct effects but also indirect pathways and interdependencies among various variables. This holistic approach is paramount in elucidating the intricate dynamics within the healthcare system, providing valuable insights for policymakers, healthcare administrators, and practitioners. Ultimately, the SEM model serves as a sophisticated analytical tool, shedding light on the nuanced connections between strategic leadership and the delivery of high-quality care in the context of sickle cell disease and hemophilia in Kenya

4.6.1 Factor Analysis

The data was examined for its underlying factor structure using factor analysis before conducting descriptive and inferential statistical analyses. Principle Components

Analysis (PCA), according to Field (2013), is a method for condensing an enormous variety of variables into a more manageable number of principle components that make up a significant portion of the variance in the variables that were originally considered. The Principal Component Method was employed to identify highly loaded factors, eliminate factors with weak or negative loading, and improve data reliability. This method focuses on identifying linear components within the data and assessing how specific variables contribute to those components.

Abd ElHafeez et al. (2022) utilized KMO measure of Sampling Adequacy and the Bartlett's Test of Sphericity to assess the instrument's validity. The components for each construct were then extracted by doing a component factor analysis on all variables using varimax rotation. The items' respective underlying variable structures based on dimensions were successfully loaded as a result. The findings are presented and discussed in the section that follows.

4.6.1.1 Factor Analysis for Strategic Leadership

Component matrix for all the 27 constructs in strategic leadership was presented on table 4.11 and 4.12 show how the factors loaded. Varimax rotation method was used with the aim of attaining a simpler structure in order to improve interpretability. Rotation maximizes the loading of each of the variables onto 5 factors, The study provided Kaiser-Meyer-Olkin Measure of Sampling Adequacy and Bartlett's Test of Sphericity for Strategic leadership in table 4.10. KMO value of over 0.5 and significance level for the Bartlett's test below 0.05 show there exist substantial correlation in the data. Variable collinearity suggests how strongly a single variable is correlated with another variable.

Table 4.11:
KMO and Bartlett's Test for Strategic leadership

KMO and Bartlett's Test		
Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		0.858
Bartlett's Test of Sphericity	Approx. Chi-Square	2280.688
	df	120
	Sig.	0.000

Source: **Field Data (2023)**

From table 4.11, Bartlett's Test of Sphericity produced a significant Chi-Square (χ^2) of 2280.688 with p-value =.000< 0.05 and Kaiser – Meyer - Olkin measure of sampling adequacy was 0.858 above the acceptable value of 0.5 (Field, 2013), showing that it was appropriate to subject data for factor analysis on (Leech *et al.,* 2013; Morgan *et al.,* 2012). After KMO showed data was adequate to be subjective for factor analysis and Bartlett's Test showed that variances are equal for all samples, two components were derived after Varimax rotation and their eigen values. The total variance explained was presented in table 4 .12.

Table 4.12:

Total Variance Explained for Strategic leadership

Total Variance Explained Component	Initial Eigenvalues		
	Total	**% of Variance**	**Cumulative %**
1	7.687	48.045	48.045
2	1.578	9.862	57.907
3	1.258	7.861	65.767
4	1.149	6.554	72.322
5	1.029	5.182	77.504
6	1.003	4.331	81.835

Extraction Method: Principal Component Analysis.
Source: Field Data (2020)

The factor analysis results in table 4.12 revealed that 6 components (strategic communication, Strategic alignment, human capital development, strategic plan, Employee Involvement and Strategic Direction) were derived and explained 7.687, 1.578, 1.258, 1.149, 1.029 and 1.003 of the variance in strategic leadership,

respectively. Cumulatively, all items in the four components explained a 45.617% variance in strategic leadership. In addition, table 4.12 showed that the two components had Eigen values of 3.032 and 1.53 respectively, which is above the accepted value of 1 while cumulative variance should be more than 40 (Yong & Pearce, 2013). Thus, the items were appropriate to explain the variable and for rotations.

Eigen value is a measure of how much of the common variance of observed variables a factor explains. Any factor with Eigen values more than 1 explains more variance than a single observed variance. In factor analysis, Eigen values are used to condense the variance in a correlation matrix. The factors with the largest Eigen value has the most variance down from those with small or negative Eigen values that are usually omitted from solutions (Tabachnick and Fidell, 2018). To figure out how many factors we could need, we can look at Eigen values, which is a measure of how much of variance of the variables does a factor explain. An Eigen value of greater than 1 means that the factor explains more variance than a unique variable.

Table 4.13:

Rotated Principal Component Matrix for Strategic leadership

	Strategic Communication	Strategic Alignment	Human Capital Development	Strategic Plan	Employee Involvement	Strategic Direction
The hospital top leadership provides timely feedback efficiently.	0.623					
The hospital top leadership has vertical communication channel for employees' inputs	0.518					
The hospital top leadership embraces more clarity of ideas/strategy before communicating	0.54					
The hospital top leadership integrate technologies such as mobile phones, Video, Conferencing, social media etc. in its communication	0.688					
The failure to respond to official communications attracts disciplinary action.	0.776					
The hospital leadership strives to continuously align operational functions in all departments		0.741				
The hospital leadership have effectively aligned IT with operation functions in all departments		0.611				
The hospital leadership ensures employees clearly understand institution's work priorities.		0.65				
Top management embraces and encourages innovative idea from employees by offering rewards		0.574				
The hospital leadership encourages and develops employees to work as a team.			0.838			
The hospital leadership ensures to provide a large variety of services without adversely affecting their quality			0.903			
The hospital leadership has implemented continuous learning approach			0.761			
The hospital leadership allows staff from all departments raise their opinions on organizational policy and work condition			0.798			
The hospital leadership has successfully implemented fundamental long-term strategic plan.				0.709		
The hospital leadership ensure all employees are trained in implementation of strategic plan				0.803		
The hospital leadership ensure all stakeholders are involved in developing a strategic plan				0.574		
The hospital leadership consult widely before coming with a strategic plan				0.645		
The hospital leadership consult widely before coming with a strategic plan				0.601		
The hospital leadership ensure there are no collaboration barriers between departments.					0.851	
The hospital leadership allows staff from all departments raise their opinions on organizational policy and work condition					0.798	
The hospital leadership analyses on why its employees succeeded or failed.					0.819	
The hospital leadership directs all its activities to meet the needs of the customers.						0.913
The hospital leadership have directed the hospitals' resources for the achievement of all goals						0.748

Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization.
a Rotation converged in 6 iterations.
Source: Field Data (2020)

After factor extraction, making the choice about the type of model as well as the number of factors to extract, the second step in factor analysis and principal component analysis performed using Varimax rotation to identify the underlying factors of strategic leadership and transform the initial factors into new ones that are easier to interpret as shown in table 4.13. The results depicted that the high factor loading scores showed that 27 items were above the minimum recommended value of 0.5 which were dropped (Hair *et al.*, 2014). Hence, 27 items for strategic leadership were retained for further analysis.

4.6.1.2 Factor Analysis for Delivery of High-Quality Sickle Cell Disease and Hemophilia Care

Factor analysis was conducted on delivery of high-quality sickle cell disease and hemophilia care activity. In general, the extraction method was principal component analysis, and the rotation method was varimax with Kaiser Normalization and the findings were presented in table 4.14 to 4.16.

Table 4.14:

KMO and Bartlett's Test for Delivery of High-Quality Sickle Cell Disease and Hemophilia Care

KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		0.91
Bartlett's Test of Sphericity	Approx. Chi-Square	3099.842
	df	91
	Sig.	0.000

Source: Field Data (2020)

Sampling adequacy was assessed using the Kaiser- Meyer- Olkin (KMO) Measure of sampling adequacy. As evidenced in table 4.14, KMO was greater than .5 (.91) as hair *et al,* (2010) recommended. This implies that the study sample size in relation to the

measurement items for delivery of high-quality sickle cell disease and hemophilia care were adequate and could be subjected for factor analysis. Further, Bartlett's Test was significant, $\chi2$ (91) = 3099.842, p-value =.000< 0.05. This indicates equal variance across samples, called homogeneity of variances showing that the correlation matrix was not an identity matrix; hence items were related and therefore suitable for structure detection. Based on the KMO Measure of Sampling Adequacy and Bartlett's Test of Sphericity results, it can be concluded that the dataset is appropriate for factor analysis, and there are meaningful relationships among the variables that justify conducting factor analysis on the data.

Table 4.15:

Total Variance Explained for Delivery of High-Quality Sickle Cell Disease and Hemophilia Care

Total Variance Explained Component	Initial Eigenvalues		
	Total	**% of Variance**	**Cumulative %**
1	9.504	67.883	67.883
2	1.081	7.724	75.606

Source: **Field Data (2023)**

Table 4.15 displays Initial Eigen values, % of the variance and cumulative % variance of delivery of high-quality sickle cell disease and hemophilia care. Results showed that based on Eigen value, more than one (Leech *et al.,* 2013), two components from delivery of high-quality sickle cell disease and hemophilia care were derived with Eigen value of 9.504 and 1.081 respectively indicating the amount of variance in the original variables accounted for by each component, which is above the accepted value of 1. In addition, components 1 accounted for 67.883% of the variance of delivery of high-quality sickle cell disease and hemophilia care activity while components two accounted for 7.724% of the variance of

delivery of high-quality sickle cell disease and hemophilia care. The Cumulative of 75.606% indicate the percentage of variance accounted for by two components. This means that items in the two components were measuring delivery of high-quality sickle cell disease and hemophilia care.

The principal component matrix for all 14 constructs in delivery of high-quality sickle cell disease and hemophilia care was presented in table 4.16 to establish the factor loadings for each of the constructs.

Table 4.16:

Rotated Principal Component Matrix for Delivery of high-quality Sickle Cell Disease and Hemophilia Care

	Component	
	1	2
We patients receive special attention whenever I go to the hospital for emergencies.	0.712	
All the test report done in this hospital have been accurate.	0.591	
Doctors have been genuinely been concern about disease.	0.808	
Staff and nurses care for me.	0.573	
Doctors and staff adhere to promised appointment times.	0.702	
Patients are seen in a timely manner according to their appointments.	0.829	
Patients Reports are processed delivered on time.	0.839	
Patients receive medical test (i.e., laboratory, x-rays, etc.) feedback on about time	0.850	
Patients requests/needs are efficiently responded by doctors/nurses/staff	0.784	
Doctors and staff are willing to help and facilitate patients.	0.699	
The hospital maintains hygienic conditions.		0.854
Wards, offices, rooms/bathrooms are kept clean, including sheets and floors.		0.831
The hospital provides a healthy environment.		0.884
There are waiting facilities available for attendants and patients		0.660

Extraction Method: Principal Component Analysis.
  Rotation Method: Varimax with Kaiser Normalization.
Source: Field Data (2023)

The principal component analysis with Varimax rotation was performed to identify the underlying factors of Delivery of high-quality sickle cell disease and hemophilia care. The results depicted that factor loadings of 14 items were above the minimum recommended value of 0.50 (Hair *et al.*, 2014). This implies that 14 items with high factor loading explained delivery of high-quality sickle cell disease and hemophilia care activity, hence retained for further analyses.

4.6.2 Validation of Measurement Model

Before testing confirmatory factor analysis in evaluating the measurement model, Hair et al. (2019), emphasizes on testing for reliability, as well as convergent and discriminant validity. To assess the measurement model, the factor loading of each item should be calculated within a particular construct. According to Hair et al. (2019), an item should be kept if its factor loading falls between 0.6 and 0.7. Findings in Table 4.20 showed that loadings for Delivery of high-quality sickle cell disease and hemophilia care latent variables (Assurance, Reliability and Responsiveness, Tangibility), strategic leadership (strategic communication, Strategic alignment, human capital development, strategic plan, Employee Involvement and Strategic Direction) had loadings above 0.6; thus, the study fulfilled the criterion for individual item reliability.

Moreover, composite reliability (CR) was tested to confirm the construct reliability as well, Hair et al., (2019) suggested a guideline to determine the composite reliability (CR) coefficient, suggesting a minimum value of 0.7. The composite reliability coefficients for each construct in the study are presented in Table 4.20. The results indicate that the internal consistency and reliability of the constructs are adequate, as all of their composite

reliability coefficients (ranging from 0.713 to 0.944) fall within the recommended range. This conclusion is supported by Zimmerman and colleagues' research from 1993

To assess convergent validity, the average variance extracted (AVE) has been employed. According to Chin's (1998) recommendation, an AVE value of 0.5 or more is considered acceptable for demonstrating the convergent validity of a variable. The findings indicate that all values of AVE (ranging from 0.555 to 0.809) exceed the recommended threshold of 0.5, as suggested by Hair, Black, and Babin (2010). Thus, the convergent validity of the specific variable is demonstrated.

Table 4.17

Reliability, Convergent Validity, Discriminant Validity

Exogenous and endogenous variables	Latent variables	loadings	CVA	reliability (Cronbach alpha)	CR	AVE
Strategic leadership	SC	0.662	56.664	0.736	0.857	0.601
	SA	0.819				
	HCD	0.804				
	SP	0.710				
	EI	0.802				
	Assurance, Reliability and	0.912			0.713	0.555
Quality Health Care	Responsiveness		83.187	0.797		
	Tangibility	0.912				

Source: (Field Data, 2023)

4.6.3 Assessment of the Measurement Model

To determine measurement model validation, Confirmatory factor analysis (CFA) was utilized. An elaborated test of the multilevel data structure called Multilevel factor analysis was used, following Dyer et al.'s research in 2005. Confirmatory factor analysis (CFA)

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Table 4.25 displayed good fit indices between the data and the hypothesized model of 2 factors. All fit indices were applied in the model, with the fit indices exceeding the threshold values of 0.9, such as TLI = 0.975, CFI = 0.984, and IFI = 0.950 (Tabachnick and Fidell, 2014). The values of the model fit, $X2/df = 68.762/48 = 1.654$, were minimum tolerable values of under 2 (Carmines and McIver, 1981). The values of error estimations were also within the required range, with RMSEA = 0.048

Table 4.18

Summary of Final CFA Measurement Model

Fit Indices	(CFA) Measurement Model fit results
χ2(df)	68.762 (49), p=.033
CMIN/df	1.403
IFI	.984
TLI	.975
CFI	.984
GFI	.950
NFI	.948
RFI	.917
PNFI	.616
RMSEA	.045
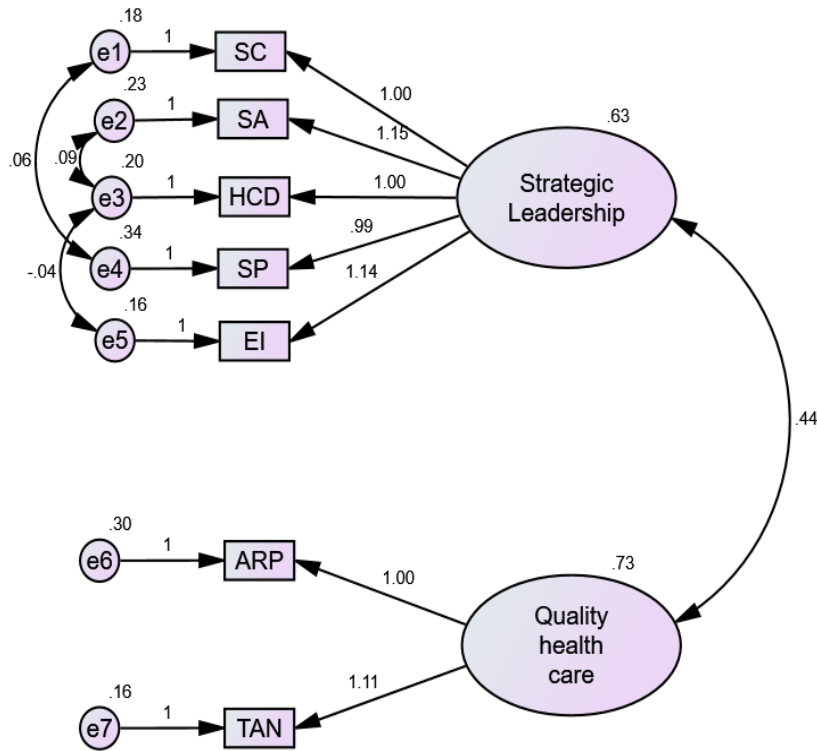
Figure 4.1
CFA Measurement Model

4.7 Final SEM model

The research used structural equation modelling (SEM) to analyse the data. SEM has reportedly been extensively used for the past 20 years to define, estimate, and test hypothesized relationships among significant variables in the social and behavioural sciences (Joreskog & Sorbom, 2004). A confirmatory factor analysis is used to validate the measurement model, and a path analysis using latent variables and AMOS version 22 is used to match the structural model. A two-step modelling procedure that stresses testing the pure measurement model that underlies a full structural equation model was proposed by Kline (1998).

4.7.1 Goodness of Fit Statistics for Final Model

According to the goodness-of-fit statistics in Table 4.26, the overall model achieved a good fit with three first-order constructs based on the observed data as shown by root mean square error of approximation (RMSEA) of 0.048. It is important to note that the root mean square error of approximation (RMSEA) value is a useful indicator of the model fit. If the RMSEA value is less than 0.05, it indicates a good fit, while a value between 0.05 and 0.08 is considered adequate or acceptable. A value between 0.08 and 0.10 suggests a mediocre fit, and if the value is greater than 0.10, the model is not considered to fit well (Hidrus, Kueh, and Kuan, 2022).

The model achieved an acceptable fit, as indicated by the estimated RMSEA value of 0.048. A good fit can be demonstrated by an adjusted goodness-of-fit Index (GFI) value of greater than 0.90, according to Cole (1987). However, an acceptable fit can also be demonstrated by a value greater than 0.80, as noted by Hu and Bentler (1995, 1998). The estimated GFI value of 0.943 shows that the model achieved a good fit. To demonstrate a good fit, the comparative fit index (CFI) value should be greater than 0.90. The CFI value of .981 obtained in this study confirms that the model achieved a good fit.

The model is considered a good fit, based on the chi-square measure, which is an absolute fit measure, and the estimated ratio (CMIN/DF) of 1.447, as reported by Hair et al. (2006). While other indices such as the goodness of fit index (GFI) (Sharma and Tewari, 2018), Hoelter index (Hu and Bentler, 1995), and normed fit index (NFI) (Marsh and Balla, 1994) are not recommended for use and are therefore not included in the table. Overall, the goodness-of-fit indices and other estimated parameters suggest that the model, which

includes first- and second-order constructs as well as observed indicators, fits the data fairly well.

Table 4.19

Goodness of Fit Statistics for Overall SEM Model

Fit Indices	Final SEM Model
χ2(df)	78.128 (54), p=.018
CMIN/df	1.447
GFI	.943
NFI	.941
RFI	.915
IFI	.981
TLI	.972
CFI	.981
PNFI	.651
RMSEA	.048
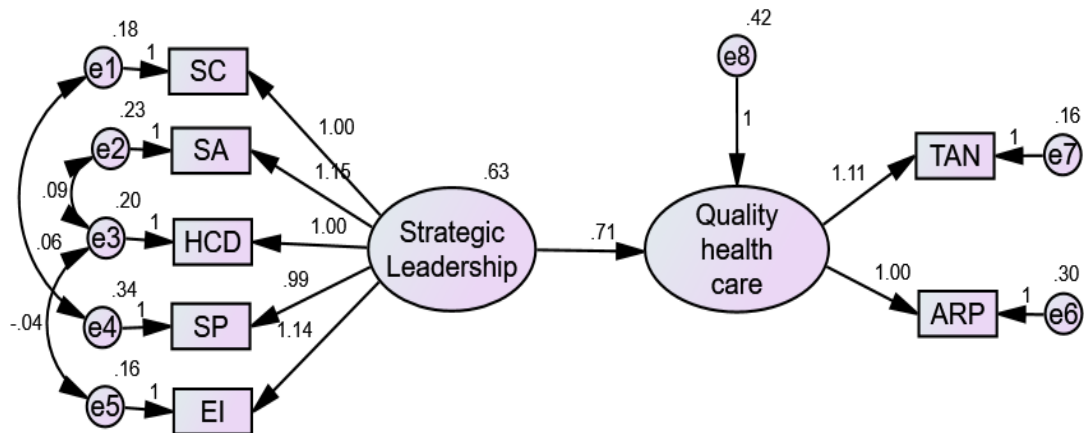
Figure 4.2
Overall and final SEM Model

The regression weights presented in the table 4.20 are the coefficients for strategic leadership: Results in table 4.20 showed a positive estimate of 0.708 and a p-value of 0.007, which is less than the significance level (.05). Thus, strategic leadership positively and significantly affect delivery of High-Quality Sickle Cell Disease and Hemophilia Care. Thus, an increase of strategic leadership with one unit increases Delivery of High-Quality Sickle Cell Disease and Hemophilia Care with 0.708 units

Table 4.20

Regression Weights

			Estimate	S.E.	C.R.	P	Label
Quality health care	<---	Strategic Leadership	.708	.082	8.682	***	par_9

4.8 Challenges of strategic leadership in hospitals providing sickle cell disease and hemophilia care in Kenya

Table 4.20 presents a comprehensive overview of the challenges faced by hospitals providing care for sickle cell disease (SCD) and hemophilia in Kenya, focusing specifically on the aspects of strategic leadership. The data encapsulates the frequency and percentage distribution of various challenges, shedding light on critical areas where improvements are urgently needed

Table 4.21

Challenges of strategic leadership in hospitals providing sickle cell disease and hemophilia care in Kenya

	Frequency	Percentage
Inadequate drugs on the shelves.	413	67
Few health workers dedicated to the care of sickle cell disease (SCD) and hemophilia patients.	375	61
Lack of involvement of policymakers and patients in setting policies.	363	59
Stigma surrounding SCD and hemophilia.	360	58
Poor supply of commodities for sickle cell patients.	349	57
Poor resource allocation.	344	56
Bed-sharing due to overcrowded facilities.	318	52
Lack of funding for research studies.	303	49
Inadequate transfusion services for SCD clients.	295	48
Poor referral system for managing the diseases.	291	47
Discrimination against individuals with SCD and hemophilia.	277	45
Low screening rates for sickle cell.	277	45
Poor stakeholder engagement and awareness activities.	254	41
Inadequate testing equipment/resources.	242	39
Incompetent leadership.	230	37
Lack of emphasis on the care of patients with SCD and hemophilia.	218	35
Lack of a specialized clinic for sickle cell, forcing patients to purchase medications externally.	207	33
Unaffordable prices for drugs.	195	32
Absence of a laid-out framework for enhancing high-quality care for SCD and hemophilia.	183	30
Gaps in harmonizing the collective approach in research, training, and access to comprehensive care.	171	28
Lack of constant supply of commodities for sickle cell patients.	160	26
Insufficient supply of blood.	148	24
Limited efforts due to lack of knowledge, understanding, and resources.	136	22
Poor timely diagnosis and treatment of children living with SCD.	124	20

The results indicate that several challenges impacting on provision sickle cell disease and hemophilia care in Kenya. Topping the list is the alarming revelation that 67% of respondents identify "Inadequate drugs on the shelves" as a pervasive issue. This points to a crucial deficiency in the availability of essential medications, posing a severe obstacle to effective patient care. Other notable challenges include the scarcity of dedicated health

workers (61%), the lack of involvement of policymakers and patients in policy-setting (59%), and the stigma surrounding SCD and hemophilia (58%), highlighting the multifaceted nature of obstacles faced by healthcare facilities.

The challenges reported above 40% underscore systemic issues that demand immediate attention and intervention. In addition to addressing the acute shortage of essential drugs, strategic initiatives are essential to overcome the scarcity of dedicated health workers and to foster greater involvement of policymakers and patients in shaping healthcare policies. The prevalence of stigma further emphasizes the need for comprehensive awareness campaigns and education initiatives. These findings collectively call for a holistic and targeted approach to enhance strategic leadership and transform the healthcare landscape for individuals grappling with SCD and hemophilia in Kenya. A concerted effort from policymakers, healthcare professionals, and stakeholders is imperative to address these challenges and pave the way for improved patient outcomes and quality care.

CHAPTER V: DISCUSSION

5.1 Discussion of Results

The primary objective of this study was to evaluate the impact of various strategic leadership on delivery of high-quality sickle cell disease and hemophilia care in Kenya. The research sought answer the following research questions; What are the aspects of strategic leadership practiced by leaders of hospitals providing sickle cell disease and hemophilia care in Kenya? Do strategic leadership practices improve delivery of high-quality sickle cell disease and hemophilia care in Kenya? And What are the challenges of strategic leadership in hospitals providing sickle cell disease and hemophilia care in Kenya?. The following section presents a summary of the findings and a discussion in relation to existing literature.

5.2 Aspects of Strategic Leadership Practiced in Hospitals Providing Sickle Cell Disease and Hemophilia Care in Kenya

The analysis of strategic leadership aspects within hospitals providing care for sickle cell disease and hemophilia in Kenya reveals a nuanced landscape. Key strengths include a commitment to employee training in the strategic plan and the ability to swiftly adapt structures to address new opportunities, showcasing a positive inclination towards strategic development. Moderately practiced aspects include adjusting plans in response to changing circumstances, disciplinary actions for communication lapses, and providing linkages between departments for coherent cooperation. However, two dimensions, ensuring employees understand institutional work priorities and analyzing employee

successes and failures, fall into the category of poorly practiced dimensions, indicating critical challenges that demand focused attention and improvement. In the realm of modern strategic management, strategic leadership is acknowledged as a crucial concept (Samimi et al., 2020). It encompasses a leader's capacity to navigate uncertain business environments, anticipate and maintain flexibility, and effectively execute strategic visions. The findings align with this concept, showcasing both strengths and areas for improvement within healthcare institutions. Strategic direction, communication, and alignment are integral elements of strategic leadership. The positive perception of commitment to employee training aligns with the strategic direction, while the need for improvement in communication and coherent cooperation resonates with the significance of strategic communication and alignment (Alzawahrah & Alkhaffaf, 2021). The identified challenges underscore the critical role of strategic leadership in fostering a conducive work environment, adapting to external changes, and optimizing organizational performance. These findings provide actionable insights for hospital leadership to prioritize interventions, leveraging existing strengths and addressing specific areas for improvement, contributing to enhanced strategic leadership practices and, ultimately, improved healthcare services (Ghonim et al., 2020).

5.3 Effect of Practiced Strategic Leadership Aspects on Delivery of High-Quality of Sickle Cell Disease and Hemophilia Care in Kenya

The findings from the Structural Equation Modeling (SEM) model highlight the significant impact of strategic leadership, consisting of six key components—strategic communication, strategic alignment, human capital development, strategic plan, employee

involvement, and strategic direction—on the delivery of High-Quality Sickle Cell Disease and Hemophilia Care (β = 0.708, p=0.007<05). This indicates a positive and statistically significant relationship, with a one-unit increase in strategic leadership correlating with a 0.708 unit increase in the delivery of High-Quality Sickle Cell Disease and Hemophilia Care. These results align with previous research by Zia, Aqib, Bin, Bilah & Raza (2017) in Indian firms, where strategic leadership positively impacted employee performance. Similarly, studies in the Kurdistan Region of Iraq by Ali and Anwar (2021) and in Iran by Guilan, Akbari, Dustar, Esmailzadeh, Hosseini (2015) demonstrated that strategic leadership enhances motivation, coordination, and productivity among employees in small and medium-sized companies (SMEs). However, Sritoomma and Wongkhomthong (2021) found no direct link between strategic leadership competencies and the delivery of quality healthcare, suggesting the need for further investigation. Meanwhile, Morténius, Hildingh, and Fridlund (2016) discovered that after seven years of intervention, strategic leadership significantly increased nurses' awareness of research and development, indicating its role in fostering innovative thinking and research engagement. These findings underscore the importance of strategic leadership in healthcare settings and suggest avenues for enhancing delivery standards through effective leadership practices, communication strategies, and employee engagement initiatives.

5.4 Challenges of Strategic Leadership In Hospitals Providing Sickle Cell Disease And Hemophilia Care

The results reveal significant challenges in providing Sickle Cell Disease (SCD) and Hemophilia care in Kenya. The foremost issue identified is the insufficient availability of

essential medications, with 67% of respondents highlighting "Inadequate drugs on the shelves." This shortage poses a critical barrier to effective patient care. Other prominent challenges include the scarcity of healthcare workers (61%), limited involvement of policymakers and patients in policy-setting (59%), and the stigma associated with SCD and hemophilia (58%). These challenges, all reported by over 40% of respondents, underscore systemic issues requiring immediate attention and intervention. Addressing the shortage of essential drugs calls for strategic initiatives, along with efforts to increase healthcare workers' availability and involve policymakers and patients in healthcare policy decisions. Combatting stigma requires comprehensive awareness campaigns and education initiatives. The challenges highlighted in Kenya's provision of Sickle Cell Disease (SCD) and Hemophilia care resonate with broader discussions on healthcare leadership and organizational management. Smith's (2019) survey in American hospitals underscores the pivotal role of communication in leadership, with 33% of participants citing it as a key tactic. Effective communication, facilitated by technology, enhances teamwork and collaboration across healthcare settings. However, Dampson & Edwards (2019) suggest that in Africa, despite the adoption of strategic leadership, fewer than 10% of leaders possess strategic skills, indicating a need for improvement. Adeoye, Egwakhe, and Adefulu (2019) emphasize the positive impact of strategic leadership dimensions such as decision-making and communication on employee performance. Strategic leaders, as noted by Obiwuru et al. (2011) and Folarin (2013), align their teams with organizational goals, foster innovation, and enhance performance. Yet, challenges persist, with Jemal et al. (2021) identifying poor nurse-physician communication, exacerbated by poor working conditions and attitudes. Odit, Rwashana, and Kituyi (2014) highlight structural

deficiencies in Ugandan health units, stressing the importance of strategic alignment in healthcare information systems (HIS). Kabetu and Iravo (2018) echo the need for enhanced strategic leadership abilities among leaders. Cherop et al. (2022) identify key domains of strategic clinical leaders, emphasizing attributes like clinical expertise and interpersonal skills. Overall, these findings underscore the complex interplay between strategic leadership, communication, organizational structures, and workforce dynamics in healthcare settings, necessitating targeted efforts to address systemic challenges and improve patient care outcomes.

CHAPTER VI: SUMMARY, IMPLICATIONS, AND RECOMMENDATIONS

6.1 Summary

The analysis of strategic leadership aspects within hospitals providing care for sickle cell disease and hemophilia in Kenya reveals a nuanced landscape. Key strengths include a commitment to employee training within the strategic plan and the ability to swiftly adapt structures to address new opportunities, indicating a positive inclination towards strategic development. Moderately practiced aspects include adjusting plans in response to changing circumstances, disciplinary actions for communication lapses, and providing linkages between departments for coherent cooperation. However, poorly practiced dimensions such as ensuring employees understand institutional work priorities and analyzing employee successes and failures indicate critical challenges that demand focused attention. Strategic direction, communication, and alignment are integral elements of strategic leadership. These challenges highlight the critical role of strategic leadership in fostering a conducive work environment, adapting to external changes, and optimizing organizational performance. Additionally, the findings from the Structural Equation Modeling (SEM) model underscore the significant impact of strategic leadership, with key components such as strategic communication, alignment, human capital development, and employee involvement significantly enhancing the delivery of high-quality care for sickle cell disease and hemophilia. This positive relationship aligns with previous studies demonstrating that strategic leadership enhances employee performance and organizational outcomes. However, challenges such as inadequate drug availability, healthcare worker shortages, limited policy involvement, and stigma necessitate immediate strategic interventions.

Effective communication and leadership skills are crucial in addressing these systemic issues and improving patient care outcomes. Overall, the study emphasizes the importance of strategic leadership in healthcare, suggesting targeted efforts to enhance leadership practices, communication strategies, and employee engagement initiative

6.2 Implications

6.2.1 Managerial Implications

For hospital management, the findings suggest the importance of reinforcing and building upon existing strengths in strategic leadership. The commitment to employee training should be further emphasized, and communication strategies should be enhanced to ensure coherent cooperation between departments. Addressing the identified challenges in understanding institutional priorities and analyzing employee successes and failures is crucial for fostering a conducive work environment. Managers should consider targeted interventions, training programs, and communication strategies to improve these specific dimensions of strategic leadership.

6.2.2 Practice Implications

In terms of practical implications, healthcare practitioners and professionals should be actively involved in the strategic development and communication processes within their institutions. Recognizing the importance of strategic leadership in optimizing healthcare services, practitioners should advocate for continuous training, effective communication, and cohesive cooperation among departments. Creating a culture that values and

prioritizes these aspects can contribute to a more resilient and adaptable healthcare environment, ultimately benefiting both the staff and patients.

6.2.3 Policy Implications

From a policy perspective, there is a need for healthcare policymakers to consider incorporating strategic leadership development programs into the broader healthcare policy framework. Policies that support ongoing training, communication enhancement, and collaborative practices within healthcare institutions can contribute to improved strategic leadership. Additionally, policymakers should encourage a culture of continuous improvement and provide resources to address specific challenges identified in the study, ensuring that strategic leadership practices align with broader healthcare goals and objectives.

6.3 Recommendation for Further Studies

To address the limitations identified in the study, several suggestions for further research emerge. Firstly, future studies could expand the scope beyond hospitals providing care for Sickle Cell Disease and Hemophilia in Kenya, encompassing a broader range of healthcare facilities. This would provide a more comprehensive understanding of strategic leadership practices across diverse contexts. Additionally, researchers could delve into a more detailed analysis of each specific dimension of strategic leadership outlined in the conceptual framework to determine its individual impact on the delivery of high-quality care. This could involve employing qualitative research methods to gather nuanced insights from healthcare professionals. Comparative studies across different regions or countries could

also be conducted to assess variations in strategic leadership practices and their effects on healthcare outcomes, thereby offering valuable insights into best practices and areas for improvement. Furthermore, employing a mixed methods research design that combines quantitative data collection with qualitative analysis would allow for a more holistic understanding of strategic leadership in healthcare, capturing both objective measures and subjective experience

6.4 Conclusion

In conclusion, the study on strategic leadership aspects within hospitals providing care for sickle cell disease and hemophilia in Kenya provides valuable insights into both the strengths and areas for improvement in healthcare institutions. The positive aspects, such as a commitment to employee training and adaptability to new opportunities, demonstrate a dedication to strategic development. However, challenges in areas like communication, cooperation, and understanding institutional priorities highlight critical areas that require attention. The nuanced landscape uncovered in this analysis suggests a need for strategic interventions to optimize leadership practices in these healthcare settings.

REFERENCES

Abd ElHafeez, S., e Cruz, M. M., Gouda, S., Nofal, M., Fayed, A., Ghazy, R. M., & Mekky, J. (2022). Sleep quality and anxiety among Egyptian population during covid-19 pandemic. *Sleep Science*, *15*(01), 8-16.

Abedalsttar, A. (2022). Strategic alignment and its impact on creating an organization's reputation and image. *Problems and Perspectives in Management*, *20*(1), 501-513.

Adeoye, I. A., Egwakhe, A. J., & Adefulu, A.D (2019), Purpose: The relationship between strategic leadership and organizational performance of selected service firms in Lagos and Ogun States, Nigeria. IOSR Journal of Humanities And Social Science (IOSR-JHSS) 24(4), p01-06

Akbari, M., Dustar, M., Esmailzadeh, M., & Hosseini, H. (2015). Explaining the Strategic Leadership Pattern for Empowerment Performance's Personnels. *Journal of Strategic Management Studies*, *6*(22), 203-218.

Akbari, M., Dustar, M., Esmailzadeh, M., & Hosseini, H. (2019). Explaining the Strategic Leadership Pattern for Empowerment Performance's Personnels. *Journal of Strategic Management Studies*, *6*(22), 203-218.

Akbari, M., Dustar, M., Esmailzadeh, M., & Hosseini, H. (2019). Explaining the Strategic Leadership Pattern for Empowerment Performance's Personnels. *Journal of Strategic Management Studies*, *6*(22), 203-218.

Al Thani, F. B. H., & Obeidat, A. M. (2020). The impact of strategic leadership on crisis management. *International Journal of Asian Social Science*, *10*(6), 307-326.

Ali, B. J., & Anwar, G. (2021). Strategic leadership effectiveness and its influence on organizational effectiveness. *International Journal of Electrical, Electronics and Computers*, 6(2), 11–24. https://dx.doi.org/10.22161/eec.62.2, Available at SSRN: https://ssrn.com/abstract=3837569

Alvi, B., Haider, A., & Akram, M. (2021). The Role of Strategic Leadership on Employee Performance with Mediating Effect of Employee Engagement: An Empirical Study of Higher Educational Commission Employees. *Global Educational Studies Review*, VI(II), 11-20.

Alyileili, S. R., El-Tarabily, K. A., Belal, I. E., Ibrahim, W. H., Sulaiman, M., & Hussein, A. S. (2020). Intestinal development and histomorphometry of broiler chickens fed Trichoderma reesei degraded date seed diets. *Frontiers in Veterinary Science*, *7*, 349.

Alzawahrah, H., & Alkhaffaf, M. (2021). The impact of strategic leadership on organisational ambidexterity at the King Abdullah Ii design and development bureau (KADDB). *International Journal of Engineering Science Technologies*, *5*(3), 20-38.

Alzawahrah, H., & Alkhaffaf, M. (2021). The impact of strategic leadership on organisational ambidexterity at the King Abdullah Ii design and development bureau (KADDB). *International Journal of Engineering Science Technologies*, *5*(3), 20-38.

Andrews, L., Higgins, A., Andrews, M. W., & Lalor, J. G. (2012). Classic grounded theory to analyse secondary data: Reality and reflections. *Grounded Theory Review*, *11*(1).

Andrews, R., Boyne, G. A., Meier, K. J., O'Toole Jr, L. J., & Walker, R. M. (2012). Vertical strategic alignment and public service performance. *Public Administration*, *90*(1), 77-98.

Asbari, M. (2020). Is transformational leadership suitable for future organizational needs? *International Journal of Social, Policy and Law*, 1(1), 51–55. https://doi.org/10.8888/ijospl.v1i1.17

Baloch, Q. B., & Siddiq, A. (2016). Role of strategic leadership in competitive healthcare services: A Case Study of Hospitals in Pakistan. PUTAJ-Humanities and Social Sciences, 23(1), 89-100.

Banzato, C. R., & Sierra, J. C. V. (2016). Implications of theory and research on strategic leadership: A critical review. *Revista Ibero-Americana de Estratégia*, *15*(3), 119-131.

Bryson, J. M., Edwards, L. H., & Van Slyke, D. M. (2018). Getting strategic about strategic planning research. *Public management review*, *20*(3), 317-339.

Bryson, J. M., Edwards, L. H., & Van Slyke, D. M. (2018). Getting strategic about strategic planning research. *Public management review*, *20*(3), 317-339.

Cai, Z., Huang, Q., Liu, H., & Wang, X. (2018). Improving the agility of employees through enterprise social media: The mediating role of psychological conditions. *International Journal of Information Management*, *38*(1), 52-63.

Carmines, E. G. & McIver, J., (1981). *Unidimensional scaling* (No. 24). sage.

Caro, D. H. (2016). Towards transformational leadership: The nexus of emergency management systems in Canada. *International Journal of Emergency Management*, *12*(2), 113-135.

Carvalho, A. M., Sampaio, P., Rebentisch, E., & Saraiva, P. (2017). Operational excellence as a means to achieve an enduring capacity to change–revision and evolution of a conceptual model. *Procedia Manufacturing*, *13*, 1328-1335.

Chanzi, S. S. (2017). *The Role of Trade Union Practices in Improving Workers' Performance in Tanzania: A Case Study of TUICO Head Office–Dar es Salaam* (Doctoral dissertation, The Open University of Tanzania).

Cherop, F., Wachira, J., Korir, M., & Bagire, V. (2022). Strategic leader attributes for clinical leaders in an HIV healthcare system: Perspectives of healthcare providers in AMPATH clinic, at Moi Teaching and Referral Hospital in Eldoret, Kenya.

Chi, M., Huang, R., & George, J. F. (2020). Collaboration in demand-driven supply chain: Based on a perspective of governance and IT-business strategic alignment. *International Journal of Information Management*, *52*, 102062.

Chin, W. W. (1998). The partial least squares approach to structural equation modeling. *Modern methods for business research*, *295*(2), 295-336.

Cole, D. A. (1987). Utility of confirmatory factor analysis in test validation research. *Journal of consulting and clinical psychology*, *55*(4), 584.

Collier, D. A., & Evans, J. R. (2020). *Operations and supply chain management*. Cengage Learning, Inc..

Conner-B & Joyce C, (2019) "*The Role of Strategic Leadership in Healthcare Profitability*". Walden Dissertations and Doctoral Studies. 7281.https://scholarworks.waldenu.edu/dissertations/7281 79-97. Retrieved from https://ajoeijournals.org/sys/index.php/ajoei/article/view/193

Conner-Boyd, J. (2019). *The Role of Strategic Leadership in Healthcare Profitability* (Doctoral dissertation, Walden University).

Cooper, D. R., & Schindler, P.S. (2014). *Business Research Methods (12th edition)*. New York: McGraw Hill.

Creswell, J. W. (2014). Research design qualitative quantitative and mixed methods approaches (p. 398).

Creswell, J. W., & Creswell, J.D. (2018). *Research Design: Qualitative, Quantitative and Mixed- Methods Approaches, (5th Ed)*. Los Angeles: Sage Publications.

Cyfert, S. & Zastempowski, M., (2021). Impact of entrepreneur's gender on innovation activities. The perspective of small businesses. *Plos one*, *16*(10), e0258661.

Cyfert, S., & Krzakiewicz, K. (2016). Resources and their impact on the effectiveness of processes which shape dynamic capabilities of Polish enterprises. *Management*, *20*(2), 160-170.

Dampson, D. G., & Edwards, A. K. (2019). Strategic Thinking, Leadership and Governance for African Universities: Lessons from Successful Universities. *Strategic Management-a Dynamic View*, *7*(8), 1-19.

Davies, B., & Davies, B. J. (2012). Developing a strategic leadership perspective. *Developing successful leadership*, 11-25.

Day, G. S., & Schoemaker, P. J. (2016). Adapting to fast-changing markets and technologies. *California Management Review*, *58*(4), 59-77.

DeSimone, J. A., Köhler, T., & Schoen, J. L. (2019). If it were only that easy: The use of meta-analytic research by organizational scholars. *Organizational Research Methods*, *22*(4), 867-891.

Dimitrios, Nasiopoulos & Sakas, Damianos & Vlachos, Dimitrios. (2013). Analysis of Strategic Leadership Simulation Models in Non-profit Organizations. Procedia - Social and Behavioural Sciences. 73. 276–284. 10.1016/j.sbspro.2013.02.053.

DuBrin, A. J. (2013). *Fundamentals of organizational behavior: An applied perspective*. Elsevier.

Ferlie, Ewan, and Edoardo Ongaro. 2015. Strategic Management in Public Services Organizations: Concepts, Schools and Contemporary Issues. New York: Routledge

Festing, M. & Harsch, K., (2019). Managing non-family talent: Evidence from German-speaking regions. *German Journal of Human Resource Management*, *33*(3), 249-279.

Fibuch E, M. D., & Arif A, B. D. S. (2016). Branding health care: important or just marketing?. *Physician Leadership Journal*, *3*(4), 30.

Field, A. (2013). Discovering statistics using IBM SPSS statistics.

Folarin, Sheriff. (2013). Africa's leadership challenges in the 21st century: A Nigerian perspective. African Journal of Political Science and International Relations. 7. 1-11. 10.5897/AJPSIR09.055.

Fraenkel, J., Wallen, N., & Hyun, H. (2011). How to design and evaluate research in education. New York: Mc Graw Hill Publications.

Ghonim, M. A., Khashaba, N. M., Al-Najaar, H. M., & Khashan, M. A. (2020). Strategic alignment and its impact on decision effectiveness: a comprehensive model. *International Journal of Emerging Markets*, *17*(1), 198-218.

Gratton, C., & Jones, I. (2010). *Research methods for sports studies*. Routledge.

Gu, J., Xie, F., & Wang, X. (2016). Relationship between top management team internal social capital and strategic decision-making speed: The intermediary role of behavioral integration. *Kybernetes*, *45*(10), 1617-1636.

Gupta, D., & Chitkara, S. (2018). Effect of time management on academic performance of management students. *Global Journal on Recent Advancement in Business Forecasting and Marketing Intelligence*, *2*(1), 1-14.

Gupta, M. (2018). Strategic leadership: An effective tool for sustainable growth. SAMVAD *International Journal of Management*, 15, 1-5. Retrieved from http://samvad.sibmpune.edu.in/index.php/samvad/index

Haemophilia Association of Kenya (2021), *Tackling Hemophilia in Kenya*, retrieved from https://borgenproject.org/hemophilia-in-kenya/

Hair Jr, J. F. (2006). Successful strategies for teaching multivariate statistics. In *Proceedings of the 7th International Conference on* (pp. 1-5).

Hair Jr, J. F., Howard, M. C., & Nitzl, C. (2020). Assessing measurement model quality in PLS-SEM using confirmatory composite analysis. *Journal of business research*, *109*, 101-110.

Hair, J. F., Black, W. C., Babin, B. J., & Anderson, R, E. (2010). *Multivariate Data Analysis: A Global Perspective* (7th edition). New Jersey, Pearson Prentice Hall.

Hair, J. F., Gabriel, M., & Patel, V. (2014). AMOS covariance-based structural equation modeling (CB-SEM): Guidelines on its application as a marketing research tool. *Brazilian Journal of Marketing*, *13*(2).

Hallberg, N. L., & Felin, T. (2020). Untangling infinite regress and the origins of capability. *Journal of Management Inquiry*, *29*(1), 17-32.

Hidrus, A., Kueh, Y. C., Norsa'adah, B., Kim, Y., Chang, Y. K., & Kuan, G. (2022). Structural equation model of psychological constructs of transtheoretical model, motives for physical activity, and amount of physical activity among people with type 2 diabetes mellitus in Malaysia. *PloS one*, *17*(3), e0266104.

Hu, L. T., & Bentler, P. M. (1995). Cutoff criteria for fit indexes in covariance structure analysis: Conventional criteria versus new alternatives. *Structural equation modeling: a multidisciplinary journal*, *6*(1), 1-55.

Hu, L. T., & Bentler, P. M. (1998). Fit indices in covariance structure modeling: Sensitivity to underparameterized model misspecification. *Psychological methods*, *3*(4), 424.

Huebner, C., & Flessa, S. (2022). Strategic management in healthcare: A call for long-term and systems-thinking in an uncertain system. *International Journal of Environmental Research and Public Health*, *19*(14), 8617.

Jemal, K., Hailu, D., Mekonnen, M., Tesfa, B., Bekele, K., & Kinati, T. (2021). The importance of compassion and respectful care for the health workforce: a mixed-methods study. *Journal of Public Health*, 1-12.

Jörreskog, K. G., & Sörbom, D. (2004). Structural equation modelling with the simplis command language. *Scientific Software International Inc., Lincolnwood, IL*, 60712-61704.

Jung, C. S., & Lee, G. (2013). Goals, strategic planning, and performance in government agencies. *Public Management Review*, *15*(6), 787-815.

Jung, C. S., & Lee, G. (2013). Goals, strategic planning, and performance in government agencies. *Public Management Review*, *15*(6), 787-815.

Kabetu, D. G. & Iravo, M. A. (2018). Influence of strategic leadership on performance of international humanitarian organizations in Kenya. *International Academic Journal of Innovation, Leadership and Entrepreneurship*, 2(2), 113-135

Kline, R. (2013). Exploratory and confirmatory factor analysis. In *Applied quantitative analysis in education and the social sciences* (pp. 171-207). Routledge.

Kothari, C. R. (2015). *Research Methodology, Methods and Techniques (Third Revised Edition).* New Delhi: New Age International Publishers Ltd.

Labrague, L. J. & De los Santos, J. A. A., (2021). The impact of fear of COVID-19 on job stress, and turnover intentions of frontline nurses in the community: A cross-sectional study in the Philippines. *Traumatology*, 27(1), 52–59. https://doi.org/10.1037/trm0000294

Lear, L. W. (2012). The relationship between strategic leadership and strategic alignment in high-performing companies in South Africa. *University of South Africa*.

Leech, C & Porter, K & Steyn, R & Laird, C & Virgo, I & Bowman, R & Cooper, D. (2016). The pre-hospital management of life-threatening chest injuries: A consensus statement from the Faculty of Pre-Hospital Care, Royal College of Surgeons of Edinburgh. *Trauma*. 19. 10.1177/1460408616664553.

L'hermitte, C., Bowles, M., Tatham, P., & Brooks, B. (2015). An integrated approach to agility in humanitarian logistics. *Journal of Humanitarian Logistics and Supply Chain Management*, *5*(2), 209-233.

Locke, E. A., & Latham, G. P. (2002). Building a practically useful theory of goal setting and task motivation: A 35-year odyssey. *American psychologist*, *57*(9), 705.

Locke, E. A., & Latham, G. P. (2002). Building a practically useful theory of goal setting and task motivation: A 35-year odyssey. *American psychologist*, *57*(9), 705.

Locke, E. A., Shaw, K. N., Saari, L. M., & Latham, G. P. (1981). Goal setting and task performance: 1969–1980. *Psychological bulletin*, *90*(1), 125.

Luftman, J., & Derksen, B. (2014). European key IT and management issues & trends for 2014. *CIONET Europe and Business & IT Trend Institute*, *1*, 36.

Madlabana, C.Z., Mashamba-Thompson, T.P. & Petersen, I (2020). Performance management methods and practices among nurses in primary health care settings: a systematic scoping review protocol. *Syst Rev* 9, 40 https://doi.org/10.1186/s13643-020-01294-w

Mahmud, M., Soetanto, D., & Jack, S. (2021). A contingency theory perspective of environmental management: Empirical evidence from entrepreneurial firms. *Journal of general management*, *47*(1), 3-17.

Marsh, H. W., & Balla, J. (1994). Goodness of fit in confirmatory factor analysis: The effects of sample size and model parsimony. *Quality and Quantity*, *28*(2), 185-217.

Miriti, J. B. (2021). *Strategic Leadership, Strategy Execution and Organizational Performance: A Survey of Savings and Credit Cooperatives in Kenya* (Doctoral dissertation, KeMU).

Morgan, N. A., Katsikeas, C. S., & Vorhies, D. W. (2012). Export marketing strategy implementation, export marketing capabilities, and export venture performance. *Journal of the academy of marketing science*, *40*, 271-289.

Morténius, H., Hildingh, C., & Fridlund, B. (2016). Strategic communication intervention to stimulate interest in research and evidence-based practice: A 12-year follow-up study with registered nurses. *Worldviews on Evidence-Based Nursing*, *13*(1), 42-49.

Muchemi, D. W. (2014). *Strategy implementation practices at the Kenya Post Office Savings Bank* (Doctoral dissertation, University of Nairobi).

Mugenda, O. M., & Mugenda, A. G. (2013). *Research methods: Quantitative & qualitative apporaches* (Vol. 2, No. 2). Nairobi: Acts press.

Mulyono, H., Hadian, A., Purba, N., & Pramono, R. (2020). Effect of service quality toward student satisfaction and loyalty in higher education. *The Journal of Asian Finance, Economics and Business*, *7*(10), 929-938.

Munyao, S. M., Chiroma, N. H., & Ongeti, W. J. (2020). Effects of strategic direction on the performance of Africa Inland Church Theological Training Institutions in Kenya.

Ng'ang'a, L. W. (2018). The perceived influence of strategic leadership on organizational performance tourism government agencies in Kenya (Unpublished doctoral dissertation). Kabarak University, Nakuru, Kenya.

O'Shannassy, T. F. (2016). Strategic intent: The literature, the construct and its role in predicting organization performance. *Journal of Management & Organization*, *22*(5), 583-598.

Obeidat, A. M &. Al Thani, F. B. H., (2020). The impact of strategic leadership on crisis management. *International Journal of Asian Social Science*, *10*(6), 307-326.

Obiwuru, T. C., Okwu, A. T., Akpa, V. O., & Nwankwere, I. A. (2011). Effects of Leadership Style on Organizational Performance: A Survey of Selected Small-Scale Enterprises in Ikosi-Ketu Council Development Area of Lagos State, Nigeria. Australian Journal of Business and Management Research, 1, 100-111.

Odit, M. C. A., Rwashana, A. S., & Kituyi, G. M. (2014). Antecedents and dynamics for strategic alignment of health information Systems in Uganda. *The Electronic Journal of Information Systems in Developing Countries*, *64*(1), 1-20.

Owino, E. O. (2019). *Inequality of Opportunity in Maternal Health Among Adolescent in Kenya* (Doctoral dissertation, University of Nairobi).

Pallant, J. (2011). Survival manual. *A step by step guide to data analysis using SPSS*, *4*(4).

Peterlin, J., Pearse, N., & Dimovski, V. (2015). Strategic decision making for organizational sustainability: The implications of servant leadership and sustainable leadership approaches. *Economic and Business Review*, *17*(3), 1.

Pitelis, C. N., & Wagner, J. D. (2019). Strategic shared leadership and organizational dynamic capabilities. *The Leadership Quarterly*, *30*(2), 233-242.

Pitelis, C. N., & Wagner, J. D. (2019). Strategic shared leadership and organizational dynamic capabilities. *The Leadership Quarterly*, *30*(2), 233-242.

Price, L. R. (2016). *Psychometric methods: Theory into practice*. Guilford Publications.

Raza, B., Ali, M., Ahmed, S., & Moueed, A. (2017). Impact of managerial coaching on employee performance and organizational citizenship behavior: Intervening role of thriving at work. Pakistan Journal of Commerce & Social Sciences 11(3), pp.790-813

Raza, B., Ali, M., Ahmed, S., & Moueed, A. (2017). Impact of managerial coaching on employee performance and organizational citizenship behavior: Intervening role of thriving at work. *Pakistan Journal of Commerce and Social Sciences (PJCSS)*, *11*(3), 790-813.

Salkind, N. J. (Ed.). (2010). *Encyclopedia of research design* (Vol. 1). sage.

Samimi, M., Cortes, A.F., Anderson, M.H. and Herrmann, P. (2020), "What is strategic leadership?developing a framework for future research",The Leadership Quarterly, Vol. No. ahead-of-print,doi: 10.1016/j.leaqua.2019.101353

Saunders, M., Lewis, P., & Thornbill, A. (2015). *Research Methods for Business Students (7th edition)*. New York, U.S.A: Pearson Publications.

Sayed, A., & Theeb, K. (2019). The impact of strategic leadership on marketing excellence at Jordanian special hospitals. *Islamic University for Economic and Managerial Studies*, 2, 117–142.

Shala, B., Prebreza, A., & Ramosaj, B. (2021). The contingency theory of management as a factor of acknowledging the leaders-managers of our time study case: The practice of the contingency theory in the company Avrios. *Open Access Library Journal*, *8*(9), 1-20.

Sharma, E., Tewari, R., & Singh, A. (2021). India-specific corporate social responsibility-consumer perception scale. *International Journal of Corporate Governance*, *12*(1), 57-78.

Sherehiy, B., & Karwowski, W. (2014). The relationship between work organization and workforce agility in small manufacturing enterprises. *International Journal of Industrial Ergonomics*, *44*(3), 466-473.

Sibghatullah, A., & Raza, M. (2020). The Impact of Strategic Leadership on Competitive Advantage: The Mediating Role of Ambidexterity and Information System: Evidence from Islamic Banks in Jordan. *International Journal of Informatics and Information Systems*, *3*(2), 67-80.

Simsek, Z., Heavey, C., & Fox, B. C. (2018). Interfaces of strategic leaders: A conceptual framework, review, and research agenda. *Journal of Management*, *44*(1), 280-324.

Simsek, Z., Jansen, J. J., Minichilli, A., & Escriba-Esteve, A. (2015). Strategic leadership and leaders in entrepreneurial contexts: A nexus for innovation and impact missed?. *Journal of Management Studies*, *52*(4), 463-478.

Smith, R. (2019). Leadership strategies to improve healthcare outcomes (Doctoral dissertation, Pepperdine University).

Snyder, K. A., & Brewer, B. B. (2019). Workforce agility: An answer to turbulence in acute care nursing environments?. *Nursing management*, *50*(8), 46-50.

Sohrabi, H., Talebnia, G., & Nikjoo, M. (2014). The effectiveness of management accounting system on management performance. *Dama International*, *3*(3), 613-620.

Sritoomma, N., & Wongkhomthong, J. (2021). The components of strategic leadership competencies of chief nurse executives in private hospitals in Thailand. Journal of Nursing Management, 29(7), 2047-2055.

Straub, D., Boudreau, M. C., & Gefen, D. (2004). Validation guidelines for IS positivist research. *Communications of the Association for Information systems*, *13*(1), 24.

Suharyanto, A., & Lestari, R. D. (2020, December). The fall and rise of the contingency theory of leadership. In *Iapa Proceedings Conference* (pp. 479-496).

Syafitri, R., Ahadiat, A., & Hayati, K. (2021). The effect of strategic leadership on employees creativity by the mediation of voice behavior. *SSRG International Journal of Economics and Management Studies*, *8*(1), 91-97.

Tabachnick, B. G., & Fidell, L. S. (2018). Using Multivariate Statistics, 7th Edn London.

Tabachnick, B. G., Fidell, L. S., & Ullman, J. B. (2013). *Using multivariate statistics* (Vol. 6, pp. 497-516). Boston, MA: pearson.

Teece, D. J. (2017). Dynamic capabilities and (digital) platform lifecycles. In *Entrepreneurship, innovation, and platforms* (Vol. 37, pp. 211-225). Emerald Publishing Limited.

Teece, D. J., Pisano, G., & Shuen, A. (1997). Dynamic capabilities and strategic management. *Strategic management journal*, *18*(7), 509-533.

Tek, A., & Deya, J. (2020). Influence of Strategic Leadership on Implementation of Environment and Natural Resources Strategies in Nakuru County, Kenya. *International Journal of Academic Research in Business and Social Sciences*. 10(9), 542-563.

Tutar, H., Altınöz, M., & Çakıroğlu, D. (2011). Is ethical leadership and strategic leadership a dilemma? A descriptive survey. *Procedia-social and behavioral sciences*, *24*, 1378-1388.

Wanjiku, C. M., Njuguna, F., Chite Asirwa, F., Mbunya, S., Githinji, C., Roberson, C., & Greist, A. (2019). Establishing care for sickle cell disease in western Kenya: achievements and challenges. Blood advances, 3(Suppl 1), 8–10. https://doi.org/10.1182/bloodadvances.2019GS121620

Wójcik, P. (2015). Exploring links between dynamic capabilities perspective and resource-based view: A literature overview. *International Journal of Management and Economics*, *45*(1), 83-107.

Wright, E., Mainzer, A., Masiero, J., Grav, T., Cutri, R., & Bauer, J. (2018). Response to" An empirical examination of WISE/NEOWISE asteroid analysis and results". *arXiv preprint arXiv:1811.01454*.

Yamane, T. 1967. Statistics, An Introductory Analysis, 2nd Ed., New York: Harper and Row

Yong, A. G., & Pearce, S. (2013). A beginner's guide to factor analysis: Focusing on exploratory factor analysis. *Tutorials in quantitative methods for psychology*, *9*(2), 79-94.

Zhang, Y., Meratnia, N., & Havinga, P. (2010). Outlier detection techniques for wireless sensor networks: A survey. *IEEE communications surveys & tutorials*, *12*(2), 159-170.

Zia, B., Mazar, N., Reagans, R., & Argote, L. (2017). Organizational learning: Past research, present findings, and future directions. Academy of Management Annals, 11(1), 615-677.

APPENDIX A: SURVEY COVER LETTER

Dear Respondent,

Thank you for participating in our study!

I am conducting research to investigate strategic leadership roles of hospital leaders on delivering high-quality sickle cell disease and hemophilia care in Kenya. This research is a requirement in partial fulfillment for the award of Doctorate in Business Administration in Swiss School of Business and Management. You are therefore, requested to participate in this study by filling in the questionnaire which will take you less than 15 minutes.

Your participation in this research study is very much appreciated. It is my hope that the timely completion and return of this questionnaire is representative of your continued support for this type of research. Please be frank with your responses, and make sure to RESPOND TO ALL items in the questionnaire. All information you provide was strictly confidential. For questions or concerns please do not hesitate to contact me directly on +254 716 568562

Sincerely,

Samuel Mbunya

Doctor Of Business Administration (DBA) - Candidate

Swiss School of Business and Management (SSBM).

APPENDIX B   INFORMED CONSENT

Dear Participant,

The following information is provided to guide you in deciding whether to participate in

this study.

Title of the study: Strategic Leadership Roles of Hospital Leaders on Delivering High-

Quality Sickle Cell Disease and Hemophilia Care in Kenya

Principal investigator: Samuel Misiani Mbunya

Study location Kenya

Purpose of the study

To determine the strategic roles of hospital leaders and their effect on delivery of high-

quality sickle cell disease and hemophilia care in Kenya.

Description of the research

I'm pleased to inform you that you have been selected to participate in a research study. Before you decide to take part, it is important to understand the purpose and details of the study. This research aims to assess the strategic roles of hospital leaders and their impact on delivering high-quality care for sickle cell disease and hemophilia in Kenya. Specifically, it seeks to identify the aspects of strategic leadership practiced by hospital leaders, understand how these practices improve care delivery, and explore the challenges faced in implementing strategic leadership in this context. I kindly request your participation in answering a few questions, which will take approximately 25 minutes.

Potential benefit: There will be no direct benefit you as a participant, but it is hoped that the study will provide vital information that can assist in strengthening employee performance among public medical doctors.

Potential risks: There are no foreseen risks to you during your participation in the study.

Confidentiality

Your responses to this study will be anonymous. Please do not provide your name, personal number, or any identifying information in the research tool. Every step will be taken to

safeguard your confidentiality and the respondent's data will not be used for any other purpose except for this study.

Contact information

In case of any questions or clarification, you may contact the PI whose contact is provided

below:

Samuel Misiani Mbunya

Cell: +254 716 568562

Email address: samuel.mbunya@gmail.com

+ SSBM Swiss School of Business and Management

Please answer each question completely by ticking (√) the appropriate answer from the choices provided. Responses to the questionnaire was treated with confidentiality and information was purely for academic purpose.

Section A: DEMOGRAPHIC INFORMATION

1. Cadre:

    ………………………………………………...

2. Gender: Male ▢   Female ▢

3. Your age brackets? 30 years and below▢   31-40 ▢   41-50 ▢   51-60 ▢

4. Job Group/Grade:

    ……………………………………………………………………….

5. For how many years have you worked in the public service? …………………………

6. For how many years have you worked in your current station?

    ....

SECTION B: STRATEGIC LEADERSHIP

7. Select one of the numbers below to indicate how well the statement describes your 'strategic leadership practices in the hospital: 1 = Strongly Disagree 2 = disagree, 3= neutral, 4 = agree, 5 = Strongly Agree

		5	4	3	2	1
SL1	The hospital top leadership provides timely feedback efficiently.					
SL2	The hospital top leadership has vertical communication channel for employees' inputs					
SL3	The hospital top leadership embraces more clarity of ideas/strategy before communicating					
SL4	The hospital top leadership integrate technologies such as mobile phones, Video, Conferencing, social media etc. in its communication					
SL5	The failure to respond to official communications attract disciplinary action.					

SL6	The hospital leadership shares strategic goals with all employees					
SL7	The hospital leadership encourages autonomy among employees					
SL8	The hospital leadership is capable of shifting its structure quickly to address new opportunities					
SL9	Top management embraces and encourages innovative idea from employees by offering rewards					
SL10	If there is change of circumstances, the hospital management can adjust its current plans effortlessly					
SL11	The hospital leadership provide linkages between business units or departments so that the employees can cooperate with each other coherently					
SL12	The hospital leadership ensure there are no collaboration barriers between departments.					
SL13	The hospital leadership strives to continuously align operational functions in all departments					
SL14	The hospital leadership have effectively aligned IT with operation functions in all departments					
SL15	The hospital leadership ensures employees clearly understand institution's work priorities.					
SL16	The hospital leadership encourages and develops employees to work as a team.					
SL17	The hospital leadership ensures to provide a large variety of services without adversely affecting their quality					
SL18	The hospital leadership has implemented continuous learning approach					
SL19	The hospital leadership directs all its activities to meet the needs of the customers.					
SL20	The hospital leadership allows staff from all departments raise their opinions on organizational policy and work condition					
SL21	The hospital leadership has successfully implemented fundamental long-term strategic plan.					
SL22	The hospital leadership ensure all employees are trained in implementation of strategic plan					
SL23	The hospital leadership consult widely before coming with a strategic plan					
SL24	The hospital leadership ensure all stakeholders are involved in developing a strategic plan					
SL25	The hospital leadership have directed the hospitals' resources for the achievement of all goals					
SL26	The hospital leadership regularly evaluates the implemented of strategic plan					
SL27	The hospital leadership analyses on why its employees succeeded or failed.					

8. Please provide your views on your hospital leadership toward enhancing high-quality sickle cell disease and hemophilia care

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APPENDIX D: PATIENTS QUESTIONNAIRE

SSBM Swiss School of Business and Management

Please answer each question completely by ticking (√) the appropriate answer from the choices provided. Responses to the questionnaire was treated with confidentiality and information was purely for academic purpose.

Section A: DEMOGRAPHIC INFORMATION

1. Cadre:

   ………………………………………………...

2. Gender: Male ☐   Female ☐

3. Your age brackets? 30 years and below☐   31-40 ☐   41-50 ☐   51-60 ☐

4. For how many years have you visited this hospital? …………………………

5. For how many years have you had sickle cell disease and hemophilia?

   ....

SECTION B: QUALITY SICKLE CELL DISEASE AND HEMOPHILIA CARE

6. Select one of the numbers below to indicate how well the statement describes your 'care you received from the hospital: 1 = Strongly Disagree 2 = disagree, 3= neutral, 4 = agree, 5 = Strongly Agree

		5	4	3	2	1
	Assurance					
A1	We patients receive special attention whenever I go to the hospital for emergencies.					
A2	All the test report done in this hospital have been accurate.					
A3	Doctors have been genuinely been concern about disease.					
A4	Staff and nurses care for me.					
	Reliability					
R1	Doctors and staff adhere to promised appointment times.					

R2	Patients are seen in a timely manner according to their appointments.					
R3	Patients Reports are processed delivered on time.					
	Responsiveness Dimension:					
Resp1	Patients receive medical test (i.e., laboratory, x-rays, etc.) feedback on about time					
Resp2	Patients' requests/needs are efficiently responded by doctors/nurses/staff					
Resp3	Doctors and staff are willing to help and facilitate patients.					
	Tangibility Dimension:					
T1	The hospital maintains hygienic conditions.					
T2	Wards, offices, rooms/bathrooms are kept clean, including sheets and floors.					
T3	The hospital provides a healthy environment.					
T4	There are waiting facilities available for attendants and patients					