The Influence of Internalized Moral Perspective on Resilience of the Kenyan Health System

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Abstract

Internalized Moral Perspective is a construct of authentic leadership. It provides moral reasoning which confers self-regulation to individuals, organizations and systems in the face of acute and chronic shocks. This paper looks at internalized moral perspective through the lens of two sub-constructs: capability approach and consequential evaluation. The Study was carried out between March and September 2022 – response phase of pandemic response. The sampling frame consisted of Level 5 and 6 hospitals that served 8 counties identified as high risk for COVID-19 in Kenya. A modified Authentic Leadership Questionnaire was administered face-to-face, through email or through WhatsApp. Twenty six (26) hospitals responded (two Level 6, and twenty-four Level 5 hospitals). The Study revealed a high score of Internalized Moral Perspective = 17.9. Nakuru and Garissa County expressed the highest level of Internalized Moral perspective while Kakamega had the lowest expression. There was a weak positive linear correlation with Resilience Index (rho = 0.147) and a good path analysis (t = 2.016, p <0.05). Thus, the Study rejected the null hypothesis that stated, internalized moral perspective does not influence resilience index in the Kenyan health system. The Study concluded that internalized moral perspective not only confers resilience to the Kenyan health system, but is also an opportunity for growth in order to confer cultural competence to the leaders. The Study recommended increased experience sharing in disaster response and adoption of crisis outreach model for mental health. Experience sharing needs to be not only in-hospital but also, inter-hospital and inter-county for better resilience. Channels include: continuous medical education, conferences, seminars, workshops and publications.

Keywords: Internalized Moral Perspective, Leadership, Resilience, Health

Introduction

On March 13, 2021, the then President of Kenya declared closure of all learning institutions due to the COVID-19 pandemic. This heralded the closure of offices, travel restrictions and curfews. The health sector was stretched beyond its capacity. This led to deaths at home; livelihoods were affected; and there was an increase in mental illness and marital violence.

Kenya's epidemic preparedness index has been ranked 4th globally out of a ranking of 1-5 with 5th being worst prepared (Oppenheim et al., 2019). This has been attributed to lack of stewardship (Frey, 2020), and political will (Kenya: National Policy for Disaster Management, 2009, (Mfutso-bengo et al., 2017). During COVID-19 pandemic, manifestation

of this mistrust was seen in strikes by healthcare workers, legislative stand-offs due to embezzlement of funds (Kenya's fight against coronavirus difficult with its two-tiered governance system, 2020), and poor attendance to health facilities for essential medical services (State of Devolution Address of 23 July 2020 (2020). This has been attributed to ineffective and autocratic leadership style (Maticka-Tyndale, 2017). It has been worsened by disjointed coordination across sectors and various levels of healthcare (Curran et al., 2018). Internalized moral perspective, Self-awareness, balanced processing and relational transparency.

Internalized Moral Perspective enables a person to deal with moral and ethical dilemmas. It has also been referred to as moral reasoning. This Study reviewed internalized moral perspective using two subconstructs: Capability approach and Consequential Evaluation.

Literature Review

Internalized Moral Perspective is defined as a prosocial behavior that determines one's presence or absence of altruistic actions and/or discipline (Schwartz & Howard, 1984). Not only is it a component of Authentic Leadership, but it is also a component of Ethical Leadership. It requires exposure to difficult situations in order to yield productive deviant workplace behaviour (Skubinn & Herzog, 2016) and to result in benefits of positive workplace behaviour and attitudes.

Internalized Moral Perspective is a determinant of one's choice between personal needs and social obligations. Depending on the theory that seeks to elucidate it, it can be described using any of three facets: cognitive (psychoanalytic theory), behavioural (social-learning theory) or affective (attribution theory) (Hoffman, 1985). These internal workings are subject to evolution because they are not only shaped by one's developmental experiences, but also by their experiences later in life (Hinojosa et al., 2014).

It is measured using the Authentic Leadership Questionnaire. Analysis of the same has been done using factor analysis and Structural Equation Modelling (Walumbwa et al., 2008), (Purwanto et al., 2021).

This Study adopted two subconstructs of Internalized Moral Perspective: Capability approach and Consequential Evaluation. Both were measured using the modified Authentic Leadership Questionnaire. Analysis was conducted using factor analysis and Structural Equation Modelling.

Methodology

The study was guided by a pragmatic philosophy and adopted a convergent mixed method design. The sampling frame consisted of Level 5 and 6 hospitals which served 14 counties that had been identified as high risk for COVID-19 spread. The target population was hospital leaders of the Level 5 and 6 Hospitals. The sampling technique was purposive. It included the leaders of departments which were handling COVID-19 patients, and departments that were offering essential services as prescribed by the Keya Health Policy.

Data was collected using a semi-structured modified Authentic Leadership Questionnaire. The questionnaire was modified by addition of Kruk's et al. (2017), Resilience Index components as part of the questionnaire. Descriptive statistics were derived through means, standard deviations and sums. These were presented in tables. Inferential statistics were derived in a multi-step method. Kaiser-Meyer-Olkin was used to evaluate sampling adequacy. A score of more than 0.7 gave guidance to the use of principal factor analysis to

test construct validity. Spearman's correlation was used to determine the direction of relationship between the independent and dependent variables. Finally, path analysis was determined using structural equation modeling. The first component of the PCA of the Resilience Index was taken as Kenya's Resilience Index.

Results

Resilience Index

Kenya's Resilience Index was determined as 51.2% using Principal Component Analysis. This was derived from the first factor.

Table 1. Principal Component Analysis – Resilience Index

Factor analysis/correlation		Number of obs =	184
Method: principal factors		Retained factors =	3
Rotation: (unrotated)		Number of params =	78

Factor	Eigenvalue	Difference	Proportion	Cumulative
Factor1	6.41197	4.53651	0.5124	0.5124
Factor2	1.87546	0.33182	0.1499	0.6623
Factor3	1.54364	0.41368	0.1234	0.7857
Factor4	1.12997	0.18877	0.0903	0.8760
Factor5	0.94120	0.33482	0.0752	0.9512
Factor6	0.60638	0.03926	0.0485	0.9997
Factor7	0.56712	0.21594	0.0453	1.0450
Factor8	0.35118	0.01923	0.0281	1.0731
Factor9	0.33196	0.11185	0.0265	1.0996
Factor10	0.22011	0.01855	0.0176	1.1172
Factor11	0.20156	0.03996	0.0161	1.1333
Factor12	0.16160	0.07773	0.0129	1.1462
Factor13	0.08387	0.04677	0.0067	1.1529
Factor14	0.03710	0.02345	0.0030	1.1559
Factor15	0.01365	0.04866	0.0011	1.1570
Factor16	-0.03500	0.03473	-0.0028	1.1542
Factor17	-0.06973	0.01555	-0.0056	1.1486
Factor18	-0.08528	0.01932	-0.0068	1.1418
Factor19	-0.10461	0.03078	-0.0084	1.1334
Factor20	-0.13538	0.01384	-0.0108	1.1226
Factor21	-0.14923	0.02337	-0.0119	1.1107
Factor22	-0.17259	0.03404	-0.0138	1.0969
Factor23	-0.20663	0.00708	-0.0165	1.0804
Factor24	-0.21371	0.03203	-0.0171	1.0633
Factor25	-0.24574	0.02172	-0.0196	1.0437
Factor26	-0.26746	0.01132	-0.0214	1.0223
Factor27	-0.27878	.	-0.0223	1.0000

LR test: independent vs. saturated: chi^2 (351) = 2000.99 Prob>chi^2 = 0.0000

Kenya's Resilience Index was determined as 51.2% using Principal Component Analysis. This was derived from the first factor which accounts for the highest total variance (Table 1). Three factors were retained and conferred 79% of the resilience. However, for this study, focus was placed on deriving the resilience index.

Internalized Moral Perspective

Table 2. Sum of Internalized Moral Perspective

Variable	Obs	Mean	Std. Dev.	Min	Max
IMP	184	17.85326	2.421486	5	20

Test scale = mean (unstandardized items)

Internalized Moral Perspective had a high sum of 17.9. High scores of authentic leadership range between 16-20. This means that leaders in the Kenyan health sector had high levels of Internalized moral perspective.

Table 3. Internalized Moral Perspective Score

	(1)	(3)
	Resilience Index	**Internalized Moral Perspective**
Total	91.87	89.27
	(11.72)	(12.11)

Standard deviation in brackets

The influence of Internalized Moral Perspective to the Resilience Index was 89% as shown in Table 3. The standard deviation (12.11) as compared to the Authentic Leadership scores (8.6) was more than 2. This further confirms that leaders in the Kenyan Health System had high levels of Internalized Moral perspective.

Table 4. Kaiser-Meyer-Olkin Measure of Sampling Adequacy for Internalized Moral Perspective

Variable	kmo
Internali~15	0.8211
Internali~16	0.8955
Internali~27	0.815
Internali~28	0.8422

The KMO score for Internalized Moral Perspective confirmed a meritorious sample. It ranged from 0.82 -0.89 thus justified the use of factor analysis for further inferential analysis.

Table 5. Internalized Moral Perspective by County

	Internalized Moral Perspective
Garissa	92.00
	(6.708)
Kakamega	87.22
	(8.333)
Kiambu	85.45
	(12.74)
Kisumu	84.19
	(14.60)
Machakos	85.83
	(12.76)
Mombasa	92.19
	(10.95)
Nairobi	91.47
	(11.36)
Nakuru	93.89
	(6.009)
Total	**89.27**
	(12.11)

Standard deviation in brackets

The influence of Internalized Moral Perspective on Resilience Index by County is demonstrated in Table 5. The scores ranged between 84% and 93.9%. Nakuru, Mombasa and Garissa counties demonstrated the highest scores at 93.9%, 92.19% and 92% while Kakamega County scored lowest at 84%. However, only Nakuru, Garissa and Kakamega counties had standard deviations of more than 2. This meant that Nakuru, Garissa and Kakamega counties were strongest in Capability Approach and Consequential Evaluation while Kakamega County was weakest in this regard.

Table 6. Internalized Moral Perspective by Ownership type

(3)	
	Internalized Moral Perspective
Public	89.38
	(12.54)
Private	89.16
	(11.75)
Total	**89.27**
	(12.11)

Standard deviation in brackets

A comparison of Internalized Moral Perspective and Resilience by ownership is demonstrated in Table 10. Both public and privately owned hospitals had a similar score of 89%. The standard deviation was less than 1. This means there was no difference in Capability Approach and Consequential Evaluation between leaders in the public and private hospitals.

Table 7. Internalized Moral Perspective by Hospital Hierarchy

	Internalized Moral Perspective
Level 5 Hospitals	89.00 (11.37)
Level 6 Hospitals	91.58 (17.48)

The different hierarchies of hospitals were compared as demonstrated in Table 7. Level 6 hospitals scored higher at 91.6% while Level 5 hospitals scored 89%. The standard deviation for Level 6 hospitals was five standard deviations from the mean (12.11). This makes the Capability Approach and Consequential Evaluation in Level 6 hospitals more significant than Level 5 hospitals thus depicting their leaders as having more Internalized Moral Perspective.

Table 8. Correlations between Resilience Index and Internalized Moral Perspective

Variables	**(1)**	**(2)**	**(3)**
Resilience Index	**1.000**		
		1.000	
Internalized Moral Perspective	0.147	0.452	**1.000**

The Spearman's correlation revealed a weakly positive linear correlation (rho = 0.147). This means that there internalized moral perspective had a weak influence on the resilience index in the Kenyan health system.

Table 9. Influence of Internalized Moral Perspective on Resilience – Path Analysis

	(1)	(2)	(3)	(4)
Resilience Index (%)				
Internalized Moral Perspective Score (%)		0.142**		
		(2.016)		
Constant	66.39***	79.17***	67.69***	83.51***
	(8.347)	(12.45)	(10.67)	(15.54)

t statistics in parentheses

* p<0.1, ** p<0.05, *** p<0.01

The path analysis between Internalized Moral Perspective and Resilience Index was significant (t =2.016, p<0.05). This is demonstrated in Table 9. Despite internalized moral perspective having a weak influence on resilience index, it was significant. This led to rejection of the null hypothesis: Internalized Moral Perspective does not influence Resilience Index in the Kenyan Health system. This meant that there is an opportunity for capacity building in capacity approach and consequential evaluation.

Table 10. Influence of Internalized Moral Perspective on Resilience moderated for the respective aspect with Pandemic Occurrence

	(2)
Resilience Index (%)	
Internalized Moral Perspective Score (%)	0.058
	(0.559)
Internalized MP*Pandemic Occurrence Score	0.004
	(1.096)
Constant	79.56***
	(12.53)

t statistics in parentheses

* p<0.1, ** p<0.05, ** p<0.01

The path analysis for moderation of internalized moral perspective by Pandemic occurrence was not significant (Table 10). This meant that Pandemic Occurrence did not moderate the influence of Internalized Moral Perspective on resilience index of the Kenyan Health system.

Discussion of Findings

The Study evaluated the influence of Internalized Moral Perspective on Resilience of the Kenyan Health System. Two subconstructs were used: capability approach; and consequential approach. The Study established a high score of Internalized Moral Perspective = 17.9. A meritorious KMO (0.8) determined the use of factor analysis to get inferential statistics. There was a weak positive linear correlation with Resilience Index (rho = 0.147) and a good path analysis (t = 2.016, p <0.05). Pandemic occurrence did not moderate the relationship between Internalized Moral Perspective and Resilience Index. Nakuru and Garissa counties have the highest expressions of Internalized Moral perspective while Kakamega had the least expression. Level 6 hospital had higher scores (5 standard deviations) of internalized moral perspective compared to Level 5 hospitals. Thus, the Study rejected the null hypothesis that Internalized Moral Perspective does not influence Resilience Index in the Kenyan Health System.

The first principal factor of Resilience Index in the Study was self-regulating capacity. This results from high scores of Internalized Moral Perspective. This concurred with Northouse's (2016) sentiments that high scores of Internalized Moral Perspective confer self-regulation. The Study found Self-regulation had large positive associations with: Availability of Key contacts, Availability of Memorandum of Understanding between facilities, Availability of a database of providers, Availability of Emergency Operational Plans and Business Continuity Plans, Data management ability, Ability to monitor and evaluate a disaster response. This concurred with Paras and Butler (2019) who recommend a common language and structure which the users are trained for an effective command system and response.

Conservative states in the United States contrasted the findings of the Study. They downplayed the severity of illness as reported by mainstream media thus reducing compliance to preventive measures and eroding trust of the citizens in their leaders (Deslatte, 2020). This was irrespective of psychological wellness, belief in science and COVID-19 related anxiety (Rothgerber et al., 2020). There was further alignment in another study conducted in the United States. It found that compliance and self-regulation was determined

by the citizenry's disgust with pathogens and moral values regarding their care for others (Díaz & Cova, 2020). Brazil's response also contrasted the Study findings. The then president's political ideology of COVID-19 being a myth led to the government's poor response to COVID-19 at its onset (Rousseff, 2020).

Concurrence to the study was also reported in the United Kingdom. Individual behaviour, though humble was acknowledged as powerful in compliance to social distancing (Pearce, 2020). Denmark's response to the H1N1 pandemic also concurred with the study findings. It led to innovative governance that was cognizant of evidence-based decision making thus trusting its scientific fraternity (Baekkeskov, 2016).

The study findings mirror those in Norway during the H1N1 response in 2013 where resilience was achieved within 5 months (Karlsen, 2016). A review of resilience to H1N1 pandemic in Sweden, Netherlands, and Denmark revealed the need for shared epistemic where varied opinions exist due to uncertainties. This was followed by a change in policy due to evolving evidence which allowed for contextualization and consensus. It led to targeted vaccination of at-risk populations in Denmark (Baekkeskov, 2016).

Studies in Taiwan aligned with the study findings. Culturally appropriate decision-making during uncertainty was achieved through active case finding, proactive quarantine of suspicious cases, and resource allocation to ensure containment of COVID-19 (Wang et al., 2020). Findings of Thailand's response to the HIV/AIDS pandemic mirrored those of the study. Containment was achieved in 7 years from 12.5% to 1.1% due to shared values. The leaders and followers ascribe to Buddhism which reveres authority thus fast-tracked behaviour change (Maticka-Tyndale, 2017). Indonesia's commitment to organizational citizenry was pegged on leaders who are pious, tough, and responsible (Athar, 2020).

India's response to COVID-19 contrasted to the Study findings. They reached Stage 3 transmission of COVID-19 due to lack of Internal Moral Perspective. Carelessness in religious meetings and migrants' travel led to poor social distancing (Davey et al., 2020). Poor adherence to social distancing and other preventive measures were also influenced by politicization of COVID-19.

This contrasts with findings in Iran where the government interventions were not aligned with citizenry. The government bombarded the citizens with complex information as the COVID-19 evolved thus alienating them and compromising compliance to preventive measures (Naeim, 2020). Forsyth (2020) concurred with the Study findings in a study that applied group-level activities that were inconsistent with containment measures. This did not promote preventive measures in the control of COVID-19 pandemic in the United States.

Findings in Australia concurred with the study. Compliance to social distancing was achieved through alignment with subjective norms, moral obligations and perceived behavioural control (Hagger et al., 2020). In Africa, there was concurrence in the review of response to epidemics. Thus, the term - *Ubuntu – I am because we are*. This is a dynamic approach to moral and ethical reasoning that is characteristic of Sub-Saharan Africa. It resonates with daily decision making, values, and consequent practices (Sambala, Cooper, & Manderson, Ubuntu as a Framework for Ethical Decision Making in Africa: Responding to Epidemics, 2020).

The lack of plans in West Africa led to scarcity in resources, ineffective governance and leadership, hence the protracted containment of Ebola - which took 18-21 months to contain in Sierra Leone, Liberia and Guinea (Karlsen, 2016). West Africa's response to Ebola contrasted the findings in the Study. Mistrust in the government and "western actors" in

Liberia's fight against Ebola led to stigmatization and non-compliance to infection prevention measures (Jansen, 2019). Consequential evaluation was demonstrated in the engagement of Christian and Muslim religious leaders who supported the contextualization of infection prevention control measures with their religious teaching thus resulting in community compliance to infection prevention control measures (Karlsen, 2016). The religious leaders also became the psycho-social support that managed and reversed stigmatization. This innovative leadership was thus termed as *innoveadership* (Hakan, 2018).

There were contrary findings in Malawi and Ghana's response to COVID-19. Ethical decisions in pandemics arose from competitive choices (such as forced vis-à-vis voluntary vaccination); decision-making that was oblivious of morals, culture and local values; neglect of relevant facts to justify decisions; and lack of technical knowledge in ethics. However, the leaders rationalized self-interest and unpopular professional actions which manifested as failure to act and inappropriate action thus affecting their integrity and promoting mistrust with the followers (Sambala & Manderson, 2018).

Studies with concurrent findings are reported in South Africa. Simulation drills, physical and financial resources did not confer resilience to their health systems. This was due to depletion and destruction of financial and physical resources; and fear of death and disability by the healthcare workers. Instead, community empowerment allowed for the mobilization of resources required to reverse the catastrophic effects of shock and improve health outcomes and equity (Bhandari & Alonge, 2020).

In Kenya, the second COVID-19 wave was anticipated to require 404 ICU bed hospitalizations in Nairobi County but the capacity was 278 beds. The other counties mirrored a similar inadequacy in preparedness with 6,898 isolation beds against a target if 30,500 (Capital FM Digital Bulletin, 2020). This necessitated a utilitarian approach based on risk profile and the advent of home isolation practices in order to preserve hospital beds for the severely ill.

It also concurred with Aitsi-Selmi et al. (2015) who formulated the Hyogo Framework. This is a disaster management approach which has been adopted by member states to enhance resilience to disasters. Its operationalization was made simpler by including measurable elements. Thus, resulting in the Sendai Framework for Disaster Risk Reduction which has measurable elements, thus making it easier to operationalize (Murray & Waite, 2018). The Study findings were further evidence of Kenya having aligned to the WHO recommendations to have disaster plans just as European (Kern, 2016) and African countries have (Ridde et al., 2016), (Wright et al., 2020).

Kenya's fight against the HIV/AIDS pandemic was characterized by disjointed efforts thus contrasting with the Study findings. These were demonstrated by the government's directive to teach sexual education in schools while the community and religious institutions believed in abstinence. The discordance allowed the pandemic to increase to 10.5% by 2001 due to counter-cultural guidelines. The inclusion of the religious leaders, local authorities, senior women, and elders to lead the change in the communities propelled the reversal of the pandemic from prevalence from 10.5% (2001) to 5.88% (2015) (Maticka-Tyndale, 2017).

In West Pokot, Kenya, there was a delayed response to drought. The result was the government's provision of access to credit extension, formal schooling, household income, and adaptive practices. Thus, household resilience was improved (Muricho et al., 2019), and aligned to the Study findings.

Nyandiko (2020) concurred with the Study findings. He noted that during the COVID-19 pandemic, Kenya displayed alignment with the WHO, AU and EAC protocols through adoption of a common language and structure. This was achieved by incorporation of Disaster Risk Reduction into County Integrated Development Plans. However, these were challenged by: inadequate funding, weak coordination, few and poorly trained personnel, inadequate engagement of vulnerable populations and low commitment from policy makers.

Prior to COVID-19 pandemic, counties had allocated 24% of their total budgets to health as part of supporting Universal Health Coverage (State of Devolution Address 23 July, 2020). After the pandemic was declared, counties set aside an additional KES 6.2 billion for COVID-19 response while the national government increased allocation of KES 5 billion (Annual Statutory Report 2019/2020).

Wafula and Okech (2020) reported conflicting findings to the Study. Embezzlement of COVID-19 funds in Kenya created COVID-19 millionaires. The fraud led to protests by civil society, non-governmental organizations, trade unions, private sector and professional bodies over the lack of transparency and accountability (Wafula, 2020). The government's slow response was characterized by use of police force to disperse the protesters thus increasing mistrust with the citizenry (Kenya: Crackdown on demo over 'theft' of COVID-19 funds, 2020, August 21).

Recommendations

The Study recommended the application of utilitarian approach in managing disasters of any kind. This would be achieved if there was documentation of experiences and lessons learnt from previous responses so that leaders can learn from these. Therefore, healthcare leaders are encouraged to share experiences through continuous medical education, conferences, seminars and publications.

The Study recommended a crisis outreach model for mental health and wellness for healthcare workers and the community. This could be achieved through inclusion in policy, and creating an implementation framework which ensures its operation even in normal shocks.

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