Health system governance in Kenya: an assessment at national and subnational level

Thesis submitted in accordance with the requirements of the University of Liverpool for the degree of Doctor in Philosophy

By

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February 2018

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Declaration

I, Thidar Pyone, confirm that the work presented in this thesis is my own. The information derived from other sources has been acknowledged and referenced in the thesis.

Thidar Pyone

February 2018

Acknowledgements

First of all, I would like to acknowledge the PhD fellowship award from the Trans Global Health funded by the Erasmus Mundus Association. That award provided me with the opportunity to conduct PhD research alongside a full-time job at the Liverpool School of Tropical Medicine (LSTM). My initial proposed research was to assess "health system governance" in my home country, Myanmar where the new government has committed to improving governance of the country including the health sector. This has inspired my passion to study the governance of health systems in low-and middle-income countries.

Upon reflection, even though I declined the fellowship opportunity to undertake full-time research with the Trans Global Health, I do not regret my decision to study at LSTM as I have gained a great deal of experience throughout the four years. Therefore, I am grateful to my primary supervisor, Professor Nynke van den Broek, for offering me this excellent opportunity to study part-time while working at LSTM. Undertaking a PhD alongside a full-time job has given me the crucial skills to become a successful researcher including perseverance, commitment and personal sacrifice especially as the thesis is not part of the full-time job. These experiences have been invaluable as they have taught me how to juggle different projects. I learnt how to set priorities in personal and professional life and how to stay focussed to achieve the set goal. I am amazed to reflect that I have completed seven projects (two national scales, four district level and one desk review at international level), during my full-time work. Thank you, Nynke for allowing me to get involved in different projects which inadvertently sharpened my research and project management skills.

I would like to express my sincere gratitude to my secondary supervisor, Dr Helen Smith, who consistently provided me with different forms of research support. Helen has been my first point of "on-call" supervision for any research support required, even those which were not related to PhD research. Helen has always been approachable and set aside time whenever I asked her for help. I am so fortunate to have had Helen as my supervisor from the conceptualisation to the completion of the thesis and for the way she guided me to become a practical and ethical social scientist.

I am indebted to my informal supervisor and mentor who supported me unconditionally due to their research interests in governance. Professor Taryn Vian from Boston University who has supported me by sharing her strong expertise in governance and anti-corruption. Taryn, I owe a gratitude to you for the very unconditional support you have provided me that I cannot express in words. I wish to thank Dr Seye Abimbola from the University of Sydney

who has been my mentor in governance for the fruitful discussions around different approaches in the "new institutional economics", in particular. Seye, you are my mentor on institutional framing of governance!

I would like to acknowledge the funder of this research, DFID (UK Department for International Development) through the "Making it Happen" programme.

I am grateful to Europubhealth Masters Course (2008-2010) which opened my mind to global health research, inspired a Burmese doctor to conduct health system research in Kenya while based in the UK. I am also grateful to my fellow PhD researchers from the CMNH, particularly Terry Kana, Adura Banke-Thomas and Abimbola Olaniran with whom I shared the PhD journey and the support we provided one another.

I would like to express my gratitude to my family, my husband and daughter for their patience during the PhD marathon. I do not think this study would have been finished without the support and encouragement from my husband, Zaw Min Oo, who sacrificed his business and own ambitions for me. Lastly and most importantly, I am most grateful to the participants from Kenya who shared their insights and perspectives regarding the Kenya health system. I sincerely wish that Kenya prospers and provides good governance under a responsible government to its accountable citizens.

List of acronyms

BEmOC	Basic emergency obstetric care
CBHIMS	Community based health information management system
CEmOC	Comprehensive emergency obstetric care
CMA	County management authority
COH	Chief officer for health
D&C	Dilatation and curettage
DHIS	District health information system
EC	European Commission
EmOC	Emergency Obstetric Care
FMS	Free maternity services
GDP	Gross domestic product
HFMC	Health facility management committee
HMSF	Hospital management service fund
HRH	Human resources for health
HSSF	Health sector services fund
IMR	Infant mortality rate
KDHS	Kenya Demographic Health Survey
KEMSA	Kenya Essential Medical Supplies Authority
KHSSP	Kenya Health Sector Strategic Plan
KI	Key informant
MDG	Millennium Development Goals
MiH	Making it Happen
MMR	Maternal Mortality Ratio
MNH	Maternal and newborn health
MOH	Ministry of Health
MOMS	Ministry of Medical Services
MOPHS	Ministry of Public Health and Sanitation
MVA	Manual vacuum aspiration
NHIF	National health insurance fund
NIE	New institutional economics
NMR	Neonatal Mortality Rate
PHC	Primary health care
SDG	Sustainable development goals

TB	Tuberculosis
U5MR	Under-5 Mortality Rate
UN	United Nations
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
USD	United States Dollar
WHO	World Health Organisation

Publications based on the PhD work

The following papers which stem from the PhD research, have been published in peer-reviewed journals. (**Appendix 1**)

a) Pyone, T., Smith, H. & Van Den Broek, N. 2017. Frameworks to Assess Health Systems Governance: A Systematic Review. Health policy and planning, 32, 710-722. https://academic.oup.com/heapol/article-lookup/doi/10.1093/heapol/czx007
This paper forms part of Chapter 3 (Literature review).

b) Pyone, T., Smith, H. & Van Den Broek, N. 2017. Implementation of the Free Maternity Services Policy and Its Implications for Health System Governance in Kenya. BMJ Glob Health, 2 (4), e000249. http://gh.bmj.com/content/2/4/e000249
This paper forms part of Chapter 6 and 7 (Findings).

Conference presentation based on the PhD work

Chapter 7: "**Are there any differences in governance between fully functional and not fully functional facilities?**" was presented at the International Health Economics Association (iHEA) congress in Boston, USA 8-11 July 2017. The topic was presented as part of the panel discussion titled "*Health Sector Corruption: Studies on measurement, policy and strategy*."

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Abstract

Introduction: Improving health systems requires good governance alongside technical interventions. Evidence suggests that strengthening governance results in more responsive health systems. Despite receiving increased attention, governance is still a relatively new area of health systems and policy research. There is no universally agreed way to define, measure or assess health system governance. Little information exists regarding governance at sub-national (health policy implementation) level. Assessing governance at different health system levels (national, county and health facility) in Kenya is the aim of this study. The specific research objectives explored are: 1) factors influencing health system governance in Kenya; 2) key stakeholders' perspectives on health system governance and 3) whether the status of health system governance differs with the functionality of health facilities.

Methods: The study employed qualitative research methods, interviews with 39 key informants from three levels of the Kenya health system. The study used a conceptual framework adapted from previously published tools for assessing governance and draws on "institutional analysis" theory to help analyse and interpret the findings.

Findings: Key factors that influence governance in the health system include devolution, rapidly changing political context, constrained health financing and challenges in managing the health workforce. The most notable influence appeared to be the impact of devolution and frequent health workers' strikes. Stakeholders shared their views on all six principles of governance and these revealed opportunities for abuse of the system, weak enforcement of policies and accountability measures, and a lack of participation in policy development. They also commented on the lack of improvement in equity in the health system. Careful analysis using the new institutional economics theory showed that there were observed differences in governance at facility level: fully functional versus not fully functional. The most surprising difference was that staff responding to the lack or weakness of formal institutions by creating informal arrangements that might circumvent or support the goals of the formal system. Fully functional facilities had accountability mechanisms that they self-enforced; by contrast, facilities that were not fully functional lacked both self-enforcement and effective third party enforcement mechanisms. Norms and practices for controlling corruption were clear in fully functional facilities but confused in some not fully functional facilities.

Conclusions: This study provides an in-depth exploration of what factors influence institutional arrangements for good governance and how these were enforced or not.

Analysis guided by theory, with a strong emphasis on context, is an important contribution to the existing literature on governance. This study critically evaluated existing frameworks to assess health system governance from a cross-disciplinary perspective which can inform future research on governance. The findings highlight research implications for Kenya at policy and operational levels particularly, on the need to monitor health system governance over time due to rapidly changing political and socioeconomic circumstances, especially concurrent devolution.

CHAPTER 1

1. Introduction

The origins of this study lie in my experience working with public health sectors in low and middle-income countries for over 15 years as I believe that good governance is indispensable to improve a health system and technical interventions alone are not sufficient. There is strong evidence in the literature that strengthening governance results in more responsive health systems through increased accountability, enhanced participation, reducing corrupt practices, enforcing the rule of law and promoting equity.

The literature on health system governance is frequently characterised by governance audit against benchmark standards, using either rules-based (e.g. policy or procedure exists) or outcomes-based approaches (e.g. the policy has been implemented, or the rule has been enforced) (Fryatt et al., 2017; Savedoff, 2009). However, there is limited information on institutional arrangements and how these can be enforced to improve governance. Both rules-based and outcomes-based approaches to assess governance have been critiqued for their limitations as they largely depend on how and what you propose to measure (Chhotray & Stoker, 2008). Though such assessments provide valuable insights, the approach is somehow limited as it often fails to be explicit about the measurement (Chhotray & Stoker, 2008).

While the subject of governance has been studied across different disciplines, there are few studies that provide an understanding of governance at the operational level. This is one of the very few studies which have assessed governance of the health system including at health facility level in Kenya. This study sought to elucidate how governance arrangements differed with the functionality of a health facility and to generate transferable insights.

The originality of this study is that it explores health system governance including health facilities designated to provide comprehensive emergency obstetric care (CEmOC) in Kenya. No previous study has used a theoretical framework to assess health system governance at county level and below in Kenya. Hence, in this aspect, this study is unique. Using the "institutional analysis" approach to governance, this study provides opportunities to highlight stakeholders' perspectives. Despite the slow progress in the improvement of maternal health in Kenya within the last decade, governance has not been studied focussing on facilities designated to provide comprehensive emergency obstetric care (CEmOC). This

study is, to the best of my knowledge, the first one to explore the views of key stakeholders in maternal health.

This chapter starts by providing an overview on the importance of governance from the perspective of international development. It highlights how governance has been instrumental in sustainable development globally and described some initiatives of governance for development across the world. The chapter then highlights the importance of health system governance in Kenya followed by the significance of the study in Section 1.2. Section 1.3 introduces the research aim and objectives with the research questions set out for this study. Lastly, Section 1.4 presents the organisation of the study outlining the content of different chapters.

1.1 Governance for sustainable development

Governance is a relatively new concept in development. Governance was brought into the health system through international development. Governance has received increasing attention in development with the landmark report of the World Bank's World Development Report 2004 on the role of governance in service provision. The WHO brought attention into health system governance by introducing governance as one of the six health system building blocks (WHO, 2007). Health system governance is defined as "*the role of the government in health and its relation to other actors whose activities impact on health. This involves overseeing and guiding the whole health system, private as well as public, in order to protect the public interest*" (WHO, 2008). Governance rules and functions help policy and other decision makers to achieve health objectives in their countries. The World Bank measures governance performance in countries around the world annually using public expenditure tracking surveys. Likewise, USAID has been investing significant resources to improve leadership and governance of health systems to achieve better health outcomes in low-and middle-income countries in its programming over the last 25 years (USAID, 2017).

In their systematic review, Ciccone et al. (2014) highlighted that governance has a direct, positive relationship to health outcomes in low-and middle-income countries. The review identified three key governance mechanisms which have improved health outcomes: 1) decentralised decision making which enhanced local responsiveness; 2) participation and inclusiveness; and 3) strengthened social accountability. Health outcomes were measured in terms of maternal mortality ratio, neonatal mortality rate, under-five mortality rate, nutrition status of infants, immunisation and service utilisation rates.

In another peer-reviewed publication, Ramesh et al. (2013) retrospectively analysed the contribution of governance in the history of China's health care reforms since the 1980s. The study highlighted that lack of governance measures (voice and accountability) contributed to the constraints of the health system reforms in China. A mixed methods study of Balabanova et al. (2013) conducted in four countries and one state in India (Bangladesh, Ethiopia, Kyrgyzstan, Thailand and the Indian state of Tamil Nadu) identified governance as one of the key attributes of success in health systems. The study highlighted that governance underpinned all health system functions regardless of their varying definitions.

Brinkerhoff et al. (2009) and Tawfik-Shuker & Khoshaw (2010) highlighted how good governance contributed to improving health systems performance. An evaluation report by Brinkerhoff et al. (2009) assessed the progress of health system decentralisation in Rwanda by providing evidence on how enhanced local governance contributed to the better performance of the health system. Tawfik-Shukor and Khoshnaw (2010) identified an association between governance and health system performance in a cross-sectional study in Iraqi Kurdistan. The study stressed that developing the preconditions for governance at all levels (macro, meso and micro levels) was essential to achieve better health systems performance (in terms of resource allocation, health staff appointment and health service delivery).

Olafsdottir et al. (2011) brought the attention to the role of governance in improving health outcomes among 46 countries in the WHO Africa Region. The study highlighted the importance of the structural impact of health system governance on health outcomes as governance was the result of interaction within social structures of a system.

Menon-Johansson (2005); Rajkumar et al. (2008); and Reidpath (2006) highlighted the role of governance in improving health and other development outcomes. Good governance was negatively associated with HIV prevalence (Menon-Johansson 2005) but positively related to population health (healthy life expectancy, infant mortality rate, GDP and access to improved water sources) (Reidpath, 2006). Rajkumar et al. (2008) showed the association between governance and health outcomes in 91 developed and developing countries. The study highlights that increased public spending does not necessarily improve outcomes in health (under five mortality rate) and education (primary school attainment) in countries with poor governance.

World leaders agree that improving governance and its core principles would facilitate the achievement of many critical development objectives. Some examples of governance

initiatives are: the African Peer Review Mechanism (http://aprm-au.org/), the UN Convention against Corruption (UNCAC), the Extractive Industries Transparency Initiative (https://eiti.org/) and the African Charter on Democracy, Elections and Governance (http://www.chr.up.ac.za/). Some countries, such as, Mongolia, included an extra goal MDG 9, on "good governance". These examples illustrate concerted efforts made to integrate, track and measure governance into the country development agenda.

Reflecting on the experiences of the Millennium Development Goals (MDGs) and progress in different countries, governance has been widely recognised as an important part of the agenda in post-2015 development. UNDP (2014) highlighted the importance of effective governance among institutions within different systems to promote inclusive growth to deliver essential public services. Accountability of public officials played a significant role in political processes, and hence, key principles of governance such as the rule of law, accountability, participation and transparency have been included in the new Sustainable Development Goals. The SDG 16 (peace and justice) includes three targets of key principles of governance: 1) Target 16.3. Promote the rule of law at the national and international levels and ensure equal access to justice for all, 2) Target 16.6. Develop effective, accountable and transparent institutions at all levels and 2) Target 16.7. Ensure responsive, inclusive, participatory and representative decision making at all levels (Foundation for Democracy and Sustainable Development, 2017).

Good health system governance has the potential to sustain effective health interventions as well as provide the capacity to scale up. Governance is an aggregate composed of different principles such as accountability, equity and transparency within the political systems in which health systems function (Balabanova et al., 2013). Good governance is important for functioning health systems (Balabanova et al., 2013). Previous studies highlight how good governance has positively contributed to the measures of performance and outcomes of health systems. For health policies to be implemented successfully, health systems require not only technical inputs but also good governance measures (Mkoka et al., 2014). Therefore, governance is increasingly seen as crucial in health systems and expected to lead to improved performance of the whole health system and better health outcomes (Siddiqi et al., 2009). The former Secretary-General of the United Nations, Kofi Annan, stated that "*good governance is perhaps the single most important factor in eradicating poverty and promoting development*" (United Nations, 1998).

Despite receiving increased attention, governance is still a relatively new area of health systems and policy research (Fryatt et al., 2017). There is a greater understanding of what governance is and the role of various governance functions, but there is a lack of research examining governance from a wider perspective and how it relates to the health system (Brinkerhoff, 2013). Little information exists regarding governance at sub-national (health policy implementation) level. Specifically, it is unclear how governance is operationalised at the functional level of a health system, that is, health facility level. Examining governance at different health system levels (national, county and health facility) in Kenya is the core focus of this study.

1.2 Significance of the study

This is a study of the governance of the Kenyan health system where the recently elected government has promised health system reform with a specific focus on devolution. The 2010 Constitution of Kenya allocated a larger portion of health service delivery to county levels with the exception of the National Referral Services. However, devolution depends on the capacity of counties to accomplish their responsibilities and make effective use of public resources. County health management teams also face the challenge of resource shortages (both human and material) and budget constraints. Therefore, the Kenya Health Sector Strategic and Investment Plan (KHSSP) 2012-2017 proposes a three-pronged strategy for the health sector: partnership, governance and stewardship to address its national health agenda.

This study was conducted as part of a programme of work in Kenya coordinated by the Centre for Maternal and Newborn Health at the Liverpool School of Tropical Medicine (LSTM) funded by the UK Department for International Development (DFID). The Centre supported 120 facilities: 30 comprehensive EmOC (CEmOC) and 90 basic EmOC (BEmOC) through the "Making It Happen" (MiH) Programme. The programme operated in nine countries including Kenya, delivering a country adapted competency based training package to improve healthcare providers' capacity to deliver EmOC, strengthening monitoring and evaluation of maternal and newborn health (MNH) outcomes, working in close partnership with government and stakeholders in each country. Provision of Skilled Birth Attendance (SBA) and the availability of Emergency (or Essential) Obstetric Care (EmOC) coupled with Newborn Care (NC) are the key strategies that if implemented will reduce maternal and neonatal mortality and morbidity. The UN recommends five facilities providing EmOC with at least one providing comprehensive EmOC (CEmOC) for every 500,000 population.

This study explored governance of health system including facilities providing CEmOC by employing qualitative research methods. Following a review of the literature on assessing health system governance, this study adopted a governance assessment framework. Using a theoretical framework adapted from two previously validated frameworks, this study provides an in-depth assessment of governance at three different levels of the Kenyan health system (national, county and health facility levels). The study also assessed governance between fully functional and not fully functional healthcare facilities providing CEmOC.

1.3 Aim and objectives of the study

The aim of the study is to explore the situation of health system governance at three different health system levels in Kenya focussing on facilities designated to provide comprehensive emergency obstetric care (CEmOC). Specific research objectives are:

1) To explore factors influencing health system governance in Kenya
2) To explore the perspectives of key stakeholders on health system governance
3) To explore whether the status of health system governance differs with the functionality of health facilities

The following research questions have been formulated to achieve the research aim and objectives mentioned above:

1) Which factors influence the governance of the health system in Kenya?
2) How do key stakeholders from Kenya perceive governance of the health system?
3) Are there any differences in governance between fully functional and not fully functional facilities?

1.4 Organisation of the thesis

The thesis is organised into the following sections: Introduction, Background, Literature review, Methodology and methods, Findings and Discussion.

Chapter 1 introduces key features of the study starting with governance and the importance of governance for sustainable development globally. It provides the rationale for the study, followed by the research aim, objectives, research questions and the way the study has been organised. A brief description of the subsequent chapters is provided below.

Chapter 2 provides an overview of Kenya, considering basic demographic and development information. It then provides an overview of the newly reformed health system of Kenya

describing the environment in which the study took place, particularly the new institutional arrangements under the devolved government. Finally, the chapter highlights the importance of health system governance in Kenya.

Chapter 3 presents a review of the existing literature on governance beginning with how governance has been defined by providing a cross-disciplinary tour of governance. The chapter uses a theory-driven approach to reviewing the literature on governance. The chapter first conceptualises and describes governance among different disciplines before governance was introduced into the health system. This is followed by a description of the methods used to conduct the review, the systematic review method. Afterwards, the chapter presents findings from the review: 1) a critique of the different frameworks which can be used to assess governance in health systems and 2) how those frameworks have been applied. The chapter then discusses the review findings and ends with a summary of the review. The last section of Chapter 3 presents the frameworks which have been chosen for use in this study.

Chapter 4 presents the research paradigm, the methodology adopted and methods used in this study. It describes the paradigmatic orientation of the study followed by the research design. The chapter also presents the aim of the study and research objectives to provide the rationale for using qualitative research and the approaches used in this study. It then presents the study methods and procedures employed under each of the three research objectives, research validity, transferability and reliability, the researcher's positionality, practical reflections and the ethical aspects considered in this study.

The findings of this study are presented in three chapters: Chapter 5,6 and 7. Chapter 5 covers the first research objective: to explore factors influencing the governance of the health system in Kenya. The chapter describes the context in which health facilities have been governed in Kenya. The findings in this chapter have been constructed based on the accounts of respondents, reflecting the context in which they operate the health system on a day-to-day basis. Hence, the chapter begins with devolution describing how devolution presents opportunities for governance but compromises the capacity of county level government. It then illustrates the context of governance highlighting how political, socioeconomic and cultural contexts shape the way people govern the health system in Kenya.

Chapter 6 covers the second research objective: to explore the perspectives of key stakeholders on health system governance. It includes information collected from interviews

with key stakeholders using a governance assessment framework. The chapter illustrates how key stakeholders in Kenya viewed health system governance particularly in relation to specific operational principles of governance: participation, strategic vision, the rule of law, accountability, equity and control of corruption. Hence, while Chapter 5 explores "macro" institutional factors, this chapter focuses on the "meso" and "micro" factors, offering a holistic account of the governance of the health system. This chapter presents information collected from interviews with key stakeholders using a governance assessment framework adapted for use in this study.

Chapter 7 covers the third research objective: to explore whether the status of health system governance differs with the functionality of health facilities. The chapter starts by presenting the functionality of CEmOC facilities as measured in terms of signal function availability. To do so, the included facilities were grouped according to their level of functionality using the "nine signal functions" based on information collected under the "Making it Happen (MiH)" programme described in Chapter 4 (Methodology). Using the UN criteria, if a facility performs all the nine designated signal functions of CEmOC, it is regarded as a fully functional facility. Similarly, facilities performing less than nine signal functions belong to the group of not fully functional status. The interview data collected at facility level was analysed thematically using the approach laid out in Chapter 4. These themes were then interpretively analysed in view of the data that describes arrangements for good governance using the institutional analysis framework outlined in Chapter 4.

Chapter 8 presents a discussion of the results presented in five parts, structured in line with Doherty and Smith (1999)'s recommendation on structured presentation of discussions for scientific research. The first section of this Chapter summarises the main findings of the research. The second section relates the findings to the wider literature. The third section explores strengths and limitations including areas for future research and recommendations. Under the strengths section, the methodological contributions of the study and its relevance to Kenyan health system are highlighted. The last section ends the study with concluding remarks.

CHAPTER 2

2. Background

This chapter presents a brief description of the background of the country under study, Kenya. The chapter starts by considering basic demographic and development information and then provides an overview of the newly reformed Kenyan health system from three key aspects: human resources for health (HRH), intelligence and information, and financing of the health sector. Following this, the chapter describes the key contextual environment in which the study took place, particularly the history of devolution including the new institutional arrangements under the devolved government. Section eight highlights the importance of health system governance in Kenya followed by the chapter summary.

2.1 Kenya at a glance

The Republic of Kenya is a large country (580,000 km^2) situated in the east of Africa with a 400-kilometre long coastline on the Indian Ocean. The country is bordered by Ethiopia and Sudan to the north, Somalia to the northeast, Uganda in the west and Tanzania to the south (**Figure 1**). Kenya is administratively divided into 47 counties and 297 sub-counties outlined in the Constitution of Kenya 2010. The country Gross National Income (GNI) per capita is USD 1380 (the World Bank, 2017) and is classified as a lower middle-income country by the World Bank.

Kenya has three main cultural groups: the Bantus, the Cushites and the Nilotes and more than 42 ethnic groups with diverse cultures. English and Swahili are the official national languages while over 60 languages are spoken throughout the country. Kenya has a total population of 43.2 million (Global Health Observatory, 2014) and nearly 80% of the population lives in rural areas. Most land in Kenya is arid or semi-arid and sparsely populated (Government of Kenya, 2014); the main economic activity is agriculture (25% of GDP) with a strong industrial base (13% of total GDP) (Government of Kenya, 2014). Kenya has a diverse physical environment with two distinct regions: the lowlands and highlands as altitude plays an important role in the human settlement and agricultural activities. The country has savannah grasslands and woodlands, tropical rainforests and semi-desert environments.

Figure 1. Map of Kenya

Source: https://www.lonelyplanet.com/maps/africa/kenya/

The population growth rate in Kenya is high with a 2.4% annual growth rate and a very high dependent proportion (42.37%). **Table 1** presents key health and development indicators of Kenya (KDHS, 2014). The indicators highlight that the health situation in Kenya requires further improvement as there has been stagnation or worsening of some of the indicators over the last decades despite improvements in some indicators such as the under-5 mortality rate and infant mortality rate (**Figure 2**). In addition, there are significant differences between geographic areas and genders.

Table 1: Key development indicators of Kenya

Selected key indicators	National
Budget allocated to health sector (of total government budget) (Fiscal Year 2014/15)	4%*
Life expectancy at birth	58
Prevalence of underweight children under-5	11% (12.1 for boys, 9.8 for girls)
Net attendance ratio in primary education	86.6% (85.5 for men, 87.6 for women)
% of children under one immunised against measles	87.1% (87.9 for boys, 86.2 for girls)
Population with improved drinking water sources	85.7% (urban), 57% (rural), 66.9% (total)
Population with improved sanitation facilities	30.5% (urban), 21.6% (rural), 24% (total)

Sources: KDHS (2014), *MOH (2015) National and county health budget analysis report

2.2 Information on counties

This section describes key socio-demographic and health characteristics of the six counties included in this study. Detailed explanations of the rationale underlying the choice of counties are described under Section 4.4.1 (Study population and sampling) in Chapter 4 (Methodology and methods).

The six included counties varied in terms of socio-economic status, level of urbanisation, health service provision and service utilisation (**Table 2**). Nairobi county, the national capital, is an urban city and relatively prosperous compared to the other five counties. Makueni and Kitui counties are the poorest among the six included counties as the number classified as living in poverty is 22% which is below the national average (19%). The literacy rates for women in reproductive age in all counties are higher than the national average (87.8%). It is highest in Makueni county (96.9%) and the lowest in Kitui county (91.7%).

Table 2. Summary of socio-economic and selected key indicators from six counties

Key indicators	National	Kitui county	Machakos county	Makueni county	Nairobi county	Nakuru county	Narok county
Population	43.7 million	1.1 million	1.2 million	1 million	3.5 million	1.8 million	0.9 million
Area in km^2	581313.2	30496.5	6208.2	8008.8	695.1	7495.1	17933.1
Poverty level	19.0%	22.2%	19.8%	22.2%	6.9%	12.1%	10.2%
% of urban population	29.9%	14.0%	52.0%	12.0%	100.0%	46.0%	7.0%
Literacy rate of women aged 15-49 years	87.8%	91.7%	95.3%	96.9%	96.5%	94.0%	94.0%
Staff absenteeism	15.5%	13.5%	21.3%	21.9%	7.0%	14.4%	19.9%
Mean availability of maternal health tracer commodities	28.0%	23.0%	63.0%	29.0%	23.0%	32.0%	27.0%
% of women receiving ANC from a skilled provider (2014)	96.0%	98.0%	99.0%	98.0%	98.0%	96.0%	92.0%
Delivery with skilled attendants	61.8%	46.2%	63.4%	54.6%	89.1%	69.5%	40.3%
Contraceptive prevalence rate	58.0%	57.3%	75.9%	80.3%	62.6%	56.8%	47.8%
All basic immunisation coverage aged 12-23 months' old	79.0%	69.3%	93.4%	92.0%	81.2%	79.2%	66.4%

Sources: KDHS (2014), Government of Kenya (2014)

In regard to health service provision, Nairobi, the national capital, had the lowest rate of staff absent (7%) while Makueni had highest (21.9%) followed by Machakos (21.3%) and Narok (19.9%). The availability of maternal health tracer commodities was lowest in Nairobi (23%) but highest in its neighbouring county, Machakos (63%).

In regard to service utilisation, 99% of women in Machakos received antenatal care (ANC) from a skilled provider while only 92% of women in Narok did. Similarly, 93.4% of children under two years old were immunised in Machakos while only 66.4% received immunisation in Narok. 89.1% of women in Nairobi delivered with a skilled attendant while only 40.3% of women in Narok received skilled attendance during childbirth. Similarly, Narok county had lowest contraceptive prevalence rate (47.8%) while Makueni (80.3%) and Machakos (75.9%) counties had higher contraceptive prevalence rates compared to other counties.

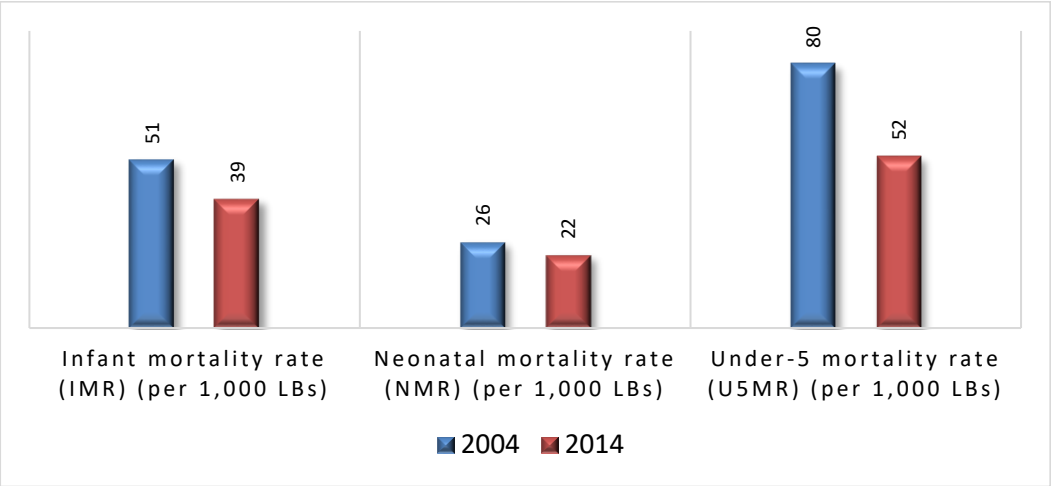
2.3 Kenya newly reformed health system

The following section provides an overview of the Kenyan health sector. The section starts with the country health status highlighted by key health indicators. This is followed by the examination of three health system inputs which are critical for the functioning of a health sector: HRH, intelligence and information, and health financing.

Improvements in health status have been marginal in the last few decades according to the Kenya Service Provision Assessment Survey (2010) led by the Ministry of Medical Services and the Ministry of Public Health and Sanitation. The disparity in health indicators still exists between different gender groups and by place of residence. According to the WHO-Global Health Observatory (2014) and the latest Kenya Demographic Health Survey (KDHS, 2014), the country's progress on MDGs 1, 4 and 6 were marginal while there was no progress on MDG 5 (**Figure 2**).

For instance, the maternal mortality ratio (MMR) has reduced marginally from 506 (614-398)/100,000 live births in 2004 to 362 (471-253)/100,000 live births in 2014 (KDHS, 2014). There have been some improvements in IMR, U5MR and NMR (Figure 2). However, there have been no improvements in the MMR since the 1990s (WHO, 2014). Noncommunicable diseases such as cardiovascular, respiratory, digestive diseases, cancers and psychiatric conditions also represent 50-70% of total hospital admissions and account for half of all inpatient mortality. Gender disparities across the country still persist with a gender development index of 0.628 in the central region to 0.401 in the northeastern region (MOMS and MOPHS, 2012).

Figure 2. Trends in key child health indicators over the last ten years



Source: KDHS (2014)

2.3.1 Human resources for health

The critical shortage of HRH is a significant challenge in Kenya as in many sub-Saharan countries (Ministry of Health, 2014b). Kenya falls short of the minimum threshold for the number of healthcare staff (23 per 10,000 population) as the current rate is 13 per 10,000 population (Ministry of Health, 2014b). According to a study conducted by Transparency International, the shortage of skilled healthcare providers is worse in rural areas where there was 50% to 80% understaffing in provincial and rural health facilities (Ministry of Health, 2014b) (Transparency International-Kenya, 2011). In a more recent survey "PETS-Plus", only four out of 46 counties in Kenya met the national benchmark of 8.7 nurses per 10,000 population (Onsomu et al., 2014). Similar findings were observed for doctors' availability as it ranged from 0 (in Mandera) to 2 (in Nairobi) doctors per 10,000 population. The same survey reported staff absenteeism ranging from 7% (in West Pokoto) to 65% (in Trans-Nzoia) which consequently affected the quality of care provided; only 64% of clinicians could correctly diagnose seven different conditions in Kilifi while this was 84% in Makueni (Onsomu et al., 2014).

The Health Services Census conducted by the Ministry of Health (MOH) in 2013 identified gaps in not only numbers but also the skills mix of human resources across all cadres and different areas of specialisation (MOMS and MOPHS, 2012:127). The Census noted that management of human resources was still manual thus many aspects of human resource management were not efficient and there is the inability to promote and appraise staff performance, track placement and training. The Health Services Census recommended three

key areas in which the current health sector needs to invest: strategic recruitment of staff; training and skills upgrading of existing staff and developing a robust information system on human resource management (MOMS and MOPHS, 2012).

Under the current HRH arrangement for recruitment and discipline of health staff, county health departments have the authority to hire and fire staff. A medical superintendent (MS) from the hospital level has the authority to reprimand staff but cannot dismiss them for discipline issues. In severe cases, the case will be referred to the County Department of Health and the County Public Service Commission, who have the authorities to suspend or dismiss health staff.

2.3.2 Intelligence and information

In Kenya, the health information system (HIS) is supposed to collect and report health information from the facility to district, county and through to national levels. The health system assessment (2010) reported that information collected at the facilities was rarely used in those facilities who viewed collating and reporting as a duty. Similarly, data reported at the national level was not fully used to inform health policy and planning processes (Luoma et al., 2010). There are other issues such as accuracy and transparency of the information collected and reported. The local government offices also complained that the information received from the national and sub-national levels was inadequate for their planning purposes (Luoma et al., 2010).

On the other hand, the information produced by the MOH was not well disseminated as only the reports available on the MOH website were available, and the majority of the health sector reports were not publicly available. Only a few low-level healthcare facilities had access to their Annual Operational Plan (AOP) while most dispensaries have never seen the AOP (Luoma et al., 2010).

In Kenya, professional bodies had a historical role in advocacy through the government although they did not have a formal role in health policy development. There have been efforts to improve communication between healthcare providers and policy makers to ensure accountability and inform policy decisions. The Community Based Health Information Management System (CBHIMS) project has made information available to both community and health officials in some parts of the country. The agency called AfriAfya (African Network for Health Knowledge Management and Communication) was established in Kenya in April 2000 to improve the communication of health knowledge among communities including

rural and other marginalised groups. CBHIMS received assistance from the AfriAfya on the use of PDAs (personal digital assistants) to improve the existing data collection system which was paper-based and needed to be completed manually. AfriAfya created opportunities for networking among organisations to improve communication technology for community health and development by sharing best practices and lessons learnt in their various projects. They also worked closely with the ministries of health to influence the policy makers in adopting the modification of the systems.

2.3.3 Health financing

Healthcare in Kenya is chronically under-funded (Korir et al., 2014). Total expenditure on health has increased from USD 17 to 40 per capita (slightly above 4% of total GDP) during the last 10 years due to contributions from government and donor resources (MOMS and MOPHS, 2012). The national and county health budget analysis report (MOH, 2015: vi) has tracked the budget allocation for the health sector and shows that this has increased from 3.4% of the national budget (KSH 36 million) in 2013/2014 to 4% (KSH47 million) in 2014/2015.

According to the new Constitution, 15% of national revenue should be allocated to fund the devolved functions of county governments including health (MOH, 2015, p-vi). Kenya has to revise the Abuja target which is to spend at least 15% of its total expenditure on health (MOH, 2015: vii).

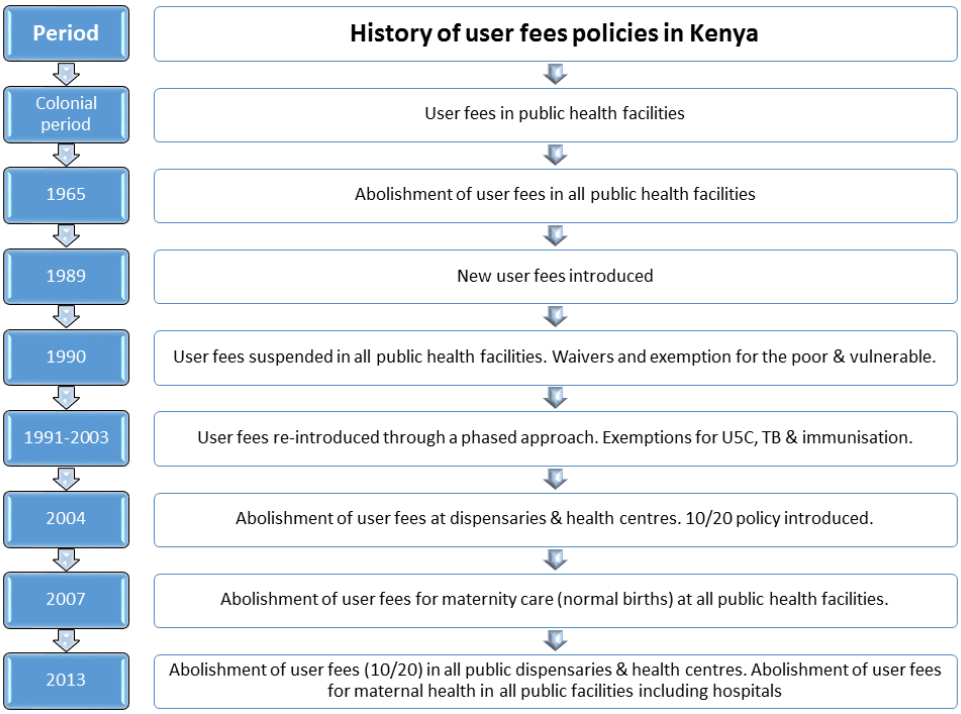
However, there is no real increase regarding health system resources as private (clients' out of pocket) health financing is still one of the main contributors. Among three main sources of health care financing, private financing accounts for 35.9% while the government and donors contribute 30% each (MOMS and MOPHS, 2012). There is no recent information on health financing and the existing data was collected before devolution (Munge et al., 2017).

The problem with health financing in Kenya is not only low spending on healthcare, but the allocation of budgets to public facilities has been uneven, with relatively more funds (approximately 70%) allocated to secondary and tertiary facilities compared to primary healthcare facilities (Health Action, 2011). Therefore, facilities need to charge user fees to provide quality health services particularly in cases where there is no other source of income. However, evidence showed that user fees and out-of-pocket payment are significant barriers to the use of healthcare services in Kenya (MOMS and MOPH, 2010). The Government has also committed to provide universal health coverage to its citizens by the year 2030. Therefore, in 2013, the government took decisive action and instituted two health financing

policies: 1) the abolition of user fees in public health centres and dispensaries and 2) free maternity services (FMS) in all public health facilities (Republic of Kenya, 2013).

In Kenya, a variety of user fee policies have been implemented since the country gained independence in 1963 (**Figure 3**). In 2004, the government set a ceiling on user fees of Kenya Shillings/KSH10 (USD0.10) in dispensaries and KSH20 (USD0.20) in health centres (known as the 10/20 policy) with an exemption for children under five years of age (U5C), for the poor and designated conditions such as malaria and TB. In addition to these exemptions, all fees for maternity care (uncomplicated births) at public healthcare facilities were abolished in 2007. The government simultaneously introduced the Health Sector Services Fund (HSSF) which transferred funds directly to health facilities to compensate for the loss of revenue as a result of the removal of user fees. The HSSF was officially launched in 2010 by the Government of Kenya, financed using domestic resources with the aim of pooling public and donor resources, and, to avoid the bureaucratic decision making process used in the past to request funds (Ramana et al., 2013). The funds were managed locally by the health facility management committee (HFMC) composed of community members (Waweru et al., 2013). There were no clear guidelines and institutional procedures for the HSSF in the devolved health system (Waweru et al., 2013).

Figure 3: History of user fees policy in Kenya



The other financing scheme, NHIF (National Hospital Insurance Fund), was established in 1996 to finance health care in public and private facilities (Ramana et al., 2013). The scheme

is mandatory for workers from formal sectors earning more than KSH1000 per month. By June 2010, the NHIF had 2.8 million principal members with 6.6 million beneficiaries (approximately 18% of the country) (Ramana et al., 2013).

In June 2013, the government introduced two additional policies to reduce the financial burden of access to health care: the abolishment of user fees for all health services in public health centres and dispensaries (primary care level); and free maternity services (FMS) at all levels of care in the government health sector (primary, secondary and tertiary) (Kenya Ministry of Health, 2015). These policies, FMS policy in particular, were part of a national strategy to reduce maternal and neonatal mortality, alleviate poverty and realise the MDG targets (Kenya Ministry of Health, 2015).

The MOH circular explaining the services which were included as part of the FMS was published on 1st April 2014 although the policy was announced in July 2013. The circular also stated that health centres/ dispensaries and hospitals would be reimbursed KSH2500 and KSH5000 respectively based on the reported numbers of deliveries conducted. The MOH used the two existing financing mechanisms to reimburse facilities for providing FMS: the health sector service fund (HSSF) for health centres and dispensaries; and the hospital management service fund (HMSF) for hospitals. Some of the payments were channelled through county revenue accounts while some were transferred directly into facility accounts (MOH, 2015). According to an assessment conducted by the MOH in 2015, 25% of surveyed facilities reported having missed reimbursements for the FMS while there were instances when these had not been received for 4-5 months.

The Government of Kenya introduced the FMS policy when the health system was undergoing new political and administrative decentralisation (devolution). Hence, devolution has been an important determinant in implementing the new financing policies of Kenya health system. The following section describes devolution of the health system and factors influencing it.

2.4 Devolution of the health system

In 2010, the majority of Kenyans voted to adopt a new Constitution in a referendum, sparking another round of decentralisation in the country. The 2010 Constitution devolved political, administrative and financial functions to 47 newly created administrative units called "counties", based upon the 1992 district framework (The Republic of Kenya, 1992). County governments were elected locally to perform new functions with formula-driven funding

from the national government and limited locally generated revenue (Williamson & Mulaki, 2015). Counties can also receive grants for priority services from the national government.

The primary purpose of devolution was political, to increase local autonomy and reduce ethnic and regional tensions (Sihanya, 2011), at the same time improving efficiency in service provision, increasing citizens' input and local participation in decision making. Schedule 4 of the Constitution provides guidance on the services that county and national governments should provide.

The health sector was devolved as part of the new Constitution in 2010. This involved allocation of essential health service delivery to county governments with the national government providing technical support to the county governments, managing provincial general hospitals (now changed to national referral hospitals) and drafting health policies. However, it was unclear who was responsible for the procurement mechanisms; the management of HRH; and with regard to the amount and processes of financial transfers as these were not defined at the beginning of devolution (Williamson & Mulaki, 2015).

According to the Transition to Devolved Government Act (2012), the initial plan was to enter into a three-year transition period to devolve services to the county governments including assessment of capacity and system. However, county governors and assemblies petitioned the President to devolve authority and resources to the counties more rapidly, once they were elected in March 2013 (Commission for Implementation of the Constitution, 2014). Consequently, the Transition Authority devolved services to the counties under the Gazette Notice Number 137 on 9th August 2013 (The Republic of Kenya, 2013).

2.5 History of devolution in Kenya

Kenya has a long history of decentralisation since it gained independence from the British colonial government in 1963 (Institute of Economic Affairs, 2010). At that time, the colonial government proposed a system of ethnic and tribal-based regional governments (Institute of Economic Affairs, 2010). To maintain political stability, the Kenya National Africa Union, then the dominant political party, dropped the proposition and established a unitary state with eight provinces comprising of 175 local authorities (The Republic of Kenya, 1977). Under this structure, power was concentrated at the centre with the Ministry of Local Government overseeing the managements of local governments (NORAD, 2009). However, local governments did not have much authority for decision making though they were responsible for service provision (Kunnat, 2009).

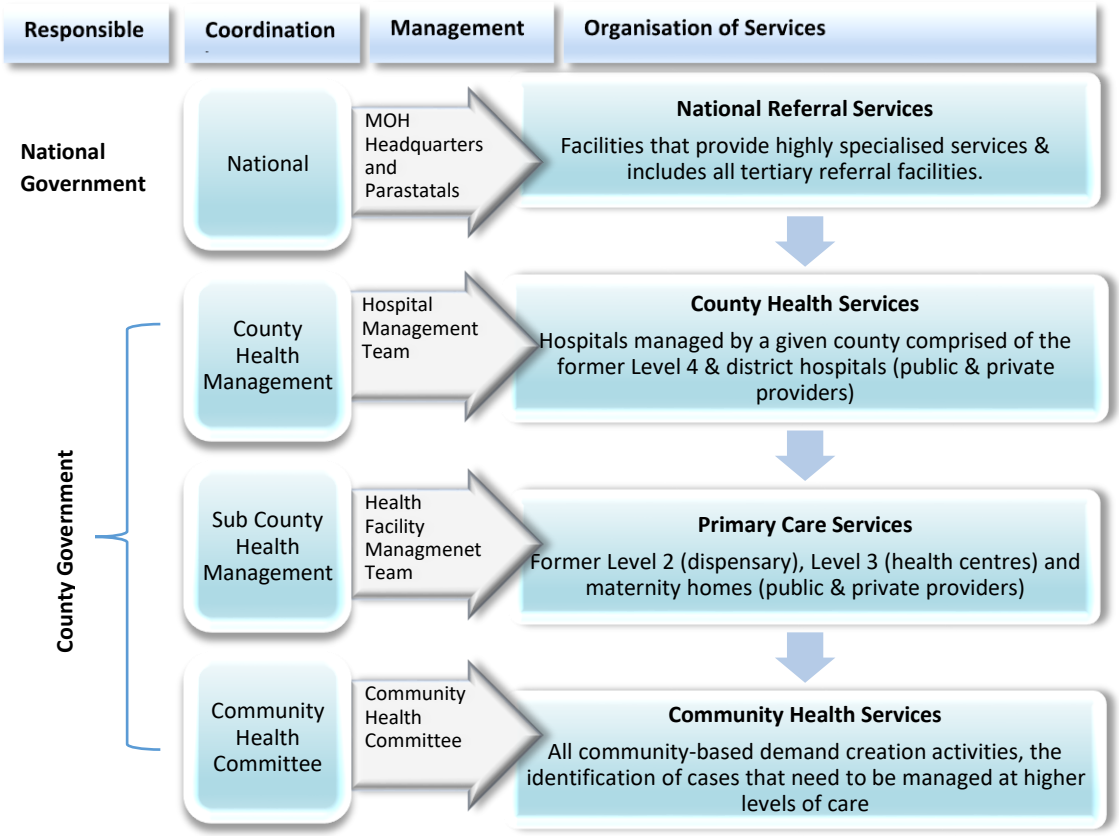
Kenya made several attempts to decentralise authority to the local government structure described above (Institute of Economic Affairs, 2010). Significant changes included the creation of six Regional Development Authorities for planning and coordination of activities in the 1970s and 1980s (KHRC, 2010) and the Rural Development Strategy, which placed districts at the centre of priority setting (Barkan and Chege, 1989). However, these developments were regarded as de-concentration of central level administrative staff as they did not empower local administrative staff and did not create clear roles and responsibilities for local government units (Williamson & Mulaki, 2015).

In the 1990s, the World Bank started to fund local governments directly under its Local Government Reform Programme (Esidene, 2008), which gave them more responsibility for service provision, without changing decision making authority (Williamson & Mulaki, 2015). This resulted in more confusion about decentralisation rather than improved administrative efficiency and clearer lines of authority (Barkan & Chege, 1989). Some authors believed that vertical funding mechanisms led to unsuccessful decentralisation (KHRC, 2010). For example, a decentralised level could have up to 13 distinct vertical funding mechanisms, creating confusion. Over time, efforts towards decentralisation in Kenya were not successful, and thus the country has remained highly centralised (Ndii, 2010).

2.5.1 Functions devolved

The devolution of Kenya's health system is ambitious. It absorbs three previous systems of administration: provincial, district and local government administrations incorporating them into a two-tier system comprising the 47 newly created counties overseen by the national Ministry of Health. According to the new Constitution, the newly formed counties are responsible for three levels of care: county referral services; primary care services and community health services while the national government is responsible for all national referral services (**Figure 4**). The current national health policy (2012-2030) defines national referral services as facilities providing highly specialised services and all tertiary level referral facilities. County referral services include hospitals managed by the relevant county and are composed of the former level four and district level hospitals (both public and private facilities). Primary care services include dispensaries, health centres and maternity homes (both public and private providers). Community health services include any community-based demand creation activities that need to be managed at the higher level of the health system.

Figure 4: Kenya newly reformed health system



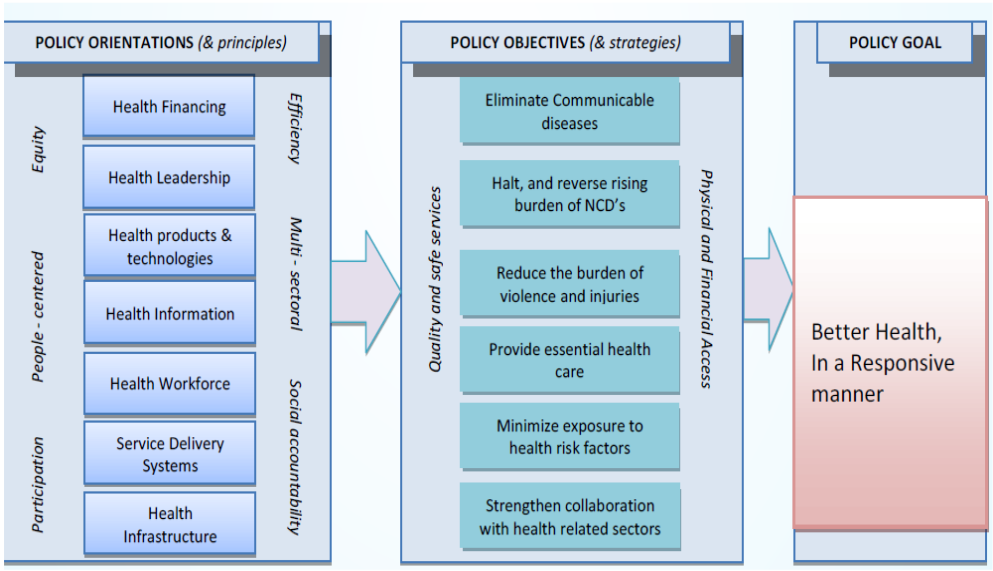
*Source: Kenya Health Policy 2012-2030 (p-13)

The fourth schedule of the Kenyan Constitution provides guidance on the distribution of functions between national and county governments including the health sector. The national government is responsible for policy formulation, technical assistance to county governments and management of national referral services. Following the "Transition to Devolved Government Act 2012", the responsibilities of counties to provide essential health services were formally transferred from the national government on 9 August 2013. KSH210 billion (one-third of the total devolved budget) was designated for health in the financial year 2013/2014 (Williamson & Mulaki, 2015). However, functions such as procurement mechanisms, management of Provincial General Hospitals and financial transfer procedures and amounts are not defined in the Fourth Schedule.

The Constitution also specifies that the transfer of functions from national to county government should take no more than three years (KPMG, 2013). Yet, this involves establishing an institutional and management structure to coordinate and manage the delivery of health services and mandates in counties that range from 100,000 to over 3 million population per county.

The National Health Policy (2012-2030) guides the health sector in achieving national health goals while implementation of the policy is planned through 5-year mid-term strategic plans. The overall aim of the policy is to attain universal health coverage in critical services, with targets including 16% improvement in life expectancy; 50% reduction in annual mortality from all causes; and a 25% reduction in time lost to ill health by 2030 (MOMS and MOPHS 2012: 15). All the health policy targets, new health system orientations and devolution require that good health system governance is in place to ensure success (**Figure 5**).

Figure 5: Framework for defining Kenya Health Policy Directions

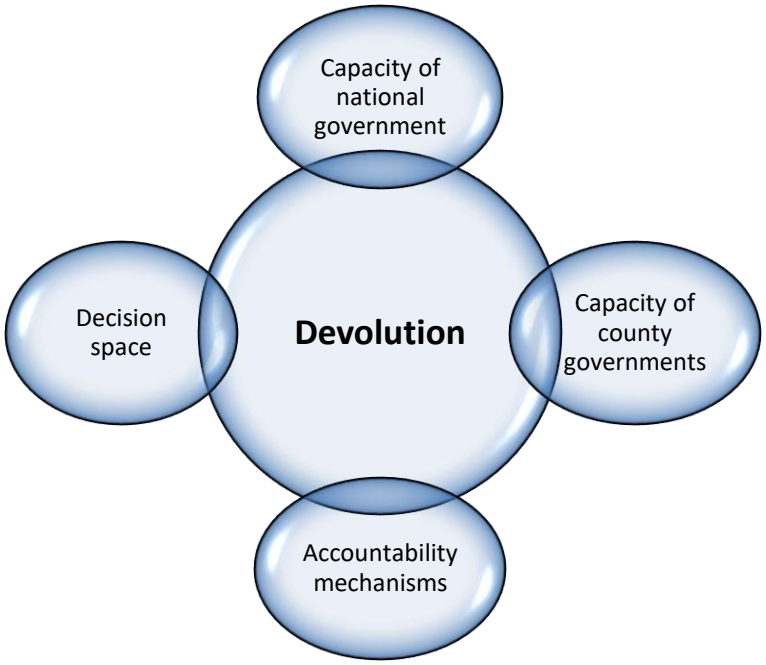


Source: Kenya National Health Policy 2012-2030 (p-13)

2.6 Factors influencing the devolution of health system

Using Bossert's (2015) framework of decentralisation, four key factors influenced the devolution of the Kenyan health system: 1) capacity of the national government, 2) capacity of county government, 3) accountability mechanisms in place and 4) decision space which the county government received (**Figure 6**).

Figure 6: Factors influencing devolution of the Kenya health system



Adapted from Bossert (1998)

2.6.1 Capacity of the national government

For the county governments to respond to the newly devolved responsibilities efficiently, national government plays a key role supporting the smooth transition of duties to county governments. Characteristics of the national government such as its capacity (administrative and technical) to support the county governments; motivation and goals; role and influence are instrumental to achieving the objectives of the newly devolved health system (Bossert, 1998).

2.6.2 Capacity of the county governments

For a devolved government to be efficient in policy making and implementation, county governments should be equipped with adequate resources and capacity (administrative and technical) (Bardhan & Mookherjee, 1998). Hence, the characteristics of the devolved government such as its capacity to innovate and implement; motivation and goals of the county governments; roles and influence are instrumental (Bossert, 1998). In reality, counties have different baseline capacities, and historical developmental challenges exist, meaning some have further to go than others before they are ready to manage services.

2.6.3 Accountability mechanisms in place

Under the devolved health system, there are multiple interactions of actors within the health system. The situation requires different accountability mechanisms in place to ensure that

different health system stakeholders are responsible for their actions. Hence, the structures for public accountability mechanisms such as county health management teams, district health management boards, facility boards and health centre management committees are becoming instrumental in the newly devolved health system.

2.6.4 Decision space

With the health system devolution, there is a transfer of responsibility and authority from the national to the county governments. Although the county governments wield a considerable level of authority due to their independence, they are not completely autonomous (Sumah et al., 2016). The "decision space" is defined as the range of effective decision making choice allowed by the central authorities (national government) to the local authorities (county government) (Bossert, 1998). There are two forms of decision space: formal decision space allowed by the rules and regulations which can be enforced; and informal decision space which is the actual exercise of authority from what is defined by the rules (Bossert, 1998). In the Kenyan health system, three functional areas of decision space have been affected by devolution: 1) service organisation; 2) HRH; and 3) financing (Mitchell and Bossert, 2010). **Table 3** describes the decision space map of three functional areas which county governments were given within Kenya health system. Using the decision space approach of Bossert (1998), this table does not aim to quantify the formal decision space but to provide virtual characteristics of its ranges within three functions of Kenyan health sector.

The county governments receive moderate decision space to set up the health service organisation although they have to follow national programmes within the national norms and standards. The county governments also receive moderate decision space in the procurement of medicines, supplies and equipment although the procurement should be with Kenya Essential Medical Supplies Authority (KEMSA). However, the county governments receive full autonomy to manage Level 2 and 3 health facilities (former district and provincial hospitals) and to contract organisations such as private providers and laboratories. Regarding insurance plans for a service organisation, the county governments have the discretion to create, manage or regulate insurance mechanisms with the National Hospital Insurance Fund (NHIF) which is a parastatal organisation.

Regarding **HRH**, the county governments receive a wide decision space with full authority to hire and fire staff and to decide basic salaries and allowances within the national standards and set up terms of employment.

For **health financing**, the county governments receive a wide decision space to prepare own budgets although the budgets are subject to approval from the National Treasury. The county governments received an equitable share which is composed of a majority of county resources and is untied. The county governments are also responsible for tax administration while the national government set broad guidelines on county tax resources.

Table 3: Decision space map of the devolved health system in Kenya

Health sector functions	Decision space			Description of county government's responsibility and authority
	Narrow	Moderate	Wide	
Health service organisation				
Required programmes		■		Modify implementation of national programmes and need to follow national programmes such as removal of user fees, FMS[1] policy.
Hospital autonomy			■	Counties have full autonomy to manage Level 2 & 3 facilities
Insurance plans	■			Options to create, manage or regulate insurance mechanism with NHIF which is a parastatal organisation.
Contracts with organisations			■	Contract with organisations to deliver specified services
Procurement of goods		■		Procure medicines, supplies & equipment locally from KEMSA[2]
Human resources for health				
Salaries			■	Decide basic salaries & allowances within national norms
Contracts			■	Handle some human resource management functions locally. Able to contract staff
Civil service			■	Determine terms of employment (recruitment, appointment, transfers, promotion, termination)
Health financing				
Sources of revenue		■		Proportional grants from national level and some local taxes
Allocation of expenditures			■	Determine budgetary allocations for planning, budgeting & execution though subject to approval for National Treasury.

[1]FMS=Free maternity services policy

[2]KEMSA=Kenya Essential Medical Supplies Authority

2.7 Challenges to devolution

The existing literature highlights that county governments have limited legislative experience and lack the required systems to manage resources efficiently (Williamson & Mulaki, 2015). Services were devolved very quickly and some outstanding questions from the health sector remain unanswered. Hence, the World Bank described Kenya's devolution as "*one of the most ambitious implemented globally*" (The World Bank, 2017). Like many developing countries which have undergone decentralisation, the capacity gaps of county governments

have been a major issue. Kenya is no exception; only a few counties have the administrative capacity to absorb the available funds and plan for effective use of these funds (Williamson & Mulaki, 2015). Although the national government originally planned to use the three-year period for transition, there was no plan for training or mentoring to close the capacity gaps (Williamson & Mulaki, 2015).

Some initial challenges such as the management of provincial general hospitals and procurement mechanisms have been resolved. However, there were still unresolved problems in the management of HRH (for instance, staff transfer, payment of salaries and terms of services). County governments are paying the salaries of the health workers seconded to them while the human resource files remain in Nairobi, leaving counties with limited information to manage the health workers fully (Williamson & Mulaki, 2015). Thus, there have been disputes over the supervision of health works leading to delayed salaries and strikes (Williamson & Mulaki, 2015).

2.8 Why is governance important for the Kenyan health system?

The Kenyan health sector is guided by the long-term Kenya health policy (2014-2030) and a five-year strategic plan, the Kenya Health Sector Strategic and Investment Plan (KHSSP). The 2nd KHSSP (2013-2017) refers to governance and defines it in the same way as WHO and other international bodies. To improve the governance of its health system, a draft Kenya Health Law has been developed together with multiple health legislations relating to different health functions and the establishment of guidelines and structures for governance at different implementation levels. Under the comprehensive Bill of Rights in which every Kenyan has the right to health, 47 counties are responsible for health service delivery and allocation of resources. This new orientation requires restructuring and strengthening of the health system to align with the Constitution. The Health Bill is in the process of being updated and will consolidate all health-related legislation. The 2nd KHSSP recognises that many national referral institutions are still not autonomous as they are still under the direct management of the National Ministry.

Within this devolved health system, good governance is crucial at different levels of the health system as the accountability structure has changed with increased responsibilities because of devolution. Existing evidence highlights a need to balance decentralisation and governance to achieve health system objectives as governance is often overlooked (Mitchell and Bossert, 2010). The Government of Kenya acknowledges the importance of governance.

Thus, in their 2nd KHSSP, "health leadership and governance" is included as one of the seven areas of investment for the country (MOMS and MOPHS, 2013).

The 2nd KHSSP recommends improving the stewardship role of the Ministry of Health through the implementation of the Government agenda. The Kenya health policy 2012-2030 was developed to guide MOH stewardship role. The recent merging of the two ministries: the Ministry of Public Health/Sanitation and the Ministry of Medical Services into the Ministry of Health will also allow for the reduction of unnecessary conflict in implementing stewardship functions. However, there are existing and forthcoming challenges to achieve coordinated stewardship.

There is evidence that the Kenya health sector has made major efforts to strengthen governance of its health system together with key stakeholders. A "Code of Conduct" for the ministries of health (Ministry of Medical Services, Ministry of Public Health and Sanitation) has been developed and is in use. The Government of Kenya has set up several joint financing agreements with donors to reform its health sector and different mechanisms to improve stakeholder participation in health policy, planning and development. However, it will take further time to set up the legislative processes needed to manage and coordinate the targeted operational plans.

Thus, understanding the governance of the Kenyan health system at different implementation levels becomes crucial. Health system governance was assessed as part of the health system assessment carried out in Kenya by the USAID Health System 20/20 project in 2010. The project assessed the whole health system and governance was included as one of the health system building blocks defined by WHO: health financing, human resources, governance, medical products management, health information systems and health service delivery. The assessment was conducted at the national level. No additional assessment of governance of the Kenyan health system at either national or sub-national level has been conducted since the recent devolution.

2.9 Chapter summary

There is little information available regarding governance at different levels of Kenya's health system since devolution. Specifically, the situation of health systems governance at the county level or below. This study examines governance of the health system in Kenya where its new government has promised health system reform with a specific focus on devolution. The government realised devolution into action by integrating into the KHSSP (2012-2018)

proposes a three-pronged strategy for improving its health sector: partnership, governance and stewardship.

Given the factors mentioned above, this study seeks to explore the situation of governance at three different levels (national, county and facility) in Kenya focussing on facilities designated to provide comprehensive emergency obstetric care (CEmOC). To the best of our knowledge, this is the first study of such kind in Kenya.

CHAPTER 3

3. Literature review

This chapter presents a review of the existing literature on governance. To be specific, this chapter starts with how governance has been defined by providing an overview of governance across disciplines. Governance in health systems is a less developed concept compared to the discourse of governance within other disciplines. The concept of governance is diffuse, all-encompassing, context specific and complex. To address those gaps and to better understand the potential of health system governance, it requires a broader engagement within the literature on governance. That is, there is a need to go beyond the health systems, specifically it is imperative to understand the theoretical foundations of the literature on governance. Therefore, this chapter uses a theory-driven approach to reviewing the literature on governance.

It uses the systematic review method to identify the relevant literature on health system governance with specific search strategy, inclusion and exclusion criteria and narrative review method to synthesise the findings. Using the systematic review method provides clear information on how literature is selected for inclusion in the review in a transparent manner. This review method also allows for the periodic update of the search until the time of thesis submission.

The chapter first describes what governance is and how it has been conceptualised in different disciplines. Sections 3.1 and 3.2 of this chapter set out the key background to the development of the concepts of governance. Section 3.3 then describes how governance is defined specifically in relation to health systems. The remainder of the chapter is devoted to an extensive review of the literature, carried out as a systematic review, to identify key concepts and principles that inform the application of existing frameworks to assess governance in health systems. Section 3.4 describes the methods used to conduct the systematic review. Section 3.5 presents findings starting with the critique of different frameworks which can be used to assess governance in health systems in Section 3.5.1, followed by Section 3.5.2 which presents the findings relating to how those frameworks have been applied. Section 3.5.3 discusses the review findings, and Section 3.5.4 draws out the main conclusions from the review. The chapter ends by presenting the frameworks chosen to inform the research process in this thesis.

3.1 What is governance?

Governance is defined as the rules (both formal and informal) of collective action and decision making in a system with diverse players and organisations while no formal control mechanism can dictate the relationship among those players and organisations (Chhotray and Stoker, 2009). Some authors criticise the concept of governance for being too vague (Schneider 2004: 25), and there is confusion over how best to conceptualise it (Kohler-Koch and Rittberger 2006:28). Governance has been discussed in many disciplines such as political science, economics, social science, development studies and international relations using different theories. Governance matters as it is concerned with how different actors in the world function and operate and the reasons behind their decisions.

3.2 Governance across disciplines: An overview

3.2.1 Governance in political science

Political scientists believe that governance is not a science which can be "adequately captured by laws, statutes or formal constitutions" (Chhotray and Stoker, 2009). Governance is a system level concept (macro level) in which networks drive systems or societies. A network involves multiple nodes (organisations) with many linkages collaborating on different activities (McGuire, 2010: 437). The assumption is that passing a law or decree from a formal authority cannot ensure the engagement of key actors and negotiation is the key to the success of governance within networks (Chhotray and Stoker, 2009). A further tenet among political scientists is that there are not enough tools to hold people accountable as governance is characterised by complicated policy networks and responsibility is diffused and shared among many stakeholders (Stoker, 2006).

There is no single theory of governance in political science as different scholars have used various theoretical lenses to examine governance (Chhotray and Stoker, 2009: 26). However, political scientists tend to use five key theoretical threads in examining governance: network management; delegation and incentive creation; the way interests are created and communicated in governance; the theory of bounded rationality; and cultural, institutional theory. Recent developments in governance in political science are the increasing role of non-governmental actors and how they share the responsibilities with government actors (Salamon, 2011: 1611).

3.2.2 Governance in new institutional economics

Governance in new institutional economics focuses on the role of institutions, which shape interactions among actors within those institutions (Chhotray and Stoker, 2009). The key concept is that individuals make rational choices based on the information available to them, so in most cases their behaviour is predictable. Further to this, it is assumed that the choices made by individuals are partially influenced by the cultural and historical context of their environment (North, 1994: 18).

Choices are made within the context of institutional rules that shape and govern what is decided (North, 1994). The word "rules" in new institutional economics has its definition. Ostrom (1986) defined rules as the instruction (explicitly or implicitly) to achieve an order within defined situations. This concept of governance has received support from other disciplines including political science.

New institutional economists perceive governance as actions which secure voluntary cooperation among key actors. Two key concepts within the discipline of new institutional economics are "transaction costs" and "collective behaviour". Ronald Coase (1960) highlighted the concept of transaction costs which are the results of incomplete information and associated costs (search costs, information costs, bargaining costs, decision costs, policing and enforcement costs) to accomplish a transaction. This concept was further strengthened by Douglass North (1990) who argued that "*institutions are formed to reduce uncertainty in human exchange to help reduce the transaction costs*". Based on empirical evidence of her own work, Elinor Ostrom (1990) also presented the theory of "common-pool resources" which analysed how individuals governed and behaved collectively especially in conditions of under-governance. Indeed, new institutional economics is interdisciplinary in scope as its concepts are the result of cross fertilising different disciplines such as historians, social science, political science and economics (Chhotray and Stoker, 2009).

3.2.3 Governance in development studies

The concept of governance was brought into development studies in the 1990s as there was increased recognition of the importance of governance and of the influence of politics on the development processes and outcomes (Chhotray and Stoker, 2009: 97). Some failed examples of universal free market policies in Africa, Asia and South America highlighted there was a need to consider governance structures and processes in development. Hence,

governance has received attention in international development, particularly due to the movement towards "good governance" in international aid (Lockwood, 2006: 54).

The World Bank has played a central role in bringing governance into the development agenda, introducing the concept of "good governance" in 1989 in a landmark report on sustainable growth in sub-Saharan Africa (World Bank, 1989: 60). The report encouraged many donor countries to be "selective" in providing support to countries with "good policy environments" (Chhotray & Stoker 2008). The central argument of governance in development is that countries with good governance can effectively rationalise and absorb the international aid in more cost-effective and transparent ways (World Bank, 1989). Governance in development is perceived as a western concept as good governance is based on the experiences of Western contexts (Draude, 2007). As a consequence, it shapes the development field significantly. Many donor organisations started to propose measures which prescribe conditions for democratic political systems within the recipient countries. Therefore, governance has been used as a political tool in international development in many ways, although this is often denied (Chhotray and Stoker 2009).

After the promotion of "good governance" in international development for two decades, there have been some critiques of the approach. Kelsall (2011) highlighted the reasons why many development programmes adopting the good governance agenda failed to provide services effectively or efficiently. Similarly, Booth and Cammack (2013) believed that the good governance approach in development oversimplified the concept of governance as the focus has been on "principal-agent" theory that assumes problems are caused by "asymmetry of information" between the principal and the agents. Booth and Cammack (2013) believed that "principal-agent" theory becomes insufficient to solve governance, which is a form of collective action. Levy (2014) also shared the same perspective that the good governance approach promoted in the World Development Report (2004) from the World Bank oversimplified the concept of accountability. The author (Levy, 2014) seems to equate governance and accountability, yet they are separate as accountability is a component of governance. The principal-agent approach underestimates the potential for improvement in service provision as public accountability concept is promoted without considering other complementary measures such as context, political leadership, top-down pressure and citizens' interest for improved performance (Levy, 2014). Indeed, a summary report from the World Bank acknowledges that the importance of power and politics in promoting public accountability as generalised and a one size fits all approach to

accountability will not be successful (Devarajan et al., 2011 cited in Booth and Cammack, 2013).

3.3 How is Governance defined in health systems?

In relation to health, governance was introduced in the World Health Report in 2000, where the World Health Organization (WHO) defined it as 'stewardship' and called for strategic policy frameworks combined with effective oversight, regulation, incentives and accountability. This definition is based on the ideology that a health system can be influenced by transparent rules, governed by effective oversight and strong accountability (WHO, 2007). More recently, health system governance has been described as '*an aggregation of normative values such as equity and transparency within the political system in which a health system functions*' (Balabanova et al., 2013). Governance has received increasing attention in the last few decades alongside efforts to strengthen health systems and improve health service delivery. Prominent international development partners advocate governance as the "most important factor" for poverty alleviation and development (UN Secretary General, United Nations 1998).

More recent definitions of governance seem to recognise the importance of informal actors that influence health systems (Siddiqi et al., 2009; Fattore & Tediosi, 2010). Employing the institutional analysis approach, Siddiqi et al. (2009) defined governance as "institutions" or the rules that shape behaviour and "organisations" which operate within the rules (institutions). The institutions composed of both formal and informal rules to carry out key functions of a health system. Similarly, the definition of governance by Fattore and Teddiosi (2010) include formal and informal laws which '*direct, administer and control the health system*'.

Some studies also consider the context in which key actors of the health sector interact in their definitions of governance. For instance, Dieleman et al. (2011) define governance as '*the rules that distribute roles and responsibilities among key actors and shape the interactions among them*'. Dieleman et al. (2011) highlight that most definitions of health systems governance focus on aspects of managing systems, and do not explicitly address the underlying context of governance.

Loewenson (2008) believes that research is needed both to explore the principles of governance in greater depth and to describe and assess governance more generally to identify ways of improving health systems. There is a multitude of frameworks for assessing

governance in health systems; these have been developed to try to operationalise and assess governance at different levels of a health system. Hence, the summary and critique of existing frameworks become essential to understand whether and how they might inform the assessment of governance at the operational level of a health system (the health facility). In so doing, it is believed that the frameworks can provide direction on what to consider in assessing governance for this study. Duran & Saltman (2016) noted hospital governance depends on three interrelated levels: macro-level (health system within which the health facility operates); meso level (institutional decision making) and micro-level (hospital management focussing on day-to-day operations).

The systematic review discussed below describes and critiques these frameworks and how they have been applied in different health systems. The review aims to contribute to the knowledge of health system governance through a theory-informed critique.

3.4 Systematic review of health system governance

This systematic review was published in a peer review journal, Health Policy and Planning on 3rd of March 2017 (Pyone, et al., 2017) (**Appendix 1**).

3.4.1 Aim and objectives of the systematic review

A systematic review was conducted to identify key concepts and principles that inform the application of existing frameworks to assess governance in health systems. The review had two objectives:

1) To identify frameworks that assess health system governance, describe and critique how the concept of governance and the theories underpinning it have been applied to health systems globally.
2) To identify how frameworks have been used to assess governance in health systems.

3.4.2 Search strategy

Two inclusion criteria were developed in order to meet the review objectives. For the first objective, the review included any report or peer reviewed journal article that reported frameworks for assessing or defining health systems governance. For the second objective, only articles reporting research or application of governance frameworks (**Table 4**). The review was limited to articles reporting on governance frameworks which can be applied to the health sector, irrespective of discipline. The search was limited to English language

articles between January 1994 (the year when the World Bank introduced the term Governance) and July 2017.

Table 4: Inclusion criteria used to select papers for each stated objective

Objective	Inclusion Criteria
1. Identify frameworks that assess governance, describe and critique how the concept of governance and the theories underpinning it have been applied to health systems globally.	Studies (descriptive, reports of international organisations and research institutions) describing or reporting on frameworks developed for the assessment, conceptualization or description of health systems governance.
2. Identify research that explores application of governance frameworks to health systems.	Studies (descriptive, observational, intervention studies) that describe the use of governance frameworks in the context of health systems or services.

The search included five electronic literature databases (Scopus, Medline, CINAHL, Global Health Database, Cochrane Library) using keywords combined with the Boolean operators (AND, OR). For example, the keywords for governance (governance, leadership, accountability, stewardship) were combined with terms relating to the health system (healthcare system, healthcare industry, healthcare reform, health system strengthening) and terms for frameworks (model, framework, indicator, definition, measure). All the terms were searched in abstracts, keywords, subject headings, titles and text words. The medline database was searched first and this search strategy was then adapted for use with other databases.

Although Medline is part of the Scopus database, the Scopus database was included as it has the largest number of abstracts and citations from different disciplines worldwide. Scopus also contains the EMBASE database, and it employs different indexing styles than Medline. Scopus also has a specific feature that uses quotation marks "— ",to capture search terms in phrases. This saved time by excluding records that were not relevant and not within which are not within the scope of this review. For instance, when "health system governance" is searched with quotation marks, the search will not capture other irrelevant records which are not within the scope of the review such as "health", "health system" alone. The search strategies used in each database, including search terms, search strings and results, are outlined in **Appendix 2**.

In addition to the database searches, the review also included searches of online archives of specific journals publishing research on health systems and policy including *Health Policy and*

Planning and *Health Policy* using "health systems governance" as the key search terms. Web portals of institutions including the Basel Institute for Governance; the World Bank and USAID Leadership, Management and Governance Project were also searched. Furthermore, the reference lists of studies that met the inclusion criteria were searched and the authors of identified frameworks were contacted to ask for any unpublished reports considered relevant. Responses were received from four out of the five authors contacted and useful insights and information were gained on how the authors have applied those frameworks.

3.4.3 Assessment of quality of included studies

For objective one, the review did not appraise studies reporting frameworks for defining or assessing health systems governance, as these were largely descriptive reports. For objective two, the review included articles reporting empirical research and assessed the quality of these studies using simple criteria based on published checklists (Crombie, 1996). Because of diverse study designs, the appraisal of the studies was based on: the description of the study (aim, participants, methods, outcomes); the methods (appropriate to the aim, selection of participants, valid and reliable data collection methods, and adequate description of analysis) and presentation of the study findings. For qualitative studies, the assessment included questions about appropriateness and reliability of analysis. For those reporting quantitative data, the studies were assessed on the reporting and study description including statistical information.

The review identified a total of 18 empirical studies of which 16 studies were peer-reviewed. Among the 18 empirical studies, as per the above credibility criteria, ten were rated as high quality, five as medium and three as weak (**Appendix 3**). All studies provided adequate descriptions regarding the background information of the study such as aims, study participants, methods employed and their intended measures. Fifteen studies employed qualitative methods (interviews, focus group discussions) while one used a quantitative method (survey) and three were mixed methods studies. Among them, only 14 studies provided information on how study participants were selected. Fourteen studies provided information on methods of data analysis. Among 16 studies which used qualitative methods, quotes were included in 11 studies, and only two studies (the three conducting statistical analysis) provided a rationale for statistical calculations used.

3.4.4 Synthesis of review findings

As governance originates from many different disciplines, the review undertakes an in-depth analysis offering a theory-informed critique of the frameworks and the literature on governance, extending beyond health systems. The findings of included studies were synthesised using narrative synthesis which is useful in synthesising different types of studies without losing the diversity in study designs and contexts (Wong et al. 2013, Barnett-Page & Thomas, 2009, Lucas et al. 2007). Included studies were summarised by the objectives presented in the results section, and by grouping them by the discipline from which the frameworks originate.

3.5 Description of included studies

The following section presents findings from the systematic review and is divided into two sections: 1) description and critique of governance frameworks by grouping them into the disciplines from which the frameworks originate and 2) how those frameworks have been applied in the health system.

The review identified a total of 373 articles through database searches and 39 through other sources, of which, 39 met the inclusion criteria (**Table 5**).

Table 5: Overview of frameworks identified in the review

Disciplines	Name of the framework (underlying theory if any)	Application in empirical research (Author, year) (Country)
New institutional economics	1. Multilevel framework of Abimbola et al. (2014) (Theory of common pool resources)	1. Abimbola, Olanipekun et al., 2015 (Nigeria); 2. Abimbola, Olanipekun et al.,2016 (Nigeria); 3.Abimbola, Ukwaja et al., 2015 (Nigeria)
	2. Accountability framework of Baez-Carmago (2011) (Principal-agent theory)	No
	3. Social accountability framework of Baez-Carmago & Jacobs (2013) (Principal-agent theory)	No
	4. Analytical framework of health sector governance & private sector of Balabanova et al. (2008)	Balabanova et al. (2008) (Afghanistan, India & Uganda)
	5. Brinkerhoff & Bossert's framework (2008, 2013) (Principal-agent theory)	1. Mutale et al., 2013 (Zambia) 2. Vian, 2012 (Vietnam) 3. Vian & Bicknell, 2013 (Lesotho)

Disciplines	Name of the framework (underlying theory if any)	Application in empirical research (Author, year) (Country)
		4.Ramesh et al., 2013 (desk review)
	6. Accountability framework of Cleary et al. (2013) (Principal-agent theory)	No (only literature review)
	7. European Commission (2008) (Principal-agent theory)	No
Political science & public administration	1. Health work's accountability framework of Berlan & Shiffman (2012)	No (only literature review)
	2. Accountability assessment framework of Brinkerhoff (2004)	No
	3. Patron-client relationship framework of Brinkerhoff & Goldsmith (2004)	No
International development	1. Framework of Islam et al (2007)	No
	2. Health development governance framework of Kirigia & Kirigia (2011)	No
	3. Framework of Mikkelsen-Lopez et al. (2011)	1. Marais & Petersen, 2015 (South Africa) 2. Petersen et al., 2017 (Ethiopia, India, Nepal, Nigeria, South Africa & Uganda)
	4. Ibrahim index of African governance	Olafsdottir et al., 2011 (secondary data analysis)
Multi-disciplinary	1. Governance framework of Baez-Carmago & Jacobs (2011)	Baez-Carmago and Kamujuni (2011) (Uganda)
	2. Governance assessment framework of Siddiqi et al. (2009)	1. Siddiqi et al., 2009 (Pakistan) 2. Abdulmalik et al., 2016 (Nigeria) 3. Hanlon et al., 2017 (Ethiopia) 4. Marais & Petersen, 2015 (South Africa) 5. Mugisha et al., 2016 (Uganda) 6. Petersen et al., 2017 (Ethiopia, India, Nepal, Nigeria, South Africa & Uganda) 7. Upadhaya et al., 2017 (Nepal) 8. Yuan et al., 2017 (only desk review)
	3. Cybernetic framework of Smith et al. (2012) (System theory)	Smith et al. 2012 (Australia, England, Germany, the Netherlands, Norway, Sweden, Switzerland)
	4. Vian (2008)'s framework to identify corruption in the health sector (Theory of institutional analysis-North,1990)	No
	5. George et al. (2016)'s accountability framework	Erchick et al., 2017 (Nigeria)

Nineteen papers specified frameworks for assessing governance and 18 empirical research using frameworks to assess health system governance.

One previous review on governance (a non peer-reviewed report) was identified. The review was conducted to inform the development of a framework which would be specifically used in surveys of the countries included in the Health Systems 20/20 project (Shukla & Lassner, 2012). The report provides an overview of the current literature on governance in the health sector. The authors discuss ten principles termed 'enablers' in detail and outline existing frameworks; highlighting how effective governance is associated with health outcomes in three country-level studies.

3.5.1 Description and critique of governance frameworks

The review identified a total of 19 frameworks to assess governance in health systems; of these, seven frameworks were developed based on theories from new institutional economics; three informed by political science and public management discipline; four from the development literature and five multi-disciplinary approaches (**Table 5 and Appendix 4**). (This differed slightly from the published review paper, **Appendix 1**, which identified 16 as three articles have been added since the paper was accepted for publication in October 2016.)

3.5.1.1 Frameworks originating from new institutional economics

Seven frameworks conceptually originate from New Institutional Economics: Abimbola et al. (2014); Baez-Carmago (2011) and Baez-Carmago & Jacobs (2013); Balabanova et al. (2008); Brinkerhoff and Bossert (2008); Cleary et al. (2013); and EC (2008). Among them, six (Baez-Carmago, 2011; Baez-Carmago & Jacobs, 2013; Balabanova et al., 2008; Brinkerhoff and Bossert, 2008; Cleary et al., 2013 and EC, 2008) use "principal-agent" theory while Abimbola et al. (2014) uses Ostrom's theory of "common-pool resources".

Principal-agent theory

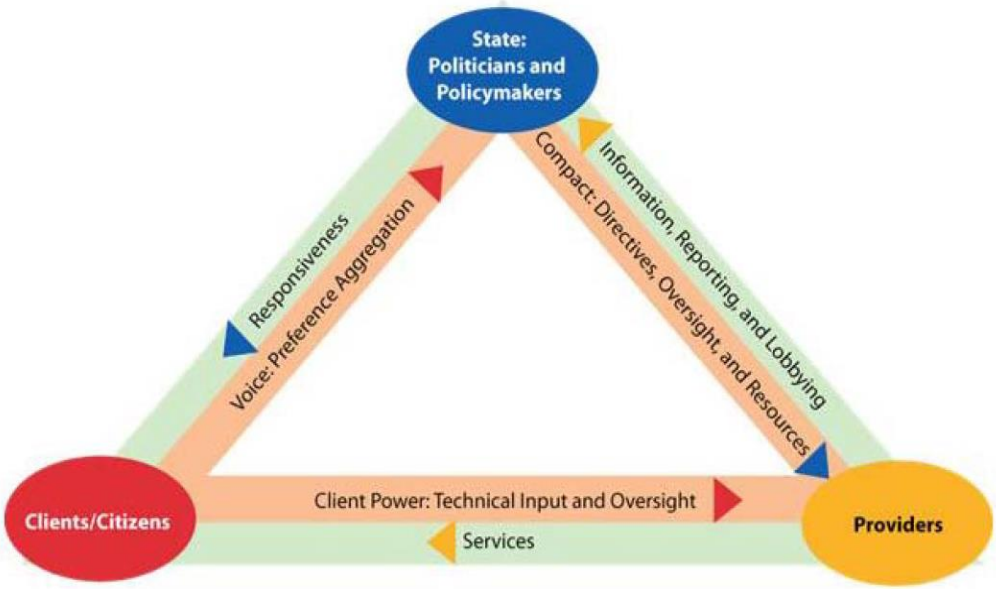
In "principal-agent" theory, a "principal" hires or contracts an "agent" to undertake a service (Chhotray and Stoker, 2009). Agents may have similar as well as different objectives from those of the principal. Agents, usually have more information than the principal, providing them with an advantage to pursue their own interests at the expense of the principal. Fundamentally, the theory looks at how much of the value that the agent produces should go back to him/her in the form of incentives i.e. the agent (healthcare provider) produces

certain services for the principal (the government), for which the agent expects some form of payment (Chhotray and Stoker, 2009).

Those frameworks assume that governance is the result of interactions among principals and agents with diverse interests. Two key assumptions using "principal-agent" theory are 1) incentives and sanctions for different key actors to be accountable for their functions; and 2) information asymmetry and power difference among different groups. Healthcare users are normally regarded as "principals" while the state and healthcare providers are "agents" providing healthcare services to users (EC 2009, Brinkerhoff & Bossert, 2008, 2013, Baez-Carmago, 2011, Baez-Carmago & Jacobs, 2013 and Cleary et al., 2013).

The framework by Brinkerhoff and Bossert (2008; 2013) is based on a World Bank (2004) accountability framework. The framework depicts three principal-agent relationships: government and healthcare providers; healthcare providers and citizens; and government and citizens (**Figure 7**).

Figure 7. Brinkerhoff and Bossert's health governance framework (2008)



Source: Brinkerhoff and Bossert (2008)

The other framework using the "principal-agent" theory is the governance framework of the European Commission (2008). The EC (2008) framework aims to assess governance at sector level specifically in the context of development and aid assistance worldwide. The EC framework considers the importance of context and assessment starts with context analysis and stakeholder mapping. Similar to the framework by Brinkerhoff and Bossert (2008; 2013), the EC framework considers power, interactions and functions of stakeholders as core

governance issues, but also includes principles of participation, inclusion, transparency and accountability. Among different principles, the framework focuses on accountability among different stakeholder groups. Although the framework is intended to be used for development and aid assistance, it does not include citizens among the defined clusters of stakeholders. The EC (2008) framework has a ready-to-use tool with detailed instructions. Examples from previous EC projects globally are provided with suggestions on how to improve governance. While the authors do not empirically test the framework, they suggest how it might be applied it to a fictional country in sub-Saharan Africa.

Baez-Carmago (2011) and Baez-Carmago and Jacobs (2013) proposed an analytical framework of "social accountability" by adapting the World Bank accountability model (World Bank, 2004). Using the "principal-agent" theory, Baez-Carmago (2011) presented incentives and sanctions within two routes towards accountability: short (direct) and long (indirect) routes. Direct accountability is most suitable in the competitive market where citizens can "voice" their preference or choose other alternatives (exit). On the other hand, with indirect accountability, the link between citizens and healthcare providers is considered 'indirect' as the government agent is involved in the accountability relationship; citizens hold the government agent accountable either through political representation (votes), and the government holds healthcare providers accountable to deliver healthcare services. Direct accountability has received the most attention as it can be promoted either through citizens' participation in service planning or voicing concern about service providers' performance (voice) or through citizens' choosing other providers (exit). However, it is important to be careful about applying the concept of direct accountability to health care in settings where market competition fails to provide healthcare services to the most vulnerable groups. The authors include tools for key informant interviews.

"Health sector governance and the private sector" framework of Balabanova et al. (2008) uses principal-agent theory focussing on the role of private sector in a health system. The principal concept of the framework assumes that with the increasing role played by the private sector, the government should take the stewardship role to protect the public interest by working together with the private sector. The framework includes a set of indicators of progress based on three key areas to assess the role of government in relation to the private sector - protecting public interest; working with private sector and learning from each other. The framework uses two principal-agent relationships: between the private sector and government, private sector and donors and government and donors in terms of three key principles: the rule of law, participation/rule of engagement and accountability.

Although they have placed citizens or service users central to their framework, the relationship between citizens and three groups of key stakeholders is not clarified.

Another framework using "principal-agent" theory is the accountability assessment framework for low-and middle-income countries developed by Cleary et al. (2013). By adopting the Brinkerhoff and Bossert (2008) framework, the authors emphasise the accountability pathways among three groups of key actors (politicians/policy makers; healthcare providers and citizens). The Cleary framework claims to assess both external and internal accountability mechanisms via three critical factors: resources, attitudes and values. The authors highlight that adequate resources are critical for proper health system functioning while it is important to understand the attitudes of healthcare providers and policy makers without neglecting the values of citizens.

Theory of common-pool resources

This review identified one framework which uses theory derived primarily from new institutional economics; Ostrom's theory of "common-pool resources" (Ostrom, 1990). This theory describes governance as an autonomous system with self-governing networks (or systems) of actors (Stoker, 1998). The theory assumes that actors in self-governing networks can not only influence government policy, but can also take over some of the business of the government (Stoker, 1998). Ostrom's theory focuses on creating different institutional arrangements to manage open resources which are finite. Communities can form self-organized networks or systems composed of interested actors who will develop incentives and sanctions to manage the resources on their own (Stoker, 1998). The theory assumes that self-organized systems are more effective than regulation imposed by the government as there will be increased availability of information and reduced transaction costs (Stoker, 1998). Indeed, the theory postulates that in situations where the government is "under-governed", social norms fill those gaps (Olivier de Sardan, 2015). A similar assumption is highlighted by Dixit (2009) as civil society organisations and non-governmental organisations emerge to fill gaps in functioning when government organisations serve poorly. The theory proposes that there are three levels of a common-pool resource problem: 1) an operational level where the working rules are set, 2) a collective level where communities set their own rules, and 3) a constitutional level from where the set rules originate (Ostrom, 1990:45).

Using Ostrom's theory of "common-pool resources", Abimbola et al. (2014) developed a multilevel framework to analyse primary healthcare governance in low-and middle-income countries. The authors borrowed the concept of "governing without government" in

situations where overall governance situations are not functioning. In such situations, communities with similar interests may develop their own rules and arrangements to manage the common-pool. Ostrom argued that self-governing arrangements lead individuals or groups to cope with problems by constantly going back and forth across levels as their key strategy. Abimbola's framework describes the three collective levels of health system hierarchy as: 1) operational (citizens and healthcare providers), 2) collective (community groups) and 3) constitutional governances (governments at different levels). A multilevel framework is believed to be more effective at assessing governance than a single unit assessment. Operational and collective governance can mitigate the failure of constitutional governance; although, there is some overlapping of roles and responsibilities.

3.5.1.2 Frameworks originating from political science and public administration

Three frameworks conceptually originate from political science and public administration disciplines: Berlan and Shiffman (2012), Brinkerhoff (2004) and Brinkerhoff and Goldsmith (2004). None of the frameworks mentions theories on which their frameworks are based. The concept of governance for political scientists focuses on "formal institutions, accountability, trust and legitimacy" for governance (Pierre and Peters, 2005:5). They are interested to see how collective decisions are made among key actors (both government and non-government actors) with different power (Chhotray and Stoker, 2009). Thus, governance theories from political science and public administration focuses on both inputs (the processes) and outputs (results of governing networks) (Chhotray and Stoker, 2009).

Berlan and Shiffman's framework (2011) assumes that healthcare providers in low-and middle-income countries have limited accountability to their consumers because of both health system and social factors. Oversight mechanisms, revenue source and nature of competition are related to the health system while consumer power and provider norms are considered under social factors. Their framework helps to identify factors which shape the accountability of healthcare providers. Social interactions and norms operating within the system and context are also prominent features of this framework (**Table 6**).

Table 6: Berlan & Shiffman's framework of accountability of health workers

Factors influencing health workers' accountability	Description of factors
Health system factors	
Oversight mechanisms	The actors and systems that supervise providers.
Revenue source	How health care is financed.
Nature of competition	The extent to which the private & non-profit sectors are involved in providing health care.
Social factors	
Consumer power	Resources, including information, are available to consumers to influence providers.
Provider norms	Provider beliefs concerning accountability to consumers

Brinkerhoff's framework (2004) is also based on accountability and aims to map out public accountability mechanisms: financial, performance and political accountability. In this framework, performance accountability is defined as agreed upon targets which should theoretically be responsive to the needs of the citizens. Political accountability emphasises that electoral promises made by the government should be fulfilled. Brinkerhoff highlights the need to map out the accountability linkages among key actors and to examine actors' interactions as too few linkages can lead to corruption while too many can undermine accountability effectiveness. Together with his framework, Brinkerhoff proposes three strategies to strengthen accountability: 1) addressing fraud, misuse of resources and corruption; 2) assuring compliance with procedures and standards and 3) improving performance. The framework includes an accountability assessment matrix which allows the user to rate accountability linkages among key actors.

The other framework that draws on political science assesses the patron-client relationship or clientelism in health systems (Brinkerhoff & Goldsmith, 2014). Despite the unpopularity of clientelism, it is regarded as an essential principle of governance which can affect corruption and accountability mostly at macro/ national level. The purpose of the framework is to identify reasons why clientelistic practices persist and the authors use a realist evaluation approach comprising of context, actions (mechanisms) and outcomes. Although the framework has not been used in the field, the authors present a diagnostic framework with sample questionnaires.

3.5.1.3 Frameworks originating from international development

In the development literature, governance focuses on predefined principles which development specialists believe to be critical for "good governance" in aid assistance.

Governance in development comprises different functions of governance which are commonly described as 'principles', 'concepts', 'dimensions', 'components' or 'attributes'; terms that tend to be used synonymously. In this study, the term 'principles' will be used. Accountability is the most frequently cited principle in development followed by control of corruption, transparency, participation and inclusiveness.

The four frameworks identified (Ibrahim, 2007, Islam et al., 2007, Kirigia and Kirigia, 2011, Mikkelsen-Lopez et al., 2011) focus primarily on how governance is defined, how it can facilitate effective aid policy, and, unlike any of the other frameworks, those in international development are concerned with how governance can be measured. Kauffman and Kraay (2007) propose measuring governance in two ways using rule-based measures (e.g. policy or procedure exists) and outcome-based measures (e.g. the policy has been implemented, or the rule has been enforced) (Chhotray and Stoker 2009).

The Ibrahim Index of African Governance (2007) was developed by the Harvard Kennedy School of Government with support from the Mo Ibrahim Foundation. The aim of the Index is to evaluate the quality of governance in sub-Saharan African countries. The purpose is to diagnose governance of African governments as the developers of the Ibrahim Index believe that governance is the result of government performance (Rotberg, 2009). Developers of the Ibrahim Index argued that the existing approaches to measuring governance are subjective as they are based on perceptions or expert judgements. The existing approaches such as the World Bank Governance Index, Freedom House measure of democracy and the Anti-Corruption Index from Transparency International use subjective measures to score principles of governance (Rotberg, 2009). Those indices also measure only principles of governance using input-based measures which may or may not measure governance performance (Rotberg, 2009). The Ibrahim Index developers believe that their indicators are objectively set, transparent and output-based measures which can be replicated following the same approach. The Index has 57 variables which can be grouped into 14 categories summarised into the following four dimensions: 1) safety and the rule of law; 2) participation and human rights; 3) sustainable economic opportunity; and 4) human development.

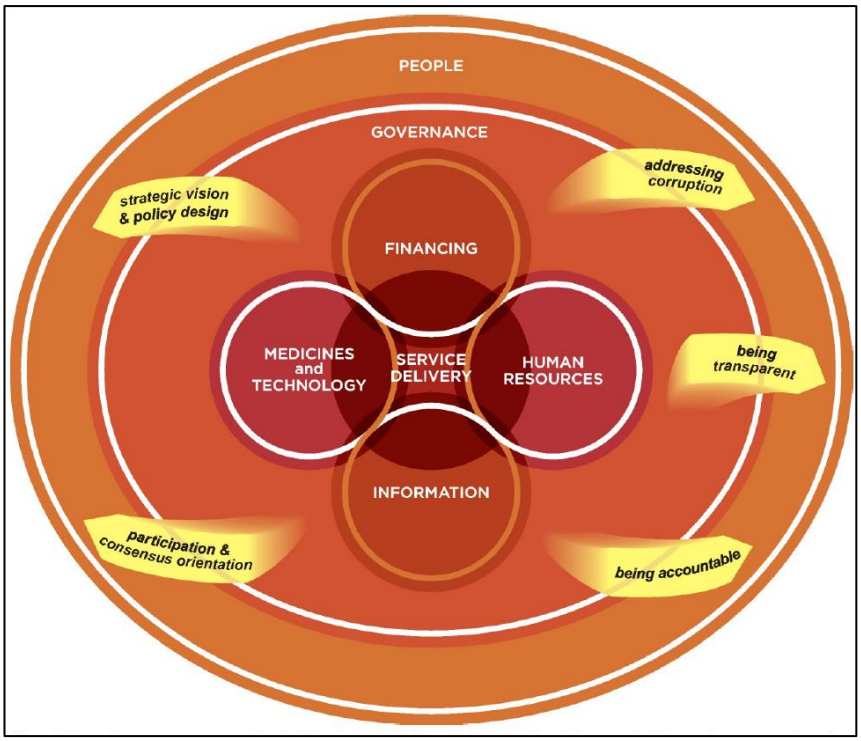
Islam et al. (2007) present a health system assessment manual which includes a framework to assess governance, developed under the Health Systems 20/20 project (USAID). The aim is to guide data collection providing a rapid but comprehensive assessment of key health system functions based on the WHO six domains of the health system (WHO, 2007). This framework groups indicators into general governance (e.g. voice and accountability; political

stability; government effectiveness; the rule of law; regulatory quality and control of corruption) and health system specific governance (e.g. information/assessment capacity; policy formulation and planning; social participation and system responsiveness; accountability and regulation). The authors suggest various sources of data for the different indicators, including interviews with relevant key stakeholders and desk-based review of relevant documents and reports.

Another framework that attempts to measure governance is the one based upon Siddiqi et al. (2009), which also includes principles of macroeconomic and political stability (Kirigia and Kirigia, 2011). The authors emphasise that development in health cannot occur without political and economic stability in the form of a national economic development plan or poverty reduction strategy, a medium-term government expenditure framework, and a non-violent electoral process. The authors argue that individual and aggregate scores of governance are needed to alert policy makers to the areas needing improvement. This is one of the few frameworks identified in this review which tries to quantify governance by using rule-based measures such as the existence of certain policy or guidelines. The authors propose a scoring system that determines whether governance is very poor (0%) or excellent (100%) for each function. Kirigia and Kirigia (2011) argue that scoring allows assessors to identify areas for improvement, and an index representing the overall governance situation in any given country can be calculated.

The final framework (Mikkelsen-Lopez et al., 2011) is based on systems thinking and uses a problem-driven approach to assessing governance in relation to an identified problem to highlight the barriers to good governance. The framework assesses governance in all four levels of a health system (national, district, facility and community) using the established WHO Health System Building Blocks and five proposed principles of governance: 1) strategic vision and policy design; 2) participation and consensus orientation; 3) accountability; 4) transparency and 5) control of corruption (**Figure 8**). The authors argue that it will be difficult to improve governance in the absence of the essential health system building blocks such as adequate financing and sufficient medical supplies. The authors developed this framework in response to other governance frameworks that provide snapshots of any given governance situation, but are unable to identify specific areas of weakness and how to intervene. However, despite providing a way to identify barriers to good governance, the framework does not easily allow for comparisons between different contexts.

Figure 8: The framework of Mikkelsen-Lopez et al. (2011)



Source: Mikkelsen-Lopez et al. (2011)

3.5.1.4 Multi-disciplinary frameworks

Five frameworks appear to be based on principles of more than one discipline (Baez Carmago and Jacobs, 2011; George et al., 2017; Siddiqi et al., 2009; Vian, 2008; Smith et al., 2012). Three of these (Baez Carmago and Jacobs, 2011; Siddiqi et al., 2009; Vian, 2008) draw on the "Institutional Analysis" theory of North (1990), originally derived from new institutional economics. The frameworks also seem to reflect predefined governance principles in line with the international development literature.

Theory of "institutional analysis"

North's (1990) theory of institutional analysis assumes that markets are created and maintained by institutions. North defined institutions as the "rules of the game" and organisations as the "players". Institutions consist of formal rules and informal constraints while organisations consist of groups of individuals with common objectives. North's principal argument is that individuals within an institution have certain opportunities which are the result of specific formal and informal constraints that constitute the institutions. Hodgson's (2006) examples of institutional arrangements embedded within the social

systems are marriage and religion (social arrangements); universities (social organisations) as institutions are a form of "social rule-systems".

The distinction between institutions and organisations of North (1994) is acknowledged in the World Health Report of WHO (2000: 61). The report echoes the definitions of North (1994) as it states: "*Organisations are the players, for example, individual providers, hospitals, clinics, pharmacies, and public health programmes. Institutions are the rules (formal rules and informal customs) - the socially shared constraints that shape human interactions, along with the mechanisms by which these rules are enforced*".

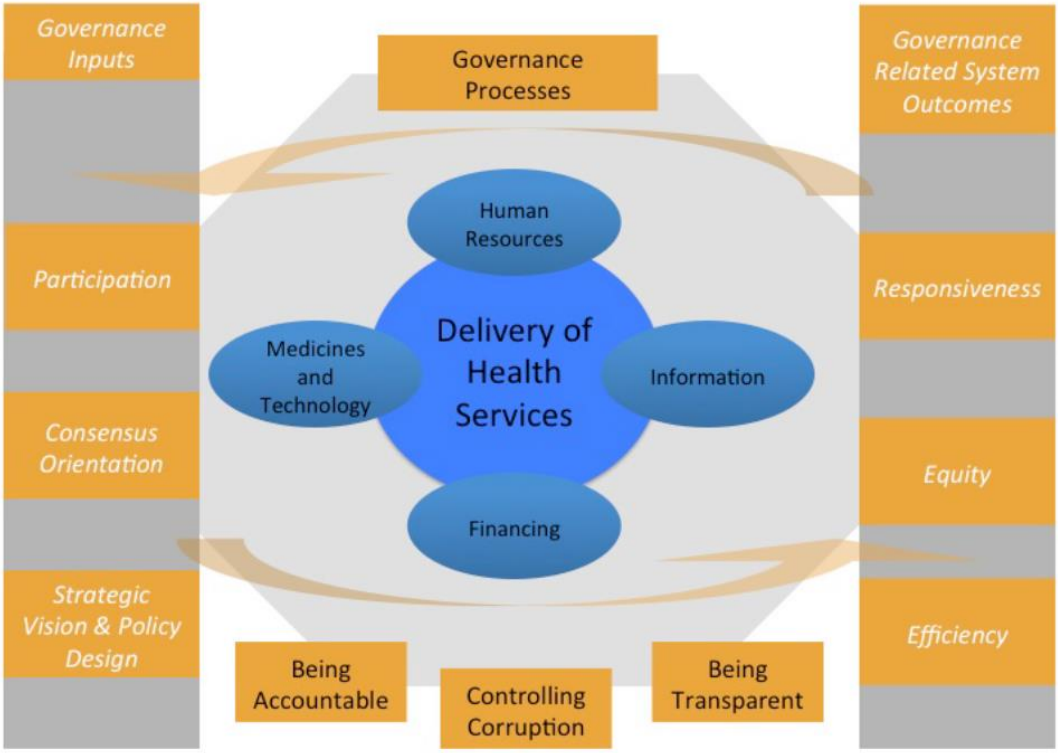
Using the theory of North (1990), Baez Carmago and Jacobs (2011), Siddiqi et al. (2009) and Vian (2008) highlighted that institutional analysis is key to assessing governance to understand the institutional arrangement and rules set by the organisations. A mapping of the power distribution can be used to identify the key decision makers who affect the behaviour of health system actors.

In addition to the application of North's theory of institution analysis, Siddiqi et al. (2009) propose a comprehensive framework to assess governance based on the UNDP principles of governance. This framework includes ten principles, disaggregated into 63 broad questions under three relevant domains: context, processes and outcomes. In conceptualising governance in this way, the authors suggest that their framework could be used to compare governance functions across countries. The framework is intended for use at both national (policy formulation) and sub-national levels (policy implementation and health facility levels) to assess all essential principles of health systems governance; something which other frameworks do not aim to do. The potential for application of the framework at subnational level is a unique feature as most other governance frameworks are developed for macro-level assessment except the multilevel framework.

Baez-Carmago and Jacobs (2011) propose an "inputs, processes and outputs" framework for health systems governance in low-income countries (**Figure 9**). The authors acknowledge the existence of other frameworks to assess health systems but set theirs apart by focussing on generating information on the complex context within which the health system operates. The framework draws on the values of good governance articulated in the development literature, and "institutional analysis" to map out key stakeholders and the power distribution among them. The framework is presented as a visual process map of causal links between inputs, processes and outcomes, which they believe helps to provide a better explanation of governance and easier application of the framework. The authors provide a

detailed methodology, tools and procedures for using the framework in practice, but acknowledge that their model cannot assess health systems governance in its entirety. It is recommended for use in contexts where a problem has first been identified.

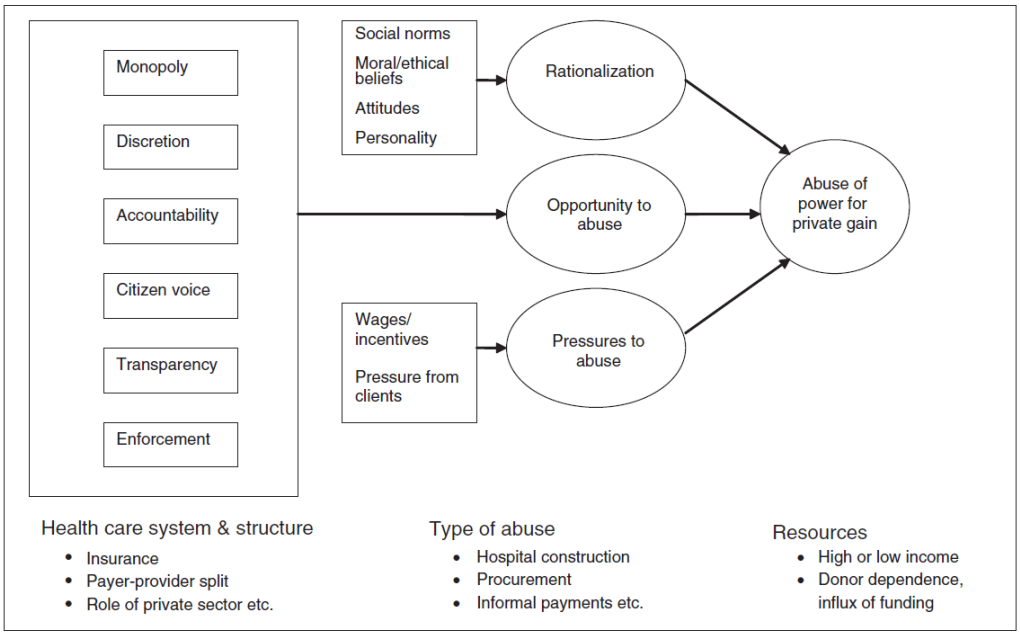
Figure 9. Baez-Carmago & Jacobs's framework (2011)



Source: Baez-Carmago and Jacobs (2011)

Vian (2008)'s framework specifically analyses corruption in the health system from the perspective of the government (**Figure 10**). Vian's framework draws on North's principal argument that key players in the health system have certain opportunities which are the product of formal and informal rules and constraints set by institutions (North 1990). The author also employs "principal-agent" theory as the framework considers asymmetric information among different actors with diverse interests within a health system. The framework assumes that corruption in the health sector is driven by pressures of government agents to abuse, the opportunity to abuse and social factors supporting the abuse of the system. Therefore, the framework is diagnostic as it aims to identify potential abuse that can occur at each step of a health service delivery process.

Figure 10: Vian's framework to assess corruption in health system (2008)



Source: Vian (2008)

George et al. (2016) developed an accountability framework from the viewpoint of government officials composed of three counterbalancing axes which mutually reinforce each other: axis of power (incentives & sanctions), axis of ability (formal & informal rules) and axis of justice (political leadership, community ownership & social equity). The framework was developed based on consensus obtained through stakeholders' workshop in Nigeria.

Smith et al. (2012) describe a "cybernetic" framework for leadership and governance which uses systems theory. This theory is interdisciplinary and is concerned with discovering patterns in the way systems (including health systems) operate. Smith et al. consider it important to view governance as hierarchical (rules and responsibilities for allocating resources) and horizontal (both incentives and the market regulate purchasing power, and systems produce common values and knowledge through professional norms). Cybernetics focuses on how systems use information, and how systems monitor actions to steer towards their goals. The framework includes three key principles related to this: setting priorities, accountability (inputs into the health system) and performance monitoring (output). The framework focused on the leadership principle of governance and was developed for use in health systems in high-income countries, so would require adaptation to low-and middle-income settings.

3.5.2 How frameworks have been applied in health systems

Among the 19 frameworks identified that can be used to access health system governance, nine (Baez Carmago and Jacobs 2011, Balabanova et al., 2008, Ibrahim Index 2007, Siddiqi et al., 2009, Smith et al., 2013, Brinkerhoff & Bossert 2008, Mikkelsen Lopez et al., 2011, Abimbola et al., 2013 and George et al., 2016) have been described in 21 publications of which 18 are empirical research. **Appendix 5** summarises the frameworks applied and groups them into different theories.

Among the 21 publications in which frameworks have been applied, eight use "principal-agent" theory; three "common-pool resources"; ten institutional analysis approach; one "Ibrahim index of governance" and one uses "cybernetics" theory.

3.5.2.1 Studies which used "principal-agent" theory

Among frameworks using "principal-agent theory", Brinkerhoff and Bossert's framework (**Figure 7**) was most commonly applied in four studies (Mutale et al., 2013, Cleary et al., 2013, Ramesh et al., 2013 and Vian et al., 2012) while the other four (Avelino et al., 2013, Balabanova et al., 2008, Huss et al., 2011 and Vian & Bicknell, 2013) used a variant of "principal-agent" theory. The USAID health system assessment team also used Brinkerhoff & Bossert's governance framework in their manual for assessing health systems. According to Health Systems 20/20, the manual is currently used in 23 Health Systems 20/20 projects funded by the USAID in countries in Eastern, Western, and Southern Africa, as well as the Caribbean Islands (Health Systems 20/20, 2012).

Mutale et al. (2013) adapted Brinkerhoff & Bossert's framework to assess governance at health facility level in Zambia while Ramesh et al. (2013) used the framework to assess health system governance at the national level in China. Ramesh et al. use principal-agent theory to identify institutional relationships among principal and agent; capacities of principal-agent; information asymmetry and power differences; and incentives which shape preferences and behaviour of principal and agent.

Cleary et al. (2014) adapted Brinkerhoff & Bossert's framework to assess accountability mechanisms of health systems in low-and middle-income countries. Cleary et al. focussed on two key areas: 1) identifying incentives and sanctions for health workers to be accountable and 2) power differences in both vertical and horizontal accountability linkages within a health system.

Vian et al. (2012) employed Brinkerhoff & Bossert's framework to assess corruption in the Vietnamese health system. Vian et al. examined institutional arrangements (including informal payment mechanisms); how rules against corruption were enforced and information asymmetry. The framework also helped the authors identify incentives and motivation among key health system actors such as financial incentives for healthcare providers to over-treat and profit motivation within the public health system including accountability for performance.

Balabanova et al. (2008) applied their own framework to assess the role of the private sector in three countries: Afghanistan, India and Uganda. The authors use the framework for diagnostic purposes to highlight the role of the private sector in health system governance particularly from the following three aspects: how the government regulates, receives contributions for health sector financing and provides a stewardship role to the private sector.

Three other studies (Avelino et al., 2013, Huss et al., 2011 and Vian & Bicknell, 2013) applied "principal-agent" theory to assess governance in Brazil, India and Lesotho, respectively. Huss et al. (2011) applied a variant of the "principal-agent" model in their assessment of governance focussing on corruption in Karnataka State, India. Contrary to the traditional application of "principal-agent", Huss et al. refer to the "state" as "principal" while "public service providers" are "agents" to deliver certain services for "citizens". Huss et al. (2011)'s application of the principal-agent theory focuses on the roles and capacities of principals and agents within the state health system.

Avelino et al. (2013) also applied principal-agent theory and focussed on interactions between the principal (municipal governments and federal government) and agents (municipal health councils), specifically exploring accountability arrangements to avoid corruption within the decentralised arrangement. They used the audit data and regression analysis to assess capacities of agents (municipals) and institutional arrangements which promote accountability such as open electoral process, federal audits and local oversight mechanisms.

All studies used two principal-agent relationships - between citizens and government and between government and healthcare providers except Vian and Bicknell (2013) and Mutale et al. (2013) who use single principal-agent model (state - healthcare provider and healthcare provider – communities, respectively). The studies consider the strategies of how those two sets of players (principal and agent) engage and interact to accomplish a collective effort.

The studies also highlighted the importance of information asymmetry among principals and agents as the agents know about a service in question better than the principal.

3.5.2.2 Studies which used the "multilevel framework" of governance

Three studies (Abimbola et al., 2015, Abimbola; Olanipekun et al., 2015; 2016) have applied the "multilevel framework" of governance developed by Abimbola et al. (2014).

Abimbola et al. (2015) adapted the "multilevel framework" to identify the effect of decentralisation on retention of primary healthcare (PHC) workers in Nigeria. The framework was used to assess government, communities and intrinsic health workers' factors influencing retention of PHC workers in the decentralised health system. The framework helped identify incentives and motivation of PHC workers and the reasons to remain in post despite socioeconomic hardships.

The "multilevel framework" was also applied in another publication by Abimbola; Olanipekun et al. (2015) to provide recommendations to improve health system governance at operational level among tuberculosis (TB) patients in Nigeria. The framework was used to assess three different levels of governance: constitutional (federal government); collective (communities) and operational (healthcare providers at local health market). In that study, the concept of Williamson's Transaction Cost Theory (1979) was used to identify the costs incurred by TB patients to receive an appropriate anti-TB treatment from a qualified provider within the health system (Abimbola; Olanipekun et al., 2015). Transaction costs are difficult to measure. Thus, Williamson suggested considering "the issues of governance comparatively". The central argument of Williamson's theory is that "high transaction costs" can be attributed to governance failure which, requires looking for alternative modes of governance to "economise" results (Williamson, 1979).

In a third study, Abimbola; Olanipekun et al. (2016) used Abimbola's multilevel framework of PHC governance to identify factors influencing policies of posting and transfer of public health workers under the conditions when there is a lack of formal national policies to post and transfer health workers in Nigeria. The interactions among federal, state and local governments are referred to as constitutional governance while factors influencing decisions of communities as collective governance and interactions between PHC workers and individual community members as operational governance. The framework helps to identify different informal mechanisms at multiple levels of the health system and how key health

system actors use their power and decision space in posting and transfer of public health workers.

In all three studies, self-governing individuals at three levels of a system are trying to overcome a common problem by identifying the ways which are workable for them.

3.5.2.3 Studies which used institutional analysis approach

Siddiqi et al. (2009) used their own framework to assess governance of the health system in Pakistan and explored governance principles in depth by using qualitative interviews. The authors assessed three different levels of the health system - national (policy formulation) and sub-national levels (policy implementation and health facility levels). The authors highlighted the importance of understanding the socio-political context of a country and show that the principles of health systems governance are value driven. Siddiqi et al. also emphasise that health system governance can be improved without improving the overall governance of a country.

Siddiqi et al. 's framework (2009) was adopted in the European Union - funded consortium project called "Emerald" to assess mental health system governance in Africa and South Asia (Ethiopia, India, Nepal, Nigeria, South Africa and Uganda) (Abdulmalik et al., 2016; Hanlon et al., 2017; Marais & Petersen, 2015; Mugisha et al., 2016; Petersen et al., 2017). The authors adapted this framework as it could assess governance at different levels of a health system hierarchy. Mikkelsen Lopez et al.'s (2011) framework was also adapted for use in South Africa and crosscountry comparison (Petersen et al., 2017) to identify key health system building blocks such as financing, HRH, medicines, supplies and equipment impeding governance. The authors employed qualitative research methods not only to assess mental health governance of individual countries but to compare governance principles across the six participating countries.

Yuan et al. (2017) also employed the framework of Siddiqi et al. (2009) to assess two rural health insurance policies in China. The authors used desk review of publications regarding the two policies. The aim was to fulfil the research gaps in understanding of the formulation and implementation of those two schemes through identifying common features of governance. Of the ten Siddiqi's principles, the authors explored six operational principles: policy guidance & vision; system design; regulation & management capacity; accountability & transparency; intelligence & oversight and collaboration & coalition building. The study

highlights the importance of health system governance in conceptualisation and implementation of such schemes.

Baez-Carmago and Kamujuni (2011) conducted an assessment of the governance of the public-sector drug management system in Uganda using the framework of Baez-Carmago and Jacobs (2011). The assessment started with institutional mapping which included interviews with both the formal and informal sectors of the supply chain in Uganda. Focus group discussions were also conducted with healthcare providers, patients and representatives of patient advocacy groups.

Erchick et al. (2017) adopted three-dimensional axes of the accountability framework developed by George et al. (2016) to explore the perspectives of government officials involved in a routine immunisation programme at Niger state in Nigeria. The authors used the three-dimensional accountability axes (axes of power, ability and justice) in developing tools for interviews with government officials for diagnosis of accountability challenges within the routine immunisation programme.

3.5.2.4 Studies which used other types of framework

Smith et al. (2012) applied their cybernetic framework at the national level to seven health systems (Australia, England, Germany, the Netherlands, Norway, Sweden and Switzerland) in high-income settings. The framework is composed of three key nodes of governance: setting priorities, accountability and performance monitoring which serve as the guiding principles in assessing hierarchy, market and network governance. One important lesson highlighted by the authors is that competency and capacity at different levels of a health system are crucial for successful implementation of leadership and governance model.

Olafsdottir et al. (2011) used the Ibrahim Index of African Governance to explore the relationship between governance and health outcomes in 46 countries from the WHO Africa Region. The authors conducted an ecological analysis using secondary data. As the Ibrahim Index was initially used to measure governance of a government, Olafsdottir et al. (2011) only used two sub-indicators of the Ibrahim Index namely RLTC: Rule of Law, Transparency and Corruption and SEO: sustainable economic opportunity.

3.5.3 Discussion of the review findings

This systematic review brings together the literature on health systems governance, firstly by describing and critiquing how the concept of governance and the theories underpinning

it have been applied to health systems, and secondly by identifying which frameworks have been used to assess health systems governance, and how, globally. A total of 19 frameworks were identified, which in principle, can be used at national (policy formulation) and subnational (policy implementation) levels of a health system. Frameworks originate mainly from three disciplines: new institutional economics; political science and public administration; and the international development literature. The most commonly used theories which underpin the frameworks originate from new institutional economics and include "principal-agent" theory, North's theory of institutional analysis and Ostrom's theory of "common-pool resources".

Frameworks that originate from the development literature tend to predefine principles of governance and attempt to measure these (e.g. Kirigi & Kirigia, 2011). Most frameworks assess overall governance while some of them assess specific principles of governance such as accountability, control of corruption and participation. Most frameworks assess governance in health systems using the qualitative methodology, based on the premise that governance is the result of interactions among different actors within a health system, and that studying the reasons for and the extent of interaction can be used to document good governance. Other authors propose using mixed methods; collecting data on framework indicators (e.g. Mutale et al., 2013) in combination with an in-depth exploration of specific problems identified.

There are three frameworks that have been used to assess governance at all levels of the health system; Abimbola et al. (2014), Siddiqi et al. (2009) and Brinkerhoff and Bossert (2008). Governance is a practice, dependent on arrangements set at a political or national level, but which needs to be operationalised by individuals at lower levels in the health system; multilevel frameworks acknowledge this and recognise the importance of actors at different levels. Some assessment frameworks explicitly mention the pre-requisites needed for the successful application, such as the framework by Baez-Carmago and Jacobs (2011) which requires that a governance problem has been identified already, and the cybernetic model presented by Smith et al. (2013) requires users' familiarity with the health system.

This review also illustrates that health system governance is complex and difficult to assess; the concept of governance originates from different disciplines and is multidimensional. Governance more generally has been debated and studied from many different perspectives. This review attempts to synthesise how these perspectives have led to the development of governance in health systems. The critical analysis shows that frameworks for assessing

governance may be applicable in one setting but not another. There is no single, agreed framework that can serve all purposes as the concept of governance will likely continue to be interpreted openly and flexibly. However, for governance principles to contribute to health system strengthening in countries, and ultimately to impact on outcomes, it is critical to at least assess and monitor if and how governance works (or not) in practice. As each health system operates in its context, and different components of governance may need to be prioritised over others in different settings and at different times, it is important that any governance assessment recognises the circumstances and has a clear purpose. Assessing health systems governance can raise awareness of its importance to health policy makers, identify problems, or, conversely, document success stories. This can encourage and catalyse improvement in health systems. The aim of this review was to provide an overview of frameworks available and describe how they have been developed, adapted or applied to assess health systems governance in operation. The review recognises that the main utility of the synthesis is not to identify features of a single agreed framework, rather the frameworks identified and reviewed can help assessors to identify relevant questions to ask of health systems governance, and identify elements that could be included in an assessment.

Outside of the limited evidence on how governance can be assessed in health systems, this review also highlights examples of how governance has been assessed in other disciplines. Both rules-based and outcomes-based approaches to assess governance have been critiqued for their limitations as they largely depend on how and what you propose to measure (Chhotray and Stoker, 2009). Though such assessments provide valuable insights, the approach is somehow limited as it often fails to be explicit about how things are measured (Chhotray and Stoker, 2009). This highlights that it is more important but difficult to identify what governance arrangements are considered appropriate for a context (prescriptive measures) than to judge the governance of a system (diagnostic measures) (Chhotray and Stoker, 2009).

Aside from providing a comprehensive overview and critical evaluation of the literature on governance frameworks to inform this study, the findings of this review could help to inform discussions among policy makers in countries considering governance as a mechanism to support health systems strengthening. The example can be seen in the Emerald project where the governance of mental health system was assessed to improve mental health in Africa and South Asia. Findings will help decision makers form a view on what governance is, and which principles are important in their context. Policy implementers at a more local level

may choose and adopt one of the available frameworks or tools to assess governance and identify gaps in governance arrangements.

3.5.4 Conclusion of the review

A variety of frameworks to assess health systems governance exist, but there are not many examples of their application in the literature. There is a need to validate and apply the existing frameworks and share lessons learnt regarding which frameworks work well in which settings to inform how existing frameworks can be adapted. A comprehensive assessment of governance could enable policy makers to prioritise solutions for problems identified as well as replicate and scale-up examples of good practice. Governance is not an apolitical process, and there are no absolute principles that define governance; it is a diffuse concept that cuts across disciplines and borrows from a range of social science theories. However, whether it is applied to health systems or political science, governance is concerned with how different actors in each system or organisation function and operate and the reasons for this. In the context of health systems governance, a multi-disciplinary approach to assessment is necessary.

3.6 Implications of the review findings for the thesis approach

Previous sections have presented a review of frameworks which can be used to assess governance within a health system, and some of which have been applied in health systems across the world. A framework is an analytical tool which can be used to identify elements and relationships among these elements and can be used to inform analysis (Ostrom 2005:28). The overarching purpose of conducting the systematic review was to help set the thesis topic in the context of related work, but also inform the development of the methods and approach taken in this thesis. Specifically, the literature reviewed in this chapter was used to a) identify the concepts and principles considered important in assessing governance in this study context and subsequent development of data collection tools and b) identify the key theories underpinning governance that could provide a structure for analysis and interpretation of the data collected.

Among the above frameworks identified, two frameworks, Baez-Carmago & Jacobs, 2011 and Siddiqi et al., 2009, were found to be relevant for this study. Both frameworks have been applied in health system research (health policy formulation and implementation levels) in low-and middle-income countries. Both are multi-disciplinary frameworks originate from new institutional economics and international development.

Therefore, I further explored the new institutional economics and development literature for inspiration on how governance has been studied within those disciplines. I also contacted the authors of both frameworks to understand how they had applied them empirically in public health settings. After discussion with my supervisors, I then decided to apply those frameworks in this thesis.

The rationale of applying Baez-Carmago and Jacobs' framework in this study is pragmatic as the assessment starts with an identified problem of health system performance. In this study, the starting point is the functionality of health facilities which are measured in terms of signal function availability. Adapting Baez-Carmago and Jacobs' framework contributed this study with an in-depth understanding of the governance problems. The framework of Siddiqi et al. (2009) was also adapted to highlight the importance of hierarchical governance, teasing out different levels of a health system: health policy formulation at national and county levels and policy implementation at the facility level.

As the systematic review findings highlight, most frameworks originating from the development literature tend to focus on "good governance" and a "government-centered approach" with the attempt to measure or quantify governance but without much insight on why and how governance functions at different levels. The frameworks adopted in this thesis are a departure from that approach as the frameworks are qualitative in nature with the possibility to provide more in-depth analysis at different levels of a health system. Both Baez-Carmago & Jacobs (2011) and Siddiqi et al. (2009) frameworks can be used for in-depth analysis of internal workings of different organisations, in addition to the government, within a health system including health facilities. This study wanted to explore in-depth the principles of governance at different levels of the Kenyan health system. The framework adopted in this thesis incorporates six principles of governance (strategic vision; the rule of law; participation and consensus orientation; accountability; responsiveness; and equity) (**Figure 11**). The data collection tool, topic guide was developed based on these six principles of governance.

Figure 11. Framework developed and used in this study

Most importantly, the two adapted frameworks use North's (1990) theory of institutional analysis to explore both formal and informal institutions influencing the governance of a health system. The institutional analysis approach is pertinent to this thesis as understanding context, and institutional arrangements are instrumental in assessing health system governance. Hence, this thesis has adopted an institutional analysis approach by considering governance as institutions (rules) of the Kenyan health system set by organisations (health system players).

Finally, combining the frameworks originating from two different disciplines, I believe that it will provide an in-depth understanding of governance from development perspectives (good governance and a government-centered approach) and new institutional economics perspectives (governance is the interaction between organisations/the health system players and institutions/the rules of the health system).

CHAPTER 4

4. Methodology and methods

This chapter presents the research paradigm, the methodology adopted and methods used in this study. Section 4.1 of this chapter describes the paradigmatic orientation of this study. Section 4.2 describes the conceptual framework and relevant theories employed in this study. Section 4.3 presents the overall research design providing the rationale for using a qualitative research methodology and the approach used in this study. Section 4.4 presents study methods and procedures entailed under each of the three research objectives. Section 4.5 describes measures taken to improve validity, transferability and reliability of the research. Section 4.6 presents the researcher's positionality and reflexivity while Section 4.7 discusses ethical aspects considered in this study. Therefore, the section below starts with the study aim and objectives.

This study aims to explore the situation of health system governance at three health system levels in Kenya focussing on health facilities designated to provide comprehensive emergency obstetric care (CEmOC). The following specific research objectives were formulated to achieve this aim:

1. To explore factors influencing health systems governance in Kenya
2. To explore the perspectives of key stakeholders on health systems governance
3. To explore whether the status of health system governance differs with functionality of health facilities

The following research questions have been formulated to achieve the above-mentioned research aim and objectives:

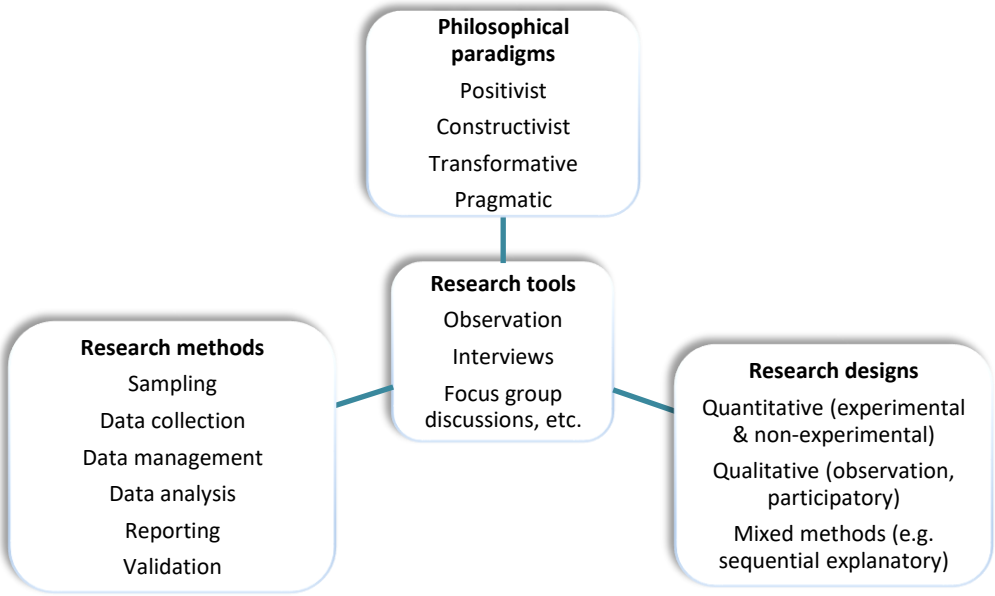
1) Which factors influence the governance of the health system in Kenya?
2) How do key stakeholders from Kenya perceive governance of the health system?
3) Are there any differences in governance between fully functional and not fully functional facilities?

4.1 Research paradigm

Every research study falls within a research paradigm depending on the area of research and methods chosen to answer the research questions. Paradigms affect the way that a researcher conducts a study. A research paradigm is formed by three elements; ontology, epistemology and axiology (Teddlie & Tashakkori, 2009). Ontology is the nature of reality or the nature of being and truth. Epistemology is a theory of knowledge and its justification. Axiology is the role of values in the inquiry. These three elements are crucial when determining the research approach and methodology.

The intersection of the research designs, philosophical paradigm and specific methods forms the research approach and choice of tools to conduct the research (**Figure 12**). Philosophical paradigms are also broadly known as "worldviews". The research paradigm begins with two main epistemological assumptions: 1) qualitative or constructivist or interpretivist approach and 2) the quantitative or positivist approach (Creswell, 2013). Currently, there are four widely discussed paradigms in the literature: post-positivism, constructivism, transformative and pragmatism (Creswell, 2013).

Figure 12: Creswell's research framework (2013)



The **positivist,** later known as **post-positivist,** paradigm represents the traditional form of quantitative research and most commonly known as; scientific method, science research,

positivist research or empirical science (Creswell, 2013). Positivist researchers hold a deterministic view in which there is a need to identify the causes which determine the effects or outcomes. The positivist researchers intend to reduce the ideas into measurable hypotheses thus numeric measures of observations are paramount for positivism. Positivists begin the research with a theory and collect data which either supports or rejects the theory followed by necessary revisions and additional tests.

Constructivism or interpretivism is a different worldview from positivism and is typically seen as an approach to qualitative research (Creswell, 2013). Constructivism dictates that any research depends on the participants' views of the situation under study. Thus, constructivist researchers focus on the interaction among individuals in a specific context which shapes their interpretation, and they position themselves in the study. Rather than starting from an existing theory, the constructivist researcher generates a theory. The constructivist researcher sees the world as formed by a complex, interactive sets of meaning and normally data is collected through observations and interviews.

The **transformative** paradigm conceives an action agenda which includes political ideology with the intention to reform or change the lives of the participants or the institutions (Creswell, 2013). Thus, the transformative paradigm focuses on the needs of marginalised individuals or groups in society and takes their ideas or help to account when designing research questions, collecting the data and analysing the information.

The other paradigm called **pragmatism** was developed later in response to the overstated divide between quantitative and qualitative methods. Pragmatism focuses on research problems and uses all possible approaches to answering the research questions (Creswell, 2013). Pragmatist researchers consider what and how to research based on their research questions using the most relevant methods to understand their research problems. The pragmatist researchers see the world as represented by sets of rules and testable theories and collect both objective and numeric data to confirm or reject the hypothesis (Mendlinger et al., 2008). This research paradigm was originated as a philosophy in the United States in the late nineteenth century (Morgan, 2014).

Among the four paradigms described above, this study uses a constructivist/interpretivist approach as it is exploratory to assess health system governance with no predefined hypothesis. As described in the literature review, governance is a diffuse concept and context specific. Hence, measuring governance is not the aim of this study. Instead, this study sought to understand the interactions of key health system actors and their actions in the context

of Kenya. The study participants were selected purposely through a known group of policy makers and implementers of the health system. The study aims to collect qualitative, subjective information in exploring the situation of health system governance in Kenya. Thus, the constructivist approach is the most suitable for this.

4.2 Conceptual framework and relevant theories

Based on the outcome of the literature review, I developed a framework to assess governance in Kenya by adapting two existing published frameworks, those of Siddiqi et al. (2009) and Baez Carmago and Jacobs (2011). The principles of governance together with the concept of institutional approach were adopted from the framework of Baez Carmago and Jacobs (2011). The concept of hierarchical governance with three different health system levels was adopted from the framework of Siddiqi et al. (2009). This study explored six principles of governance in three levels of the health system. Under each principle of governance, the same areas were explored slightly different at each health system level. For instance, to assess the "rule of law" principle, the framework focuses on how the rules were made at policy making level while it focuses on how the rules were enforced, monitored and changed for policy implementation level. **Table 7** describes the governance assessment framework developed and used in this study. This governance assessment framework was used to inform the development of the data collection methods and research tools, including the topic guides for key informants.

Table 7. The conceptual framework adapted for use in this study

No.	Governance principles	Areas to explore under each principle
1	Strategic Vision	Are there a clear vision and policies for MNH? If so, what are they? How were those policies developed? Who was involved in developing those policies? How do these policies respond to the MNH needs of the population? What have been the challenges after devolution? Are the implementation mechanisms in line with the stated objectives of health policy? What is the extent of implementation of the health policy?
2	The Rule of Law	What are the rules for free maternity services? How are they enforced? Any non-enforcement of the rules? Why? Are there procedures in place for addressing grievances of consumers & providers?
3	Participation and Consensus orientation	Who are the key stakeholders in MNH policy making? How do those stakeholders share ideas? Are there regular meetings or other ways that they can express their interests (and possibly influence

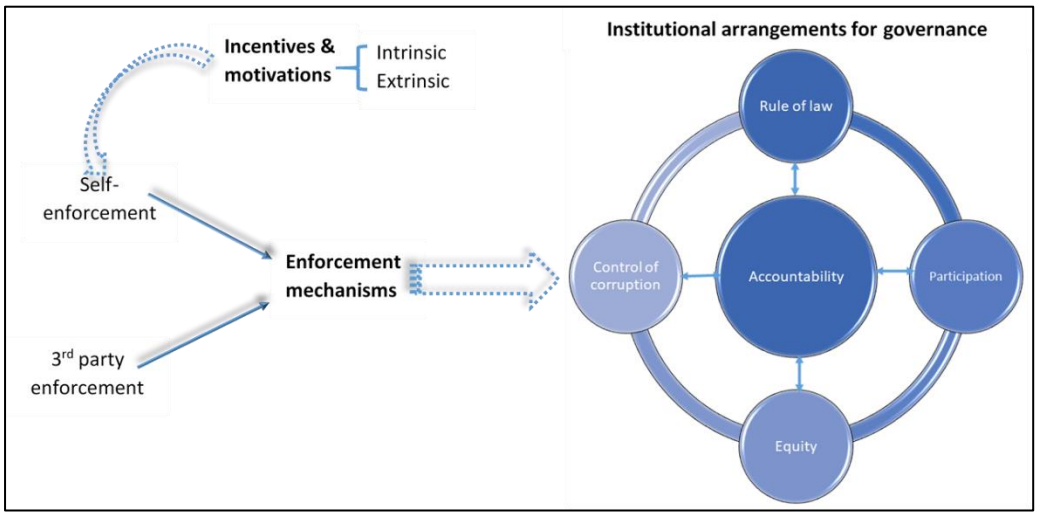
No.	Governance principles	Areas to explore under each principle
		policy or programmatic decisions about EmOC)? Did this change after devolution? Among the stakeholders, who are most powerful in MNH policy making in Kenya? Who has the greatest influence in the provision of CEmOC? Participation in MNH service planning and delivery – who participates and why?
4	Accountability	Understanding roles and responsibilities among key stakeholders in the health system since devolution. Any consequences on lack of role clarity? Do any complaint mechanisms exist? Do people feel empowered to use them? Why or why not? What are the measures of performance and non-performance? What are the rewards for those performing well and repercussions for those performing poorly? What have been the accountability successes? What are the challenges? How might accountability challenges affect the provision of MNH services and why? What can be done to improve accountability?
5	Responsiveness	What are the challenges in responding to the main health priorities in MNH? To respond to CEmOC service provision? How can they be improved?
6	Equity	What are the differences in access to care by residence, income, gender, ethnicity, religion and others? Whether devolution has affected equity and responsiveness of the health care? Which population groups are using MNH and EmOC services? Any policies in place to ensure fair access of MNH services?

Adapted from: Siddiqi et al. (2009) and Baez Carmago and Jacobs (2011)

To address research question 3, "Are there any differences in governance between fully functional and not fully functional health facilities?", a specific theory (North, 1990) was used to provide a way of interpreting the findings. Three constructs of the theory: institutional arrangements; enforcement mechanisms; and incentives and motivation have been used. The primary purpose of using the theory in analysing research question 3 was to generate meaning in the data but without relying heavily on the theory. As described in the literature review chapter (Chapter 3), governance is composed of the structures of government and healthcare organisations as well as the ways that the rules (both formal and informal) are enforced, monitored and changed. The theories from the new institutional economics have been increasingly used in governance research. Chapter 3 provides the examples of studies which assess governance using the new institutional economics approach.

Figure 13 illustrates the theoretical framework used to analyse the data collected for research question 3. The figure shows three constructs of the theory combined for use as a framework for analysis and illustrates the relationship among them. The following text describes in more detail of these constructs and how they operate in relation to governance.

Figure 13. Illustration of the theoretical framework



Institutional arrangements: North defined institutions as "the rules of the game" and organisations as "the players of the game". Institutions consist of formal rules (political or legal rules such as constitutions, contracts and property rights) and informal rules (such as code of conduct, behavioural norms and conventions). Organisations consist of groups of individuals with common objectives. North's principal argument is that the actions, decisions and relations of individuals within an organisation are both enabled and constrained by formal and informal rules that constitute the institutions. In this framework, health facilities (and health workers who work within them) are referred to as organisations while "institutional arrangements" are the configuration of the rules. In this study, there are institutional arrangements (rules) for six governance principles. They are the (formal and informal) rules for accountability, control of corruption, participation, the rule of law, responsiveness and equity.

Enforcement mechanisms: The rules are enforced by the mechanisms which ensure individual or organisations adhere to and abide by the interest of the institutions (North, 1990; Aoki, 2001). This can occur via self-enforcement such as common beliefs, reputation, kinship or via third party enforcement such as legal sanctions, contracts, rules, laws or policing (North, 1990).

Incentives and motivation: They are instrumental in achieving the organisational objectives. Individual health workers may have incentives to institute good governance if incentives are aligned to their objectives. North defines motivation as how an individual behaves in certain ways as one values the outcome of adopting a new behaviour. In this study, two forms of motivation are discussed: intrinsic motivation (health workers adhering to the principles of good governance as s/he values them) and extrinsic motivation (health workers' expectation of benefitting something by adhering to the principles of good governance).

4.3 Research design

A research design is the planned process of a research study which includes a set of guidelines connected to philosophical paradigms, research methodologies and methods for data collection (Denzin and Lincoln, 2000) (**Figure 12**). The research design provides an action plan of how the researcher will proceed from research questions to the findings. Research design emphasises the product of research while the research methodology focuses on the research process, the methods used to collect data and tools and procedures to achieve the research objectives (Creswell, 2013).

This study used a **qualitative research approach** as the research begins with assumptions and use of theoretical frameworks to inform the research objectives and phenomenon under study. Using a qualitative research design, the data was collected and analysed using both inductive and deductive approaches (Creswell, 2013: 44). Hence, the research report includes the voices and views of study participants, the position of the researcher together with the interpretation of the research findings in relation to relevant theory and its contributions to the literature.

Qualitative research explores and understands the meaning of individuals or groups attached to the phenomena being studied within a social process. The research involves data collected from the participants' settings while the researcher interprets the findings based on the data collected, focussing on individual meaning and highlighting the situation. Qualitative data is textual and non-numerical data which tries to capture the lived experience of participants (Denzin and Lincoln, 2011). The major characteristics are induction, hypothesis generation, subjectivity, the researcher being the primary instrument of data collection and qualitative analysis (Johnson and Onwuegbuzie, 2004). This research approach uses a flexible, emergent design in which stages of data collection and analysis are conducted concurrently (Morgan,

2014). This research approach is also known for the researcher being close to the data and usually being the "research instrument" throughout the research process.

In this study, qualitative research methodology is used to gather a deeper understanding and perception of individuals as well as the context influencing health system governance in Kenya. By using qualitative research methods, it is feasible to explore factors influencing health systems governance at three different levels of the health system and the perspectives of key stakeholders on governance.

Therefore, this study employed a "context-sensitive design": qualitative research method for exploring the situation of governance and "capturing local wisdom" from the study participants (Berwick, 2008). Governance of the health system in Kenya requires a greater understanding of the nature of the issue and hence, open and generative nature of qualitative methods allowed the exploration of health system governance in Kenya. The study requires participants' knowledge and views on governance which may be related to their positions within the health system context in Kenya. Using qualitative research methods such as face-to-face interviews using carefully framed and responsive questions help the participants uncover and relay the intricacy of their responses and views (Ritchie et al., 2013). **Table 8** illustrates key features of the study design highlighting the strengths and weaknesses of the research design.

Table 8: Key features of the study design

Features	
Content area and field of study	Health systems governance in Kenya
Philosophical paradigm	Constructivism
Conceptual frameworks	A framework developed by adapting the frameworks of Siddiqi et al. (2009) and Baez Carmago and Jacobs (2011)
Relevant theory	Institutional analysis theory of North (1990)
Research methods	Qualitative research method: semi-structured interviews with key informants, document review, systematic review and analysis of secondary data
Strengths and limitations	-Inductive (governance data emerges from interviews) -Deductive (use of a conceptual framework to assess governance and relevant theory) -Subjective (perspectives and interpretation of the researcher and participants) -Contextual (detailed understanding of Kenyan health system governance)

By employing the proposed research design, governance data can be emerged from interviews (inductive). On the other hand, the use of the conceptual framework and relevant theories allows for deductive analysis in guiding the diffuse concept of governance.

4.4 Study methods and procedures

The following section presents how the qualitative research methods have been employed to answer specific research objectives. **Table 9** provides an overview of the study design matrix (Maxwell, 2012), reporting the type of research methods used in each chapter of the thesis as well as the sampling and analysis methods employed.

Table 9: Research design matrix

Thesis chapter	Research methods used	Sources of information and sample	Analysis employed
Chapter 2 (Background)	-Document review	-32 documents	-Descriptive analysis of the study settings
Chapter 3 (Literature review)	-Systematic review	-39 documents	-Theory driven approach to literature review
Chapter 5 (Factors influencing governance of the health system in Kenya)	-Key informant interviews at three health system levels -Document review	-39 key informants from national, county and facility levels -32 documents	Thematic framework analysis
Chapter 6 (Perception of key stakeholders on health system governance)	-Key informant interviews at three health system levels	-39 key informants from national, county and facility levels	Thematic framework analysis
Chapter 7 (Governance between fully functional & not fully functional facilities)	-Secondary data analysis of MiH database -Key informant interviews at health facility level	-10 CEmOC level health facilities in six counties -19 key informants from 10 health facilities	Descriptive analysis of facility functionalities Directed content analysis of interview data

The Sections 4.4.1 to 4.4.3 describe the data collection and analysis methods used to collect primary data from key informants. Sections 4.4.4 and 4.4.5 explain the rationale and analyses used to review the documents and secondary data obtained from the Making it Happen programme.

4.4.1 Study population and sampling

The study used **stratified purposive sampling** (Ritchie et al., 2013) to first select facilities to include in the research and then to select individuals from the three main participant groups for this research. The sample was stratified according to the key characteristics of the participants and their level of involvement in the Kenyan health system. Participants were purposively selected mainly based on their job descriptions as they were employed in positions allowing them to provide useful insights into the research objectives. The first participant group represented health workers from the study facilities, the second group were key informants working in the health system at the county level, and the third group of participants, national level stakeholders, were also selected for interview based on purposeful sampling.

Purposeful sampling is also known as "criterion-based" sampling (Mason 2002; Patton, 2014) as sample participants are chosen for their characteristics based on the research questions. Although "purposeful" is the most commonly used term, LeCompte et al. (1993) suggested that the term "criterion-based" is more appropriate as all sampling is purposive to a certain degree (Ritchie et al., 2013). Two main characteristics of purposeful sampling are: 1) sample participants are chosen based on their relevance to the research questions, 2) enough diversity is considered to explore different characteristics (Ritchie et al., 2013). Since there is no straightforward sample calculation as in quantitative research, the precision and rigour of a qualitative research sample are defined by its ability to present salient characteristics (sometimes called symbolic representation) (Ritchie et al., 2013). The sample size was also determined by the **saturation** of information from the data collected. Teddlie and Tashakkori (2009) defined saturation as the additions of more participants does not result in new information that can be used in new theme development.

At the county level, the study was conducted in six counties (Nairobi, Machakos, Makueni, Kitui, Nakuru, Narok) from which the study facilities were selected. According to the WHO SARAM report (2013), these six counties had a total population of 9.7 million (approximately 22% of the country) and are served by 2066 health facilities, of which, 38% (784) are public health facilities. Basic socio-demographic and health information describing the participating counties have been described in Chapter 2 (Background) under Section 2.2.

Selection of study facilities

The sampling started with the purposeful selection of health facilities (district and county level hospitals) from the "Making it Happen" programme database described in Chapter 1, Section 1.2. Health facilities were selected based on their performance in relation to the nine key signal functions a CEmOC facility recommended by the UN (**Box 1**). The CEmOC signal functions consist of the life-saving treatments and procedures listed in the **Box 1** which must be available 24 hours a day, seven days a week. Global experts in maternal health identified emergency obstetric care as effective interventions in reducing maternal deaths as it is composed of life-saving interventions to prevent direct maternal complications (WHO et al., 2004; 2009). In order to provide emergency obstetric care, health facilities should have adequate medicines, supplies, equipment, infrastructure and trained healthcare providers. Hence, the UN's nine signal functions have been widely used as proxy indicators for functionality of facilities which are designated to provide CEmOC services.

Box 1. Signal functions of comprehensive emergency obstetric care (CEmOC) are defined as:

1) Administration of parenteral antibiotics
2) Administration of parenteral oxytocic drugs
3) Administration of parenteral anticonvulsants
4) Performance of manual removal of placenta
5) Performance of removal of retained products of conception (e.g. manual vacuum aspiration)
6) Performance of assisted vaginal delivery (e.g. ventouse delivery)
7) Newborn resuscitation with mask and bag
8) Performance of obstetric surgery (caesarian section)
9) Performance of blood transfusion

In this study, if a facility performed all designated nine signal functions of CEmOC, it was regarded as a 'fully functional' facility. Similarly, facilities performing less than nine signal functions belonged to the group of 'not fully functional' status. From this list, the study sampled at least one fully functional and one not fully functional facility from each county although this was not always feasible. Among the ten study facilities, six were not fully functional while four were fully functional. Hence, the study included total six counties with ten CEmOC level health facilities, instead of including all types of facilities within one county, imposing some limitations in providing an in-depth, county-specific information. **Table 10** illustrates the level of functionality for ten selected healthcare facilities providing CEmOC.

Table 10: Functionality status of health facilities included in the study

County	Facility name	SF1	SF2	SF3	SF4	SF5	SF6	SF7	SF8	SF9	Total SFs available
Nairobi	Hospital 1	1	1	1	1	0	0	1	1	1	7
	Hospital 2	1	1	1	1	1	1	1	1	1	9
Machakos	Hospital 1	1	1	1	1	1	0	1	1	1	8
Makueni	Hospital 1	1	1	1	1	1	0	1	1	1	8
Kitui	Hospital 1	1	1	1	1	1	1	1	1	1	9
	Hospital 2	1	1	1	1	1	1	1	1	1	9
Narok	Hospital 1	1	1	1	1	1	0	1	1	1	8
	Hospital 2	1	1	1	1	1	0	1	1	1	8
Nakuru	Hospital 1	1	1	1	1	1	0	1	1	1	8
	Hospital 2	1	1	1	1	1	1	1	1	1	9

Source: MiH database

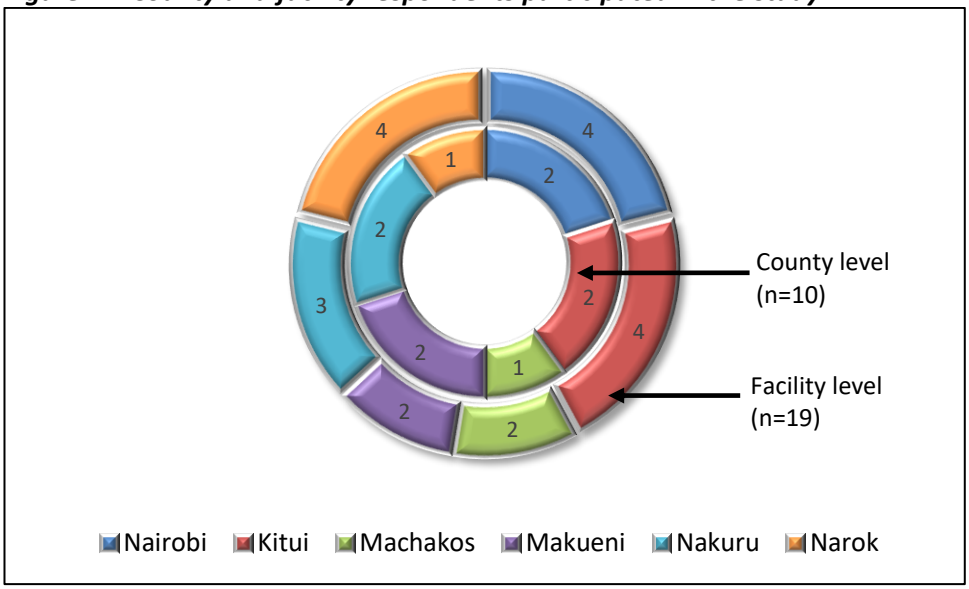
Legend: 1= Yes, 0 = No, SF= Signal function

Selection of participants for key informant interviews

Given that the focus of this study is the Kenyan health system, the inclusion of key stakeholders from each of the three levels of the Kenyan health system is important. "**Information rich**" individuals who could potentially answer the research questions best were intentionally selected (Patton, 1990). After identification of the facilities, key informants from each facility were selected including at least one Medical Superintendent or doctor-in-charge and one matron-in-charge from the maternity ward. These individuals were selected based on their job titles and positions as they could potentially provide useful information for this study.

Then, county level participants were selected from participating facilities which included Chief Officers for Health (COH) and county health management team under each COH's responsibilities, who were thought to be the individuals most likely to be able to share their experiences regarding health policy making and implementation within the newly devolved health system. Participants selected from the county health management team were county directors of health responsible for clinical services and medical superintendents of county hospitals as the director of clinical services falls under the remit of maternal health.

Figure 14. County and facility respondents participated in the study



At the national level, I was interested in interviewing those in a leadership position for planning or managing health services or directly involved in governance activities. The study included directors from three service areas: policy, planning and international health relations, reproductive health and curative and rehabilitative services as the director of curative and rehabilitative services falls under the remit of reproductive health. This study also sought to include representatives from multilateral and bilateral organisations who play a key role in health policymaking in Kenya. **Table 11** outlines the types of participants with their positions.

Table 11: Key informants who participated in the study

Health system level	Institutions	Positions	N=39
National (policy formulation)	Ministry of Health; multilateral and bilateral organisations	Senior directors and advisors	10
County (policy formulation/ implementation)	County Health Department	Chief Officer of Health County Director of Health	5 5
Facility (implementation)	Government health facilities providing comprehensive emergency obstetric care	Doctor in charge Nurse in charge	10 9

4.4.2 Data collection

There are four main types of qualitative data collection methods: interviews, focus groups, observation and document review (Curry et al., 2009). This study used semi-structured interviews with key informants.

Semi-structured interviews are interviews with a loose structure around topics and a series of open-ended questions. An interview is a research method in which the interviewer has one-to-one interaction with the interviewee to explore their perceptions and experiences in detail. Key informants are those with first-hand knowledge of the problem or issue being researched (health system governance), chosen for their experience and understanding.

Interviews are regarded as a powerful tool for data collection as they can provide an ample amount of information if the researcher can ask the respondents additional questions to clarify their responses during the conversation (Teddlie and Tashakkori, 2009). They are useful for exploring attitudes and other content of interest by allowing the interviewer to probe and obtain in-depth information. Interviews are very useful if there is no "power asymmetry" between the researcher and the participant such as fear or concerns about providing negative statements (Creswell, 2013). They can generate substantial amounts of information and are used for initial exploratory studies or gaining a better understanding of unfamiliar topics (Teddlie and Tashakkori, 2009). They are also useful for the conceptualization of new, potentially unfamiliar issues under study particularly if these are cross-cultural. Health systems governance is a relatively not a well-understood topic as the concept of governance is diffuse, all-encompassing, context specific and complex. Hence, the open and generative nature of qualitative interviews allowed the exploration of governance as this method did not "force" the participants to fit their answers into the researchers' questions. Instead, qualitative interviews allowed participants to express understandings explicitly. The interviewers also have the opportunity to further probe for more information allowing a deeper understanding of the topic.

4.4.2.1 Interview topic guide

This study used topic guide for key informant interviews which were based on the framework described in Section 4.2 of this chapter (conceptual framework). Topic guide was adjusted according to the characteristics of the participants and the level of the health system they were working (**Appendix 6**).

Pilot testing of the tools

Pilot testing of the topic guide was conducted with four non-participating respondents from Kenya in advance of field data collection. The participants in the pilot test represented two levels: national level policy makers and facility level policy implementers. The aim was to

adjust the topic guide as needed by modifying the questions. The pilot testing focussed on participants' understanding of the topic guides and content of the interview.

The pilot test results were recorded in order to revise the topic guide after each stage of the pilot. The initial topic guide was based on the framework developed for this study. During piloting, I noticed that explanations along with examples of governance terms were indispensable and often needed to be clarified during the discussion. For instance, questions relating "understanding roles and responsibilities, measures of performance and non-performance, existence and use of complaint mechanisms of the health service provision" were included under the accountability principle to use them as prompts when necessary. It was also noticed that some interview questions required rephrasing for facility level participants as participants seemed not to understand the questions.

The pilot tests served as a preparatory exercise and the results were used to revise the wording and sequencing of the questions. They also helped identify places where prompts and probes should be added. Prompts were used to direct the interviewee to talk about a specific aspect. Hence, the interviewee was given an example or a scenario to reflect on. Probes were also used to follow-up questions to elicit more information and the interviewee was asked to expand or explain to provide deeper information on what s/he has answered.

Most importantly, I could conduct one pilot test over Skype in the presence of one of my supervisors who observed the whole interview and provided feedback immediately afterwards.

4.4.2.2 Recruitment

The LSTM in-country research coordinator helped in identifying potential participants for the research through phone calls and other contacts. Once individuals were identified, the in-country research coordinator familiarised them with the study during a telephone call and shared the participant information sheet (**Appendix 7**) by email. Potential participants were given a week to consider the information and decide whether or not to participate in the research. For those who indicated their willingness, the in-country research coordinator arranged a convenient time and place for the interview. The participants also received the interview topics (**Appendix 8**) prior to the scheduled interview time. On the day of data collection, the researcher provided them with and explained the information sheet again. The researcher then sought consent and moved to the actual data collection. At the beginning of each interview, the participants were again asked to read the letter of consent,

check their willingness to participate and record it on the consent form (**Appendix 7**). Informed consent to audio record the interview was also obtained (see Section 4.7 on ethics below).

4.4.2.3 Conducting Key Informant Interviews

A total of 39 interviews were conducted with key informants from three levels of the Kenyan health system during two field trips. The first field trip took place in April 2015 when interviews were conducted with a total of 11 participants: six from the national level, two from county and three from facility. The second field trip conducted in September 2015 after an interval of five months in between the two trips, providing the opportunity to reflect and analyse the first batch of interviews including adjusting the topic guides. It provided enough time to develop and receive feedback from my supervisors on the initial analysis. It also allowed for the addition of some prompts and probing questions, removal of statements which might confuse the participants, replacement of some questions with specific examples. The description of the topic guide modification is in **Appendix 9**.

During the second trip, some of the interviews were conducted by a Kenyan research assistant who was employed as a field coordinator of an international non-government organisation. The research assistant received a one-day formalisation workshop on tools and refresher training on ethics followed by a mock interview with a non-participating respondent and one formal interview with a facility level participant in my presence. The research assistant conducted a total of nine interviews in two counties which were all audio recorded. He reported to me about progress on a daily basis and sent me interview recordings by uploading them on a shared drive and files were deleted after downloading. It provided me with the opportunity to listen to his interviews and provide him with feedback as to the areas where he should provide prompts and probes.

All interviews were conducted in English with an average duration of one hour. Depending on the availability and engagement of the participants, the duration of interviews took between 30 to 100 minutes. The interviewers ensured that both copies of the consent form handed out to the participants at the beginning of the interview were signed. One copy was given to participants while the other was kept in the research file in Liverpool.

During every interview, maximum effort was made to ensure that there was open and free dialogue. When time allowed, the notes were read back to the participants before closing the interview so that they could clarify or correct the points made. The study has kept a

record of recruitment outcomes noting agreement or refusal to participate (with brief reasons). In this way, the study could keep track of both the intended and recruited sample.

Throughout the data collection process, I kept a field memo (**Appendix 10**) to note down facts such as:

- The time, date and venue where the interview took place
- The setting in which the interview took place particularly certain significant situations such as participant's reaction and interruptions
- My feelings and reflections of the interviews
- The most significant features of the interviews
- Any modifications required to the topic guide or additional information that should be added to the topic guide

The field memos were organised in brief words and phrases in Microsoft Excel with the above observations in order. As May (2001) recommended, the field memo was guided by what was relevant to the study rather than used for documenting everything.

4.4.3 Data management and analysis

The study generated audio files, verbatim transcripts of the interviews, observational notes and field memos. In qualitative research, the analysis tends to start at the time of data collection (Ritchie et al., 2013), and this is the approach I followed so that I could reflect on the emerging data. For the data analysis, I followed a two-stage process: data management, and description and explanation (Ritchie et al., 2013). Data management consists of transcribing, familiarisation, coding and developing a thematic framework while description and explanation involve the use of charts and matrices to look across the data and interpretation. All interviews were audio-recorded and transcribed verbatim. Only one interviewee did not allow me to voice record, so I took notes to capture the content of the interview.

All transcribed interviews were cross-checked with the original audio recording to ensure accuracy and quality by the lead researcher (myself). Silverman (2006) proposed three commonly used approaches to analyse qualitative data: grounded theory, thematic analysis and framework analysis. This study uses a combination of **framework analysis** guided by Ritchie et al. (2013) and **thematic analysis** guided by Braun and Clarke (2006) to analyse data relevant to the research objectives 1 and 2. To analyse research objective 3, **directed content**

analysis of Hsieh & Shannon (2005) was used (Section 4.4.3.2) as the theory guided operational definitions of key themes.

4.4.3.1 Thematic analysis using the framework approach

Thematic analysis is suitable for this study as it is very relevant for applied policy research when the research question is well defined at the beginning. The approach is both inductive (concepts are identified from the data) and deductive (use of existing thematic framework-governance assessment framework). By using the thematic framework approach, the study could identify, analyse and report themes (patterns) within the data (Braun and Clarke, 2006). From the themes emerging from the data, the study could capture interesting meaning about the data relating to the research questions (Braun and Clarke, 2006). With this thematic analysis, the framework approach of Ritchie & Lewis (2013) was used to sort and display the data thematically (across the themes) and across cases (participants). The framework approach provided a transparent process for data analysis while retaining the context of participants' experiences. By using a framework, it was possible to reduce the amount of data in an organised and structured way. A matrix was created for each theme using Microsoft Excel, and each sub-theme was allocated a column and used to code data. Each participant was allocated a row in the matrix. **Appendix 11** describes an example of the framework.

Data management

The sampling strategy was also examined throughout the data collection phase to assess whether the types of participants interviewed could, in principle, provide enough information to answer the research objectives (or not). By doing so, this could highlight potential gaps in the data set and identify limitations in data coverage. This confirmed whether there was any need to conduct further data collection or not. The first step of the thematic analysis is to become familiar with the entire data set. This involved understanding the content of the transcripts, hear what was said, what seemed important to participants and how they expressed themselves.

During and after each data collection field trip, I familiarised myself with the data by listening to the recordings and noted down immediate thoughts regarding the recordings while waiting to receive the transcripts. The interviews were transcribed verbatim by a Kenyan research assistant. The coding process started after identification of the ideas from the data set. Initially, I tried to code for as many themes as possible in order not to miss out any

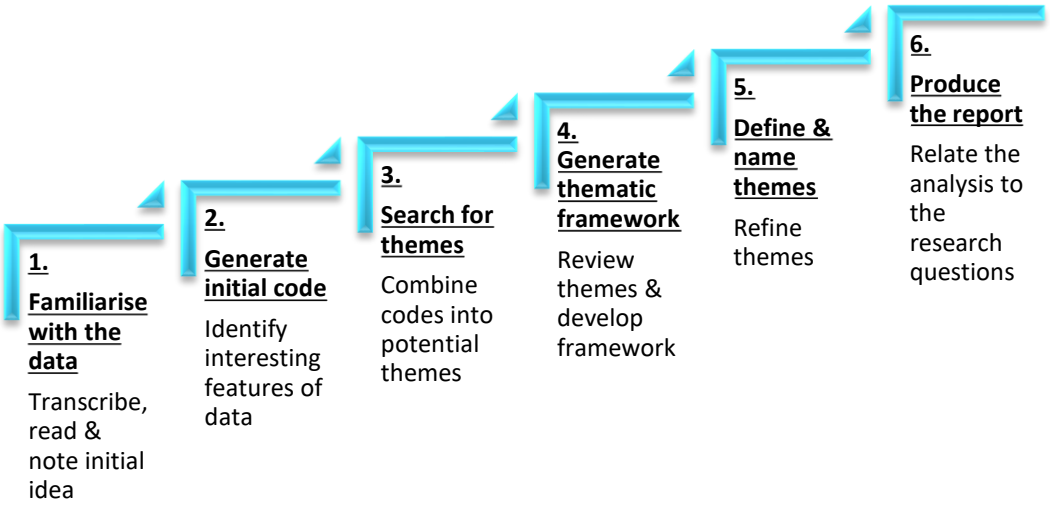
important information. The codes included data extracts from interviews either in phrases or sentences or paragraphs with surrounding text in order not to lose the context. The coding was done directly onto the printout of transcripts and by using post-it notes and later highlighting sections of text in the transcripts.

After a list of codes had been identified, codes that appeared to have a similar meaning or describe the same concepts were combined. From this initial grouping of codes, it was possible to construct a preliminary thematic framework to organise the data. The approach was inductive at the beginning and became deductive as the governance principles informed the data groups. The framework was revised from time to time after familiarisation with the data and identification of other important aspects.

After reviewing and refining the thematic framework, a final structure of themes and sub-themes was developed and applied to the entire dataset. During this stage, the validity of the entire series of themes was ensured, and there was an accurate representation of the data. This process continued until no additional codes and themes emerged from the entire data set. The themes were then defined and named with the description which could provide information on the scope and sense of the themes. Microsoft Excel was used to create a matrix for each main theme to display columns referring to the sub-themes and rows displaying the cases. **Appendix 11** provides a worked example of a matrix.

Each matrix provided a summary of all the data relating to a theme. This was used as a basis for writing up the description of each theme. The matrix was used to identify how frequently or strongly a view was expressed and any divergent views. The matrices also allowed constant comparison across participant groups to identify patterns in the data. The key steps of framework analysis (Braun & Clarke, 2006) used in this study are outlined in **Figure 15**.

Figure 15. Thematic analysis using the framework approach



Data description and explanation

During interpretation of the findings, the results were related back to the research objectives. For presenting findings, illustrative quotes were used to best represent the voices of the participants and allow for validity and transparency in the analysis. This study used three types of quotes described by Richardson (1990): "*short, eye-catching"* quotes; "*embedded quotes"*; and "*longer quotes"* to provide more complex understandings (Creswell, 2012: 219). Data was presented in visual maps generated from the Mind Genius® Business software to show the patterns (see Figures 18 to 27).

In explaining the findings, two approaches (implicit and explicit explanations) of Ritchie et al. (2013:393-395) were used. "Implicit explanations" (Ritchie et al., 2013: 395) were used to present most of the findings. That is, the explanations were constructed by the researcher, myself, by linking together the evidence stated by the participants. The categories were constructed based on the participants' accounts reflecting what had been reported. For instance, in Chapter 5, the themes "devolution" and "contextual factors" were implicit explanations constructed by the researcher. These were based on the accounts of participants who described the contexts involving the interplay of political and socioeconomic factors, devolution and dispositions of the Kenyan health system.

"Explicit explanations" (Ritchie et al., 2013: 393) were also used in this study. That is, the explanations based on the accounts given by the participants, accompanied by illustrative quotes, describing how the explanations have been reached. The example can be seen in

Chapter 6 (Section 6.6.1), where the explicit description was made on what the participants discussed about who participated.

4.4.3.2 Directed content analysis

In addition to using thematic analysis, "directed content analysis" (Hsieh & Shannon, 2005) was used to analyse data collected to answer research objective 3: to explore whether the status of health system governance differs with the functionality of health facilities. The use of new institutional economics theory described under Section 4.2 of this chapter has helped to identify key concepts for initial coding categories for research objective 3 as it is guided by a structured process using the theory (Hsieh & Shannon, 2005).

Despite the use of new institutional economics theory, the analysis ensured that the theory did not hinder the emergent themes which were pertinent to this study. In line with Maxwell (2012: 52), the analysis ensured to striking a balance between the insights provided by the theory and its limitations. By using the framework approach, the analysis allowed for inductive coding within the predetermined themes (deductive coding). Hence, although the theory was used to analyse the data for research objective 3, the analysis focussed on exploring and describing what was occurring in a given context alongside the established themes of institutional arrangements, enforcement mechanisms and incentives and motivation.

The theory provided the main themes (institutional arrangements, enforcement mechanisms, incentives and motivation) while codes were derived from the data reflecting the participants' accounts. As analysis progressed, sub-themes emerging from the data were coded inductively under the parent themes.

4.4.4 Analysis of secondary data

To answer Research Objective 3, this study analysed secondary data collected as part of the facility records under the Making it Happen programme. The findings from secondary data analysis are described in **Table 10** (Chapter 4), **Table 12** and **13** (Chapter 7). The data analysed were collected under the Making it Happen programme at one point in time, December 2014, 18 months after the health system was devolved from national to county governments. The primary aim of analysing secondary data was to purposely select health facilities which were designated to provide CEmOC. These included signal function availability, annual delivery rates, availability of maternity staff and medical equipment which were required to provide the nine signal functions. The functionality of health facility was not intended to give

statistically generalisable findings. Instead, it aimed to provide a descriptive view of facility functionality using nine UN signal functions as proxy measures.

4.4.5 Document review

Document review was also used in this study, particularly in Chapter 2 (Background) and Chapter 5 (Factors influencing governance of health system in Kenya). Document review was useful in Chapter 2 as it set the scene for the study, providing background information about the study setting in Kenya. For Chapter 5, document review was used to corroborate findings from key informant interviews particularly in portraying key contextual factors. This was an iterative process between interview data and document review as it aimed to clarify, confirm or justify the arguments of key informants, providing a holistic picture of the situation under discussion. The documents included policy reports and strategic papers from the MOH as well as peer-review publications. Some of the policy reports and strategic papers were received from key informants during and after interviews. Other documents were obtained through searching reference lists of relevant documents. The list of documents that were reviewed in this study is provided in **Appendix 14**.

4.4.6 Triangulation of the study results

The next step of this study involved triangulation of the study results, sources of data, data analysis and data interpretation. Triangulation refers to combining two or more methods or data sources or investigators in a single study to examine a phenomenon to validate the findings (Teddlie & Tashakkori, 2009). Triangulation is a process of collecting evidence from different sources to highlight a theme or perspective (Creswell, 2012). Triangulation reduces the risk of systematic bias and chance associations when using a specific method (Maxwell, 2012).

In this study, the information on governance was triangulated with different perspectives from three levels of key stakeholders in Kenya. It also involved triangulating the quantitative data (facility functionality) alongside the qualitative data on governance. This was particularly relevant for research objective 3 to assess whether the status of governance differs with the functionality of health facilities. In this way, the study could elucidate key issues and factors influencing governance in Kenya resulting in a more comprehensive understanding.

4.5 Research validity, transferability and reliability

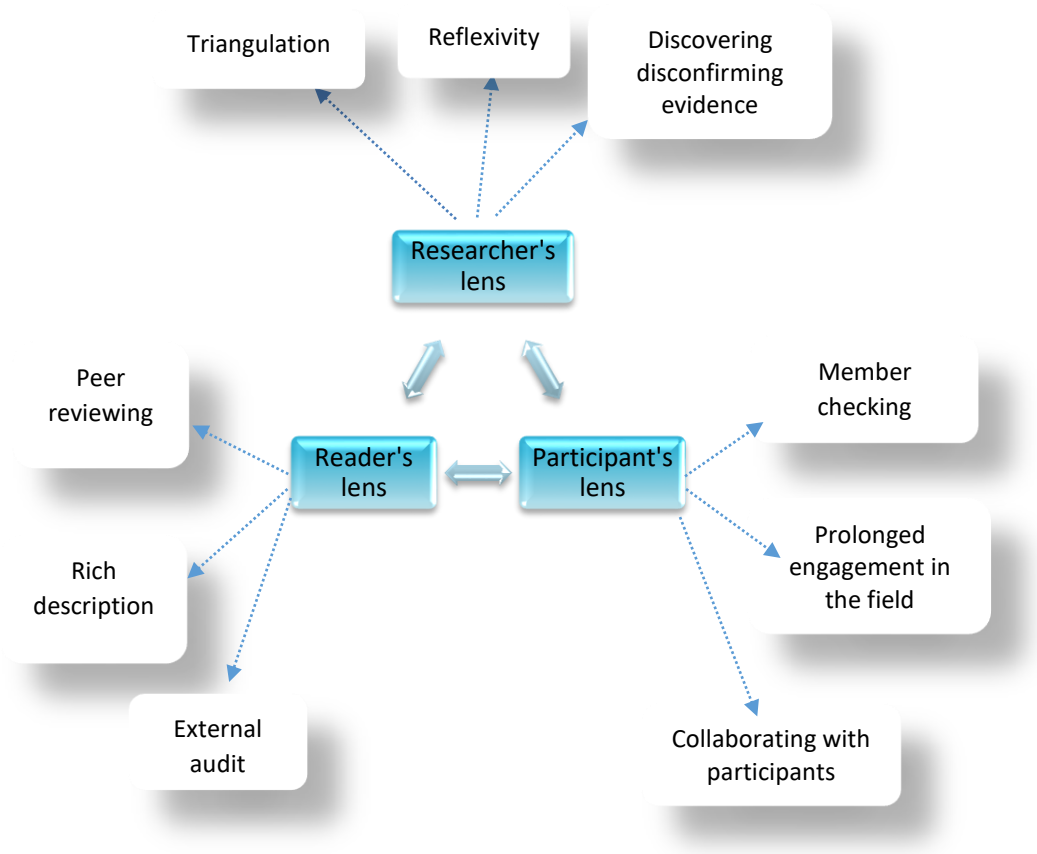
This section describes a reflection on the research design and methods used in this study referring to methodological concepts in qualitative research. In line with Pope and May (2006), this study ensured conducting a self-conscious research design and the research is systematic throughout the research process (conceptualization, data collection, data management, interpretation and reporting). This research considers the following three aspects to ensure a good research quality: validity, transferability and reliability.

4.5.1 Validity

Validity refers to the extent to which a finding is well-founded and reflects the accuracy of a phenomenon of a study (Ritchie et al., 2013). Validity is part of the research design which considers potential threats to the study and strategies to overcome them and assess if they are plausible in the actual research situation (Maxwell, 2012). Validity is also known as credibility or authenticity (Glasser and Strauss, 1967 cited in Ritchie et al., 2013). A research tool is valid if it measures what it is meant to measure. Thus, validity is traditionally understood as "correctness" or "precision" (Ritchie et al., 2013). Qualitative researchers address validity threats after the research has begun (Maxwell, 2012).

Creswell and Miller (2000) believe that "validity refers not to the data but to the inferences drawn from them". Creswell (2017) recommends that qualitative researchers should engage at least two of the following nine strategies from three different lenses (researcher's lens, participants' lens and reader's lens) to improve the validity of their study. They are 1) triangulation, 2) clarifying research bias, 3) discovering disconfirming evidence, 4) member checking, 5) having a prolonged engagement in the field, 6) collaborating with participants, 7) external audits, 8) providing a rich description and 9) peer-review or debriefing of the research process. (**Figure 16**).

Figure 16: Creswell's strategies to improve the validity of a research study (2017)



In this study, five strategies were employed to maximise the validity of the research. The following section describes how these strategies were employed to minimise the validity threats from three different lenses.

4.5.1.1 Researcher's lens

Triangulation: The information collected was triangulated with data from three groups of key stakeholders (national, county and facility participants), documents and reports. This was useful for opposing or contradicting information as I could identify how different findings corroborate different opinions. This has been described in Section 4.4.4.

Clarifying researcher's bias or reflexivity: The researcher discloses her own position, theoretical standpoint and experiences since the outset of the study. These include her personal and professional characteristics such as education, social and professional backgrounds. This has been described in details in Section 4.6 (positionality and reflexivity).

Discovering disconfirming evidence: Throughout the research process, all evidence was given equal attention considering both positive and negative cases. During reporting, both cases were highlighted to ensure that different perspectives were incorporated.

4.5.1.2 Participants' lens

Member checking: The researchers validated participants' interpretations during or after completion of each interview to minimise the researcher's bias or errors. If necessary, the participants were asked to provide specific examples to make the right interpretation of a situation. This approach was indispensable in this research as governance is conceptual and principles of governance can sometimes be difficult to understand. Therefore, researchers have asked for specific case examples after participants' explanation where relevant.

4.5.1.3 Reader's lens

Rich description: During reporting, a rich description of the findings was provided so that the readers can decide on the "transferability" of findings (Creswell, 2017: 263). A clear and transparent description of the research process such as data collection, data management and analysis is also ensured. For instance, in describing a case, the rich description was provided with illustrative quotes where relevant.

4.5.2 Transferability (external validity)

Transferability is the equivalent of "external validity" or "generalisation" or whether the findings are transferable to other settings beyond the context in which the study was conducted (Ritchie et al., 2013: 348-353). Among three types of generalisation proposed by Ritchie et al. (2013), representational, inferential and theoretical generalisation, inferential generalisation is relevant to this study. Indeed, the findings of governance from this study can be inferred to other contexts beyond Kenya (inferential generalisation) as this thesis report sufficiently presents the reader to judge whether the findings are applicable in similar low-and middle-income settings.

4.5.3 Reliability/dependability

Reliability is generally related to "dependability" or "trustworthiness", the extent to which all methods and decisions are documented in the audit trail. In line with Braun and Clarke (2013: 279), traditional quantitative approaches to reliability will not be useful for judging the reliability of qualitative research. Therefore, the following four aspects of reliability are considered for "dependability" or "trustworthiness" of the study particularly regarding

methods of data collection and analysis: appropriate sampling, reliable data collection, systematic analysis and reliable interpretation.

4.5.3.1 Is the sample symbolically representative of the target population?

The study has used stratified purposeful sampling to ensure that the sample symbolically represents the target population. The sampling process has been described in details in Section 4.4.1.

4.5.3.2 Was the field work carried out consistently?

This study used semi-structured interviews with a topic guide comprising a list of open-ended questions on issues relevant to the topic. The topic guide also included prompts and probing questions where relevant. By using appropriate prompts, researchers could direct the interviewee to discuss specific aspects by giving an example to reflect on. By employing appropriate probes, researchers could follow up on what the participant has said, why and how. This allowed the researchers to encourage interview participants to illustrate with specific case examples rather than general description. The researchers could also check whether the responses were providing standard responses or not. For example, when a facility participant described embezzlement, they were asked to provide specific examples or case stories of particular incidence.

By using a semi-structured interview guide, consistency in data collection (questioning, emphasis, potential reaction and interview timing) could be maintained although there were two interviewers. The researchers also tried their best to be as facilitative as possible to avoid the influence of their presence during the interviews. The researchers ensured the participants were comfortable and honest in answering the questions by assuring their anonymity and confidentiality. Researchers also explained to the participants that they were outsiders and could not influence their career paths. Interviews were conducted in the absence of their managers or head of departments. There was also a research diary throughout the research process, and the researcher reflected her position from time to time. The researcher's perceptions were noted in filed memos reflecting the interviews conducted particularly on what she learnt regarding the guiding questions and the responses obtained. Bowling (2002) recommends pilot testing of the tools before embarking on the study to examine practicability, reliability and validity of the tools.

The topic guide for this research was based on the framework which was adapted from the already validated frameworks of Siddiqi et al. (2009) and Baez Carmago and Jacobs (2011)

(Chapter 3. Literature review). Both frameworks have been applied in low-and middle-income countries, e.g. Pakistan, India, Nepal, Ethiopia, Nigeria, Uganda, South Africa (for Siddiqi et al., 2009) and Uganda (Baez Carmago & Jacobs, 2011). The institutional analysis of Douglass North (1990) was used as the theoretical framework of research objective 3 (to explore whether the status of governance differs with the functionality of health facilities). Bertone & Meessen (2013) have applied the concept of institutional analysis to evaluate the implementation of Performance Based Financing in Burundi.

Nevertheless, the frameworks used in this study were also piloted with non-participating respondents. The progress in developing different versions of the interview topic guides were documented throughout the process. Replicability of the applied policy research to wider context is an important aspect of reliability (Lewis et al., 2013). In this study, efforts have been made to ensure that data were rigorously and consistently interpreted and inferable to the wider context of the study.

4.5.3.3 Was the analysis carried out systematically and comprehensively?

Silverman (2006) recommends six approaches to address the reliability of a study using qualitative methods: 1) a tape recording of field notes; 2) transcription of the recordings; 3) coding by research staff who were blinded to the study; 4) analysis conducted by research staff who were blinded to the study; 5) using computer-assisted programme for transcripts and analysis and 6) inter-coder agreement. Of these six strategies, this study engaged in two strategies: tape recording and transcription to maximise the reliability of the study. Detailed description of the analysis can be found in Section 4.4.3.

4.5.3.4 Does evidence support the interpretation?

The study used a transparent approach to analysis with a rich description of data. Relevant quotes are used in the appropriate places and described in the previous section under validity (Section 4.5.1).

4.6 Positionality and Reflexivity

4.6.1 Positionality

This study uses qualitative research methods thus it is important to be aware of the presence of subjectivity as it is not possible to be entirely objective in qualitative research (Ahern, 1999). Therefore, I actively reflected on my own stance and how my personal and

professional backgrounds may affect the research process. The following section describes the issues relevant to "positionality" of myself as a researcher in this study.

I am external to the Kenyan health system, and it was crucial to understand subtleties in cross-cultural research (Kvale, 2008: 68). Therefore, I have taken the "emic" approach which allowed me to understand the participants' perspective inductively from their accounts and setting get aside my own assumptions and underlying theories (O'Reilly and Kiyimba, 2015: 5). I might not have a good understanding of the local culture and how things happen in the political and socioeconomic environment in Kenya. However, efforts have been made to conform to expected social protocols of Kenya by using appropriate means of communication and by demonstrating respectful manners. Being a "new face" to Kenya, it was difficult to gain access to potential participants, and I was required to obtain official permission to approach certain key informants. I had to work through various gatekeepers to obtain access to the participants. For instance, some county officials could be approached only through their focal reproductive health coordinators while other county officials responded directly. However, through the in-country research coordinator from the "Making it Happen" programme, some of the potential participants were identified and contacted before I travelled to Kenya. I was also fortunate to interview a participant from a multilateral organisation who provided me with an updated contact list of international organisations which played essential roles in the Kenyan health sector especially regarding governance. Indeed, this reduced the time taken to look for contacts of potential participants from multilateral and bilateral organisations.

There are several advantages of being an outsider of the system under study as the participants are in an "expert" position while the researcher, myself, is "ignorant" of the situation (Berger, 2015). This situation prevents my potential, subjective interpretation of the Kenyan health system as I could not impose my experience on participants and could not create the potential for bias. This has also made interview participants comfortable participating in the study as I was not part of their system and I had nothing to do with the progress of their career pathways. This study also benefited from the presence of my department in the country to gain access to the right participants for the study. Our department is a registered charity in Kenya, operating with approximately ten in-country staff based in Nairobi. However, I strictly adhered to research ethics, neutrality and academic integrity throughout the whole process. I have made it clear that I was not part of their health system. To address my limited understanding of the health system, culture and politics in

Kenya, I have been interacting with different health policy makers and implementers from Kenya and sub-Saharan African settings so that I could make sense of the data collected.

I obtained my undergraduate degree from a medical university in a similar resource constrained setting. This has helped me to understand how to approach gatekeepers and potential participants. Before my doctoral study, I also worked in different low-and middle-income countries including sub-Saharan Africa. Thus, I am familiar with different health systems and governance. All my experiences in health systems and governance have been embedded within this doctoral study (see details under Reflexivity). I am also conscious of my own beliefs and principles such as the health needs of a population cannot be met without strengthening the governance of a health system together with the political will to do so.

During the interviews, I found myself, involuntarily, recounting my own professional experiences in public health systems. I believe that this has helped me in discussion with the interview participants to solicit meaningful responses rather than to be simply presented as a "post-graduate student".

4.6.2 Reflexivity

Reflexivity is also known as "self-appraisal" in qualitative research (Berger, 2015). Reflexivity helps the researcher to recognise their own situation within the study and its relevant impact on the research process from developing research objectives to accessing and recruitment of study participants, data collection and interpretation. Reflexivity is an "active acknowledgement" in which the researcher recognises their own situation and actions upon the meaning and context of the research process (Horsburgh, 2003). Reflexivity is crucial in qualitative research as it shapes the nature of the research in three main ways: access to the "field", the nature of "researcher-researched relationship" and the researcher's interpretations (Berger, 2015). The section below reflects the research itself followed by a more personal reflection on my role as a researcher in the generation, analysis and interpretation of data.

4.6.2.1 A reflection on the research itself

This section describes some practical reflections related to the research process including participants' recruitment, making appointments for interviews and engagement with participants. In general, recruitment of participants was satisfactory as 39 out of 43 people shortlisted for interview participated in the study. One common reason for non-participation

was unavailability during the data collection period. Among non-participating individuals, one was from national level; two from county and one from health facility. The rest of the interviews were successfully conducted, although there were some unavoidable postponements. Indeed, it surpassed my expectations and overcame the anxiety which I had before the field work. I could collect quite a varied set of responses across the three levels of the health system; and inclusive of both multilateral and bilateral organisations.

In general, the study received a high level of interest and engagement from multilateral and bilateral organisations. Most of them were keen to see the results of this study as they perceived that governance has been instrumental in the development of the country. This study had to conduct one interview with a participant from a bilateral organisation over the phone as she could not attend a face-to-face interview. However, she felt obliged to participate after she cancelled two earlier appointments.

On the other hand, the experience with public sector participants from national level ranged from a participant hurrying me through the discussion to another participant who gave me adequate time for interviews, supplied me some useful policy reports and referred me to another potential participant who was not on my list. There was also one senior public sector official who did not allow me to record the conversation; instead, he allowed me adequate time to take notes.

Most of the county level participants were quite engaging, although most of the appointments could be made only after several phone calls either directly or through county reproductive health coordinators. The study conducted a total of 10 interviews with officials from county health departments, of which, one interview was not very productive. The participant was reluctant to express his opinion and hence, asked for the presence of his reproductive health coordinator (a subordinate officer to him) during the interview and asked her to answer some questions on his behalf.

Among facility level participants, there were quite noticeable differences in participation levels. Some openly expressed their views, as they perceived the interviews as an opportunity to present their critical voices, while others were more reserved in sharing information. In extreme cases, facility level participants from one county disclosed their frustrations and dissatisfaction directed to their county government. Interestingly, this happened in facilities where the research assistant conducted the interviews.

I did not perceive any differences in the level of engagement due to participants' positions within a health facility, as this study received insightful information from all cadres. One common observation was that among the 19 facility level participants, those holding senior management positions (such as a medical superintendent) provided information from both a health system perspective and an operational perspective, in contrast to mid-level cadres who discussed operational aspects with a greater focus. This might be due to that the mid-level cadres may have less opportunities or experience with independent thinking and problem-solving in their jobs which made it difficult to conceptualise answers to less concrete questions.

4.6.2.2 A personal reflection on my role as researcher

This section describes a more personal reflection on my role as researcher. This includes my own theoretical starting point and how that shaped and changed over time; awareness of the social setting of the research and my interactions with participants; the broader sociopolitical context and how these shaped the data collection, analysis and interpretation.

Before conducting this research, I viewed governance as a concept linked to international development. I may have been influenced by my profession as a medical doctor with several years of experience in public health. However, the feedback from the peer reviewers of my literature review enlightened my thinking on governance (Chapter 3). I realised that it might be beneficial to explore governance not only from the standpoint of international development but different disciplinary perspectives. Political science, new institutional economics and international development have all shaped the concept of governance and how it is interpreted in health systems research. Hence, the review shaped this study, particularly to consider governance from cross-disciplinary perspectives.

Field data collection started with interviewing participants from the central level, especially during the first round of data collection. During the first round of interviews, a total 11 interviews were conducted, two of which were at the county level and three at the facility. Although I was coming to the interviews with the experience of interviewing participants from a similar background within the African context, I was uncertain about the best way to frame my questions. Although I had pilot tested the topic guide, I was still anxious about how the first interviews would go. Specifically, I found it a bit difficult to frame the interview questions for facility level participants at the beginning of the process. I believe that the first few interviews could have been better conducted and I note that I gained better insight and

feedback as the interviews progressed. I then became quite familiar with the main issues and could lead the questions to those areas of interest.

I had an opportunity to analyse my data before my second field trip and draft some key themes which provided me with a chance to review and modify my topic guide. Indeed, I got better insights about the subject area and could add probes or reframe the questions to get the right information. My supervisor also reviewed my codes which allowed me an opportunity to reframe my thinking. Therefore, during my second field trip, I felt equipped to collect another batch of data. Also, I was fortunate to receive real-time feedback from my supervisor during the second round of data collection on how to rephrase the interview questions, particularly for facility level participants and areas to prompt and probe. Hence, during interviews, participants were encouraged to illustrate what they meant, not just mention or declare the principles of governance.

I found that reflexivity was very important in this study in order to be aware of the circumstances under which the research was conducted. Therefore, I have been regularly questioning my own stance and assumptions about how data was collected and analysed. I have kept a contemporary research diary throughout the study to record my thoughts and feelings. The way in which I approached this study was influenced by my own professional background, previous work experiences, my supervisors, peer reviewers of my PhD publications and the reaction of participants in Kenya.

4.7 Ethical considerations

This study received approval from the LSTM ethics review committee and the in-country ethical committee (the Kenyatta National Hospital-University of Nairobi Ethics Research Committee) (**Appendix 12 and 13**). All data collected were managed in accordance with the LSTM data policy.

Four key ethical principles were considered in this study: voluntarism, beneficence, privacy and confidentiality (Morse, 2007). The following section describes possible risks or harm of this study and how ethical principles were upheld.

4.7.1 What were possible risks or harm of this study?

The study clearly informed any potential participants that financial incentives would not be given for participating in the research so they would not have any immediate and direct benefit. It was anticipated that some participants might not be interested in the study as

there was no financial or other form of assistance offered to take part in the study. This was minimised by providing a clear explanation of the potential benefits of the study and explaining the lack of information to date.

It was anticipated that participants might have had problems in taking time off from work to participate in the study. To allow for this, all the interviews were arranged at a time convenient for the participant to ensure minimum disruption to their work routines. For every interview, the researchers ensured timeliness during the data collection. The participants were also given adequate notice and information before the interviews so that they had time to prepare.

4.7.2 Which ethical principles do I uphold in this study?

4.7.2.1 Voluntarism

An essential component of the ethical considerations of the study was ensuring that the research participants were not coerced but volunteered freely to participate. They were provided with adequate information to participate in the study.

This study made clear to the participants that the choice to participate depended solely on them. They could choose to withdraw from the study at any time during the research without any consequence to them. They could refuse to answer any questions they do not want to answer and still be part of the study.

This study used an informed consent form which included study information. This was developed to be easy to understand and included all required information about the research to make an informed decision. The participant information sheet included information on what the study was about, the study procedures and duration, what would be involved if they agreed to participate in the study and what would happen to the information collected. The information sheet stated that the participants were guaranteed certain rights and their rights were protected throughout the study process. The information sheet explained that the researcher intended to use some verbatim extracts from the interviews in the thesis report and publications in the form of anonymised quotes. The information sheet also advised potential participants that they had the right to withdraw from the study at any time without giving a reason. Contact details of the principal investigator and the two ethical review committees were included if participants had any concerns about the conduct of the research and if they did not want to contact the principal

investigator. Participants had the option to opt out of the audio recording by indicating this in the consent form.

At the beginning of each interview, participants were again given the information sheet and received the explanation from the researcher who sought their consent to move to the next step of actual data collection. Sufficient time was taken to explain the purpose of the interview and to obtain informed consent at the beginning of each interview. Participants were asked to read the letter of consent, check their willingness to participate and record that on the consent form. They were specifically asked for consent to audio record the interview. During interviews, the researchers focussed on the understanding and content of the interview as well as on the personal interactions during the interviews. The researchers have tried their best to use a facilitative approach in conducting interviews maturely and openly.

4.7.2.2 Beneficence (doing no harm)

Participants' discomfort during the discussion was also considered. Participants were informed that they did not have to answer any questions which they felt uncomfortable about or did not want to answer and they could stop the interview at any time. However, it was also explained that an open and honest discussion was expected regarding health system governance in their country, how key stakeholders perceive, practise and interact with good governance. There was no withdrawal or refusal during the interviews, and all interviews were conducted completely regardless of the busy participants' schedules.

4.7.2.3 Privacy and confidentiality

Maintaining confidentiality was another crucial ethical component considered in this study. This study has taken care to ensure that the data collected from research participants were appropriately protected. Research participants were assigned a code number so that data could be anonymised. After each interview, the voice recording was uploaded to a password protected laptop. Every recording was checked to ensure that they were audible the original recording was then deleted from the voice recorder. The interviews were stored on the laptop and not on a network or shared drive. The shared drive to which the research assistant uploaded recordings during his field trip was deleted on completion of data collection. The electronic files related to the participants were kept in a separate location from other research data with specific password-protected electronic devices. Any electronic files relating to the study were stored on one laptop which was backed up and protected from

computer viruses. Paper documents were kept in a locked storage cabinet restricting accessible only to the researcher. All recordings will be deleted from the laptop once the thesis is completed and approved by the University.

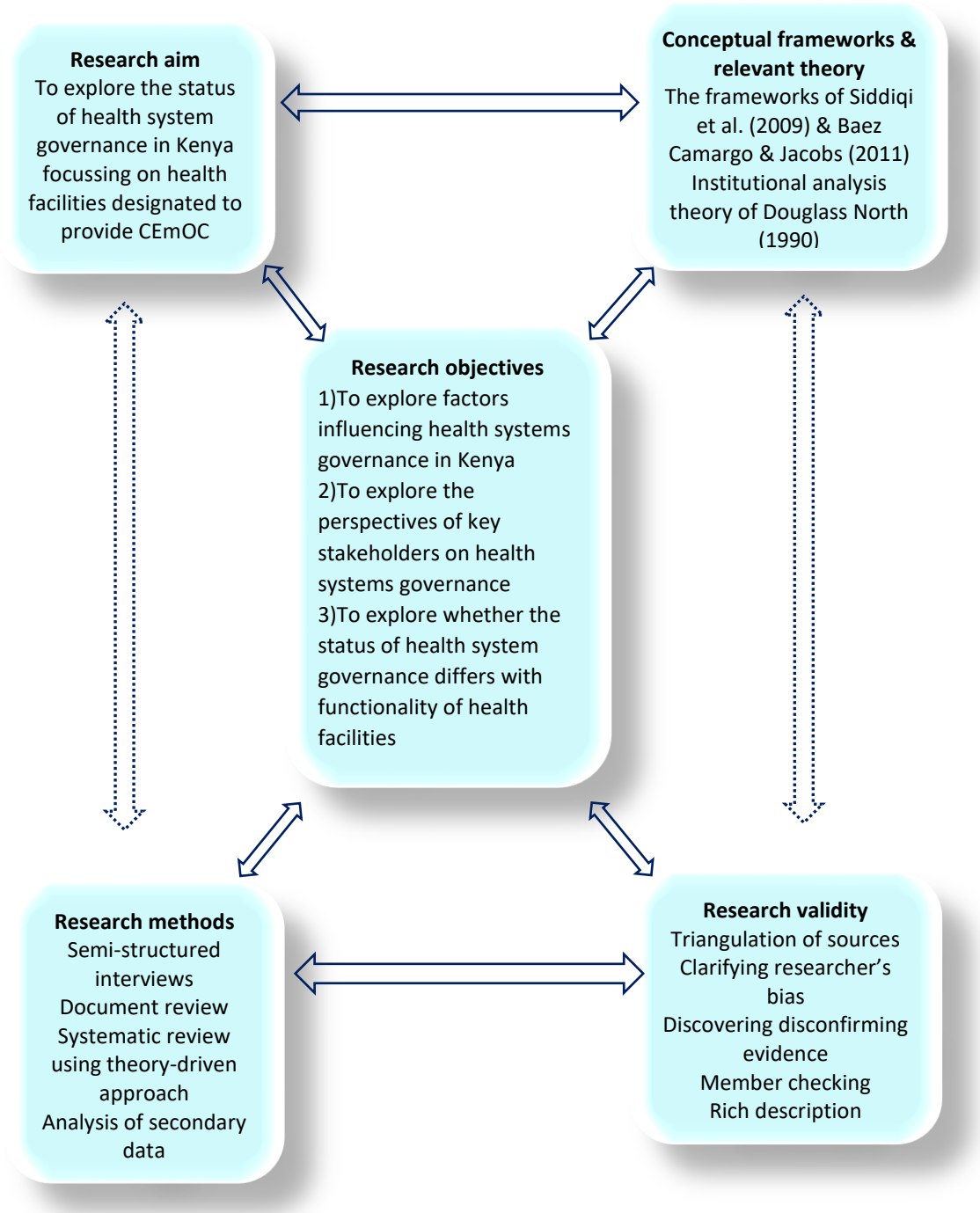
Sometimes researchers experience situations where they may have to breach confidentiality, and I thought this through before starting my study since it could touch on topics such as corruption or malpractice. I proposed plans to deal with these situations, although I did not, in the end, come across any in this study. If I became aware of unethical practices (e.g. corruption), I planned to act as an external person to the Kenyan health system. If I thought this was appropriate, I might encourage the participants to share the information with a relevant colleague by themselves, but I would not do so. If I became aware of serious unethical practices or corruption, I would first seek informed consent from the participant to seek advice from the senior members/supervisors of the research team. If this was not possible or it became necessary for me to share this knowledge with a third party, I would stop the interview at that time and immediately report to my supervisors. My supervisors would liaise and discuss any serious matters surrounding unethical or corrupt practices with the Chair (or other designated person) of the LSTM ethics committee and seek their advice. At no point, would I act as a whistle-blower.

4.8 Chapter Summary

This chapter describes the methodology that was applied in this study in detail and summarised in **Figure 17** which illustrates the interactive map of the research design adopted in this study. The research objectives were central to the research design as it connected to other components of the research and closely linked to the research aim. The research objectives guided the choice of conceptual frameworks and relevant theory suitable for this study. Hence, the upper triangle of the design map was conceptual (Maxwell, 2014) but crucial as the research objectives were informed by current knowledge and theory in governance which guided the researcher to make informed decisions when choosing the relevant conceptual frameworks and theory.

The bottom triangle of the design map was operational (Maxwell, 2014), guiding and help the researcher justify the choice of research methods for data collection. It also reminded the researcher to consider potential validity threats and the measures to mitigate them.

Figure 17: Design map of the research design



Adapted from Maxwell (2012)

CHAPTER 5

5. Factors influencing governance of the health system in Kenya

This chapter describes an interpretation of the context of health system governance in Kenya. The chapter aims to answer the first research question: Which factors influence health system governance in Kenya? The chapter seeks to describe the context reflecting the accounts of study participants and a further reflection of this account given the context in which they operate, by the researcher. Indeed, all interview participants were keen to describe the context including the interplay of political and socioeconomic factors, with special reference to the devolution and dispositions of the health system even though these were not directly inquired in the interview guide. Understanding the context is imperative in health system and policy research as it influences the process of policy development (Mirzoev et al., 2015; Walt et al., 2008). It is also imperative to interpret the findings on how stakeholders view health system governance (Chapter 6) and if and why governance differs between fully functional and not fully functional facilities (Chapter 7).

Hence, the chapter presents five key themes identified in the study based on participants' characterisations of the context which are identified through the thematic analysis approach laid out in Chapter 4 (Methodology). These themes were then interpretively analysed in view of data that described the context in which the study took place. The themes related to the contextual factors were generated from the interview data while the data on pertinent factors originated from policy documents and reports. In this regard, documents and reports mainly aim to triangulate and provide a contextual understanding of the participant's illustration. Key themes of the findings are presented in Figures 18-22 with different sub-themes portraying the context: how devolution presents opportunities for good governance; how devolution compromises the county health system; political; sociocultural and health system context.

5.1 Governance in the context of devolution

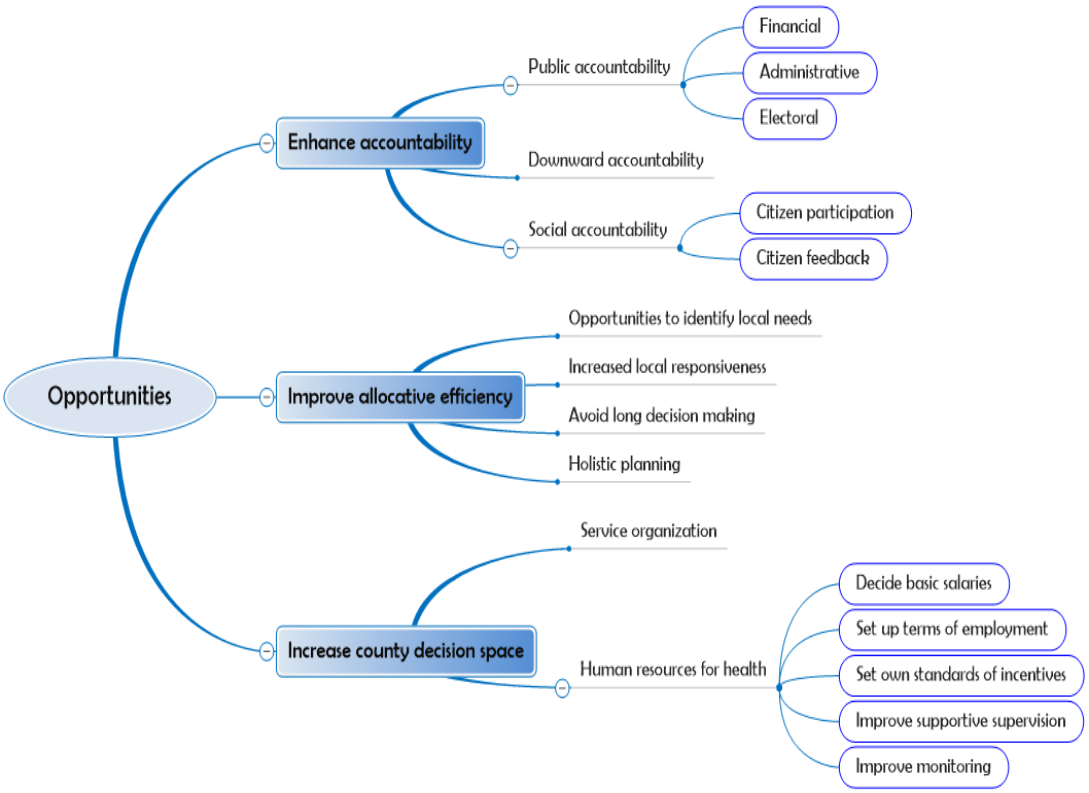
In August 2010, 67% of Kenyans voted in favour for a new Constitution. According to the new Constitution, administrative, political and financial functions have been devolved to the 47 counties. Health and agriculture were the first two public sectors to embrace devolution, with most decision making devolved to county level by 2015. The Constitution defines that

national government will no longer provide services but will continue to draft health policies, provide technical assistance to counties and manage national referral health facilities. Since 2010, devolution has been a much-debated topic among both healthcare workers and policy makers, and all interview participants were keen to discuss it. Based on the accounts of participants' descriptions, two specific areas have been identified: 1) devolution presents opportunities for good governance and; 2) devolution compromises the capacity of the health system at the county level.

5.1.1 Devolution presents opportunities for good governance

While the reasons of devolution in Kenya have been diverse, good governance through increased local accountability has been central to devolution as it enhances different forms of accountability. Devolution also improves allocative efficiency by bringing the functioning unit (county) closer to the community with faster decision making process. **Figure 18** illustrates these three key themes of how devolution presents opportunities for good governance.

Figure 18: Devolution presents opportunities for good governance



5.1.1.1 Enhanced different accountability mechanisms

Strengthening governance through improving local accountability mechanisms lies at the heart of devolution as evident from the findings below. From the perspective of national participants, devolution has **improved** both **bureaucratic** (administrative) and **financial accountability**. Bureaucratic accountability has improved as devolution provides more regular oversight than before and many governors gave health a very high priority resulting in increased availability of health workers including senior staff and specialists with "removal of the ghost workers". Others described how coordination between the national and county governments has improved since devolution, attributing this to improvements in the accountability structures with clarification and redefinition of roles.

National participants perceived that devolution promoted **financial accountability** as the current Constitution included a "Finance Act" providing an overarching framework. At the same time, they acknowledged that county governments had challenges to implementing this due to limited capacities and resources. There has been an improvement in accountability mechanisms as there are structures such as the County Management Authority (CMA) which is composed of community members. The community members form the board for financial accountability and now approve the budget. The following quote extracted from an interview with a national participant from a bilateral organisation illustrates this observation:

> *"To me, we have a better governance system than before because already the devolved structure provides for that. The CMAs are people at the very low level, who are chosen by the community. They represent the community. Now, these CMAs are the ones who approve the budget." (KI-4. A national participant from a bilateral organisation)*

The current election system is perceived as a form of a **public accountability** (Mitchell & Bossert, 2010) mechanism as county leaders would not be elected again if they were not fully accountable for their services during their term time. Accountability became more important than before as devolution allowed county governments to be independent. Therefore, county scorecards have been used as a tool to assess their accountability. The other accountability measure discussed by the participants was **downward accountability** within the bureaucracy. This is accountability of the county government and county department of health to health workers. In the absence of formal feedback mechanisms, the

use of social media has increased. For instance, health workers informally disclosed the unfair treatment of their county government on social media. The following dialogue with a participant from a multilateral organisation exemplifies this point.

> ***Interviewer:*** *How about for the facility staff, to complain back to their county government, are there any mechanisms in place?*
>
> ***Participant:*** *I don't think there is a formal, most of the time, we hear is people threatening to go on strike. But there are forums because there is structural governance because in each facility there is an in-charge, this in-charge is a member of the county health, and could be represented there. So there is a channel in which they can do this, but sometimes fear of reprimand and backlashes and right now people are very sensitive about complaining, especially if you complain much and if you do happen, people may read politics in you, or maybe you want to, so they tend to restrain if they do complain sometimes* ***they sometimes complain in social media*** *or* ***the media****. So the health workers sometimes complain through that… Some counties have opened the Facebook and twitter to get reports, or they have opened channels so that somebody can write, a few of them get addressed. A few of them, of course, get reprimanded or threatened, I think recently we are hearing of a threat from a CEC that is an equivalent of a minister at the county level threatening the staff, the chief officer, equivalent of a permanent secretary so to speak threatening health workers…So you see, and it went round in the social media. (KI-15, a national participant from a multilateral organisation).*

For county participants, **social accountability** (Mitchell & Bossert, 2010) mechanisms existed before devolution as management boards (hospital management board, health facility management committee, etc.) were in place at different levels of the health system although they needed to be strengthened when devolution was introduced. Nevertheless, county participants perceived that citizens were more knowledgeable than before and held the county government accountable.

5.1.1.2 Improve allocative efficiency

Participants from national and county levels were aware of the newly defined roles and responsibilities of the two levels of governments. They felt that devolution somehow provided opportunities for good governance as it created **opportunities to identify local**

needs and facilitate policy discussions among local government and populations. Devolution **reduced the previously long decision making** processes and provided opportunities for decision making and feedback mechanisms at lower (local) levels. Devolution increased opportunities for more efficient local decision making, by "*bringing the person closer to the decision making, closer to the action"*. In doing so, county participants believed this had **increased responsiveness to local needs**, needs that would be difficult to identify at the national government level. As indicated by a county official below:

> *"The government has come down to the people, and now we can serve them better, we can now even have personalised attention to the people other than when it was centralised. We can listen to the cries of the people and be able to respond very fast because we are on the ground." (KI-20, a county official)*

While county participants believed that devolution had improved allocative efficiency in managing resources, national participants also perceived that devolution **allowed county governors to think holistically** about health system improvement including non-health sector factors such as roads, infrastructure and communication. However, there was a different perspective from facility participants as they felt that devolution reduced the integration of services at a provincial level which was in place before devolution and information sharing at a sub-national level.

5.1.1.3 Increased county decision space

Greater county control over decisions has been a motivating factor for citizens to participate in local decision making processes. County governments received greater control over decision making in two key areas of the health system functions: 1) health service organisation and 2) HRH (See also Section 2.5.4). County participants observed that they received more decision space (Bossert, 1998) to **implement required health services programmes** within the national norms and standards than prior to devolution. The following illustrative quote from a county participant portrays the situation:

> *Since devolution, we were able to implement that very effectively. We are making our decision at this lower level, so it is not very hard for us. Because we get our own funds at the county level, we can do our own supervision in our own time frame." (KI-35, a county official)*

National participants confirmed this as the Constitution gave county governments "*a lot of clout*" to develop and implement health policies as they were "*like small Presidents of their own territory*".

Regarding **HRH**, county governments received a wide decision space as they had the discretion to recruit and employ staff. These included deciding on basic salaries and allowances within the national standards and setting up terms of employment (recruitment, appointment, transfer, promotion and termination). Counties could also set their own standards of incentives for performance by providing them opportunities for further studies. The following quote from a bilateral organisation participant exemplifies this point.

> *"County health management team was told to deal with that person, discipline cases and dismissal because the county now does hire and fire. So, if there is a health worker who is not performing, the county team can do that, or the board can come in and say this person is not working well, can you remove them?" (KI-4, a national participant from a bilateral organisation)*

While national and county participants described how devolution had impacted positively on the availability of services and performance of healthcare workers, facility participants also noted that devolution improved attention, supportive supervision and local monitoring. Because previously the national government did not have "*enough (capacity) to go around the country making sure they [the work] are done*" and "*governance is brought closer to the [functioning] units.*"

5.1.2 Devolution compromises the capacity of the county health system

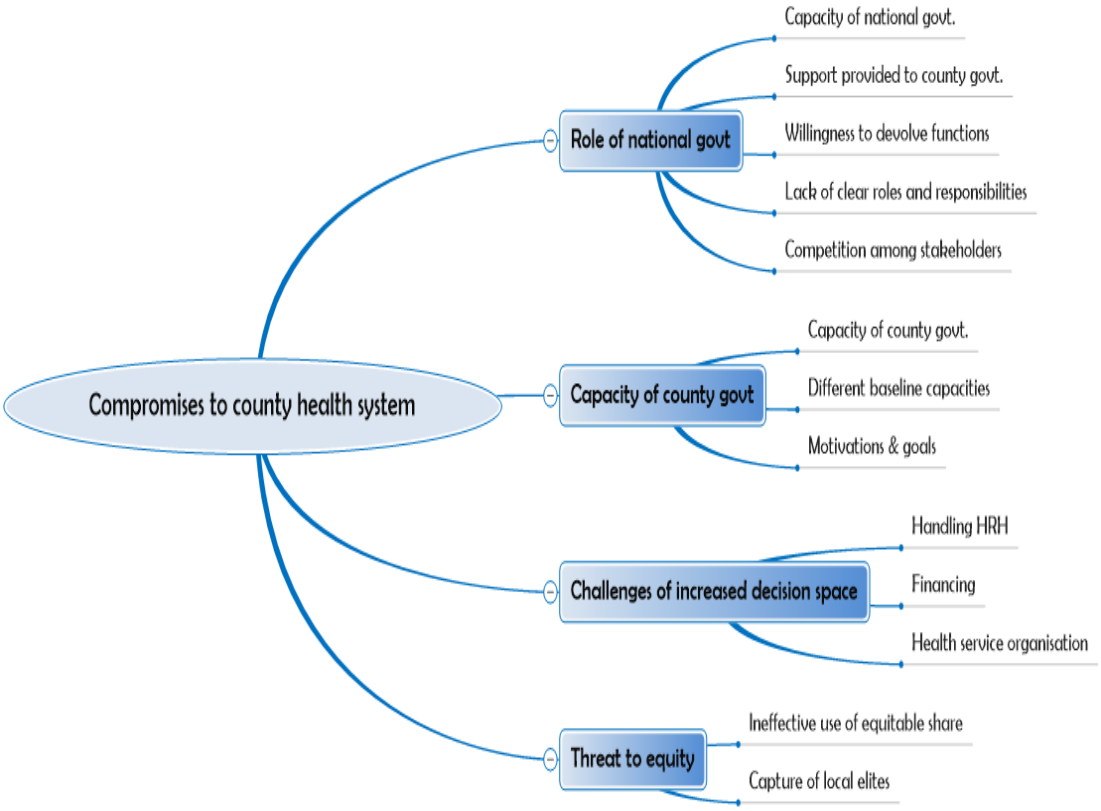
The previous section presented how participants perceived devolution as an opportunity for good governance. There is a consensus that the central authorities are best placed to oversee some public-sector functions such as health. This has been described by interview participants who provided examples of how devolution compromised the capacity of county government to deliver health services. (**Figure 19**).

During interviews, both national and facility participants described how devolution represented a "*big bang*" or a "*major shift*" in political terms. Facility participants thought that the country has "*rushed into devolution without having proper policies in place"*, and before assessing the capacities of both county and national governments to manage their new responsibilities. Others reiterated that devolution of the health sector "*was sudden*",

although it was supposed to "*happen in phases*" and this led to counties being ill-prepared. The process was hindered by the limited capacity of the national government to meet all the demands from different counties.

The following section describes the key sub-themes that emerged: the role of national government, the capacity of county government, challenges to increased decision space and a threat to equity.

Figure 19: Devolution compromises capacity of the county health system



5.1.2.1 Role of national government

There were gaps in supporting the counties particularly due to efficiency gaps within the health system. Facility participants felt that national government should maintain responsibility until counties were ready and the systems were in place so that counties in order to limit difficulties, for example, in handling health workers' payments. County participants perceived this as a lack of willingness from the central ministry to provide this support as they felt that the national government was "*used to the centralised system*" where they managed all the resources. County and facility participants perceived such situations as examples of the national government **not willing to devolve the functions** and

therefore not fulfilling their mandate. The following quotes from a county participant illustrate this point:

> *"…the Constitution is very clear in schedule two, it has listed what the things the county government will do are, and what are the things the national government will do, so everybody knows their mandate, but I think it is just the good will, the commitment and realising that… if you are used to a centralised system, where you have all the resources, where you are the one who calls all the shots, letting go is not always easy." (KI-26, a county official).*
>
> *"We think that it might be a calculated move by the national government to paint that the counties have failed in taken care of the health needs of the people so that the people are agitated. So when a referendum comes, they say counties cannot manage the health care for this country, then it is easier for people to vote back the health services back to the national government, so I think there is a lack of mutual good will from the two levels of government." (KI-26, a county official).*

The national government was criticised for not being more responsible and supportive to the county level governments. County participants felt that "*little capacity building [was] done by the national government*". A participant from a multilateral organisation perceived that prioritisation, resource management, standardising the norms across the country and leadership capacity of the national government were the key bottlenecks for the unavailability of services including those for emergency obstetric care. However, others noted that the national government themselves had limited **capacity to support the process of devolution**.

The other problem raised by facility participants was a **lack of clear roles and responsibilities** among key stakeholders. This undermined the process of devolution leading to tension and competition between the county and national governments.

There has not been adequate implementation rules and regulations to specify roles and responsibilities such as those for procurement of medicines and medical products. There have also been instances where there was de-concentration (the central level still controlled the decision) instead of devolution as the national government did not empower county administrative staff and did not create clear roles and responsibilities for county government units. Yet, the counties were held accountable when there was a problem.

5.1.2.2 Capacity of county government

County governments had variable **baseline capacities** and **historical developmental challenges** (See also Section 2.5.2), meaning some had more to develop than others before they were ready to manage services because "*some counties have been neglected for several decades*". Planning and financial management were critical administrative capacities that county governments required, and also, proper monitoring systems (programmatic and financial) needed to be in place.

National participants noted that some counties could manage to handle the responsibilities devolved from the national government while others struggled. There were county governments who were not exposed to handling large budgets. Thus they faced challenges in planning and absorbing these funds into the budget. This was also compromised by the situation as systems and structures were not in place.

All facility participants from a particular county wished to "*go back to the centralised health system*" as they felt the situation worsened after devolution. Some facility participants perceived that their county government did not understand their roles and hence it was difficult to discuss with the challenges health workers were facing, therefore *"the health system since devolution is confusion, a total confusion!"* The particular aspect which facility participants felt that "*there was no positive aspect at all*", was with regard to management of HRH and medical supplies though there were some "*visible, infrastructural improvements*" in some areas. The following quote from a facility participant illustrates this observation:

> *"For devolution, in terms of facilities and all that you tend to see some improvements, some slight improvements. But in terms of human resource, it is awful; there is no positive aspect of it at all. There is no positive aspect because I am yet to hear someone praising devolution for the human resource aspect of it." (KI-38, Health worker)*

Similarly, a national participant perceived infrastructural improvement as "*political*" since "*everyone was putting up infrastructures, [rather than] investing in the real needs"*. Additionally, these challenges were not believed to be entirely due to inadequate capacity of the county government but considered them due to **lack of will among county governments** to improve the situation. The following dialogue with a national participant from a multilateral organisation exemplifies this point. The participant believed that

although the county government had the discretion to discipline their health staff, it was not happening.

> ***Participant:*** *"We felt that devolution was an opportunity to manage their human resource for health better, because when it was centralized governance, it was very difficult to take action where health worker is misbehaving, beyond giving a disciplinary letter, there was very little you could do, all the actions were taken up at the central level. But now that function can be done at the county level, so we were hoping that it will make the performance of the health worker better, it is not quite happening."*
>
> ***Interviewer:*** *Why?*
>
> ***Participant:*** *For me, I feel I go back to capacity again and then the goodwill at the county level, you see there is a lot of tribalism, nepotism. (KI-14, a national participant from a multilateral organisation)*

5.1.2.3 Challenges of increased decision space

Under Section 5.1.2.1 of this chapter, how greater county control over decisions on two health system functions (HRH and health service organisation) presented opportunities for good governance was discussed. At the same time, participants discussed how these two areas of health system functions had been affected as a result of devolution with limited health financing.

Handling HRH was the biggest challenge for counties as they became responsible for managing the payroll within a given "resource envelope" set by the national government. Hence, any decision of the county on handling human resources was limited by the budget ceiling which the county government received. County participants shared their frustration regarding a pre-set budget ceiling which did not allow them to expand services because of a shortage of human resources. HRH files (information to manage HRH system) remained with the national government, even though counties were paying health workers' salaries. Although the national government handed this over to the county governments, they did not have the system and structure, causing delays in payment of health workers' salaries. Discrepancies in payroll between the national and county appointed staff also caused dissatisfaction among health workers. These factors led to frequent health workers' strikes

which disturbed health service provision compromising the trusting relationship between county government and health staff. The following quote from a county participant illustrates this point:

> *Recently, I went for a governor meeting in Mama Lucy. I found nurses there are about to go on strike ten days ago because they had not received their salaries, they congregated in the compound say, from today they are not working, so we have to call the county headquarters and find out from the human resource. As I came here, people had started going on strike. Mothers are lining up in MCH, nobody is seeing them. Now we were told salaries would be sent today to their accounts so that we talked to them and they said if you don't receive the salaries by the end of tomorrow, we are not coming to work. That is becoming a very big problem. If it is not streamlined, it will create a lot of challenges. So, we have human resource challenges whereby the delayed salaries and others being paid higher than the rest for the same job because of two parallel contract agreement and payroll." (KI-7, a county official)*

Some health workers disagreed with the decision to devolve payroll to the county level because they felt insecure about their jobs being managed by the counties. The following quote from a national level multilateral organisation participant illustrates this observation:

> *"It has been very complicated to roll out the devolution of the health sector moving out the whole thing from the national government to the counties...it has been tough because we had doctors refusing to be paid by the counties. Because they were not sure that the counties would be sustainable... The payroll is coming from the central government, so they were sure of the continuity...people fear change. They are not sure of what is going to happen." (KI-1, a national participant from a multilateral organisation)*

Nevertheless, the current Constitution granted a wide decision space to county governments to prioritise services and allocate **resources to finance devolved functions**. Counties had the discretion to determine the budget allocation for health. In each county, the County Executive Committee and County Department of Health were responsible for providing guidance and set the agenda for health service organisation and delivery in the county

(KHSSP, 2012). According to the 2010 Constitution, the national government set the Equitable Share to allocate national resources to counties (Republic of Kenya, 2010). However, this did not guarantee allocation of resources into the health sector as the share was not earmarked for a specific sector. As a result, the health sector had to compete for resources with other sectors. The following quote from a county participant exemplifies this observation:

> *"You cannot do more than the ceiling, so it has been a challenge to us. It gives as a limit because currently, we are operating at one-third our needs in terms of the healthcare service provider. We still have two-thirds to go, so that is a big gap… Actually, the Department of Health alone takes around 30% of the entire county budget, the health docket, at least 30% is allocated to health, and we have 10 departments, so that tells you that health is one of the major dockets that have been given priority." (KI-26, a county official)*

The 2010 Constitution also allowed counties to generate their own revenue in line with the national standards. As described in Chapter 2, the sources of revenue for most of the counties were channelled through the national government in the form of proportional grants with some local taxes. One of the main limitations of the budget ceiling which county governments faced was the inability to recruit more health staff. This bottleneck was perceived as limiting the expansion of services as per the needs. This was significant in counties with limited resources to generate their own revenue and hence relying solely on the national government. The following quote from a county participant illustrates this point:

> *"Because we generate about 5-7% of the total budget, is what the county generates within itself, that is what we sell a lot is sand, business permits within the county, parking fees, such things. But now taxes, we remit to the national government, now that is where the challenge is because all the taxes we remit nationally and get a few channels which we can be able to collect money within the county. Then we don't have major big towns, industrial zones such that are able to generate more revenue within the county, and also our county is semi -arid so the agriculture is limited and it slows down the growth." (KI-27, a county official)*

5.1.2.4 Threat to equity

Decentralisation was expected to have implications on health-related equity as it **depends on pre-existing socioeconomic contexts**. Participants described how the government has tried to reduce inequity in different counties as the government has set up an arrangement called "*equitable share"* which accounted for minimum 15% of the national government budget. However, due to inadequate resource generation by the county governments, the development budget has been allocated to pay health workers' salaries instead of the recurrent budget. With devolution, recruitment of human resources led by county governments ensured equal opportunities through the promotion of people from marginalised communities. However, in some counties, it was impossible to recruit health staff from the local communities due to their level of education. Some counties were quite disadvantaged in that they had difficulties in attracting and retaining health workers due to the poor socioeconomic situation and lack of health workers originating from their communities. Health workers working in the Maasai region stated that they "*didn't have a single Maasai doctor working in this county*". Hence, facility participants perceived that the MOH should take a leadership role and set standards to regulate facilities across counties as counties had different standards since devolution. The following quote from a health worker illustrates this point:

> *"We should standardise health, in terms of if a patient is to be seen in a level two facility. For instance, in Kirinyaga and they go to maybe Turkana they should get the same services. Because of devolution, different counties have put different measures to achieve their goals. If the minister of health which is the oversight ministry comes with regulations and policy to synchronise health, I think we will be in a better position." (KI-32, Health worker)*

The other challenge was "**capture of local elites**" as powerful elites or politicians wanted to interfere with the management of health workers within the county department of health. The following quote from a county participant exemplifies this observation:

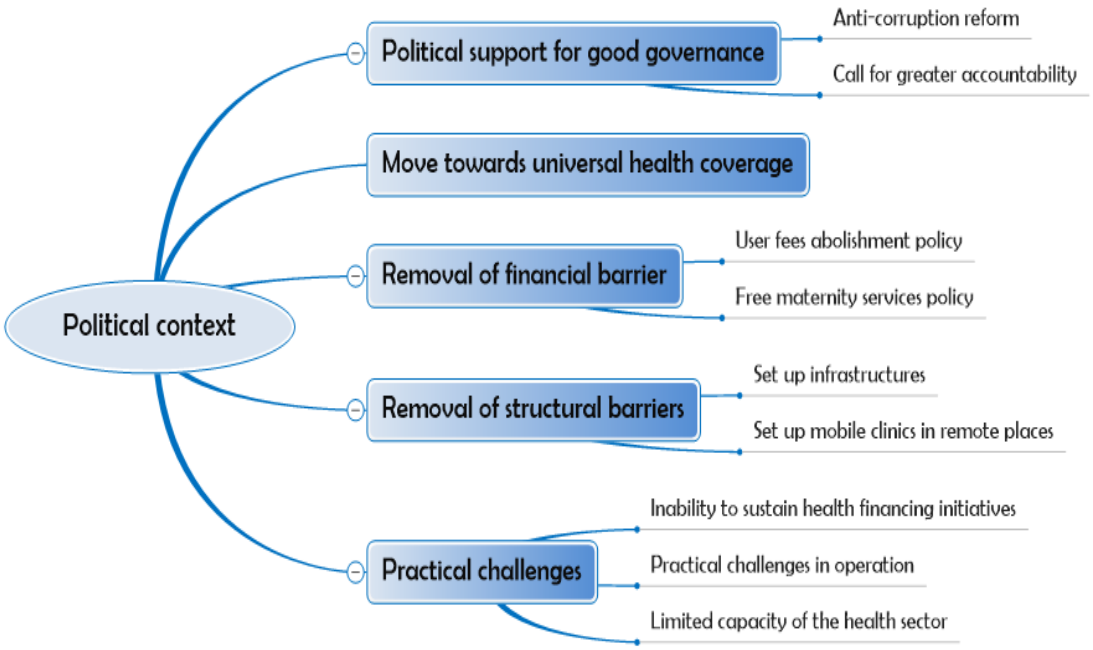
> *"The politicians sometimes they interfere because an elected leader will call me and tell me there is this patient, why wasn't this done. Don't you think you should have done it this way… Politicians would want you to do something different which might not be ethical; sometimes there is that interference… They have a lot of influence, like one time they called the governor and the governor called the local minister, so the local minister told us to say what happened, but everything was well written, there was no case of mismanagement." (KI-27, a county official)*

5.2 Context of governance

Contextual factors consistently influence the way health system govern and how key stakeholders interact. Hence, the following section describes macro, contextual factors (particularly political and sociocultural context) influencing the health system. **Figure 20** portrays current political context highlighting how it supports good governance with the move towards universal health coverage recounted by different level of interview participants from the study.

5.2.1 Political context

Figure 20: Political context



One national participant recalled how Kenya had experienced several political hurdles since independence; the one party political regime presented challenges to good governance including the collapse of public institutions. Since 2002, government elections have been held every five years. Participants from bilateral and multilateral organisations perceived that there was *"very good **political support**"* **to improve governance** of the country as the government, including high-level government officials, have initiated anti-corruption reforms and called for greater accountability. The President himself *"has taken a very strong stand*" against corruption, as illustrated by the report presented to Parliament implicating high officials in corruption cases.

Participants from different levels of the health system suggested that the current political environment also favours investment to improve maternal health within the country; for example, the Vision 2030 strategic planning document states that every Kenyan should have access to free, good quality healthcare services. Participants described how other policy statements appeared very supportive of the **move towards universal health coverage**: the government has prescribed two new health financing policies including one which abolishes user fees in public primary care facilities, and another which assures free maternity services in all public facilities regardless of the level of care. Along with this, there are other high-level initiatives such as the *"Beyond Zero"* campaign led by the First Lady which aims to **reduce structural barriers** for women to access healthcare services by setting up mobile clinics in remote areas.

On the other hand, some facility participants were not satisfied with the government's efforts to improve healthcare as they felt that there were not enough measures taken or political will in place to sustain those initiatives in the long run. Health financing was labelled as '*donor dependent*' as donors contributed to about 30% of total health sector budget. The government's actions which divert public resources to other neglected sectors have resulted in chronic under-funding of the health sector in the inability to meet the commitments of the Abuja Declaration, which specified that 15% of the annual budget should be allocated to health. The following quotes of national level participants from multilateral organisations exemplify this point:

> *"The health sector in Kenya is donor dependent. You study all the reports [and] you will discover that it is donor dependent. The education sector is government dependent. It's actually like 5% comes from the donors, but the health sector, its majority comes from donors. Kenya has not been able to push the budget to at*

least 15% of the GDP as it was agreed in Abuja declaration…we are still around 6%, so health is not as well funded by government". (KI-1, a national participant from a multilateral organisation)

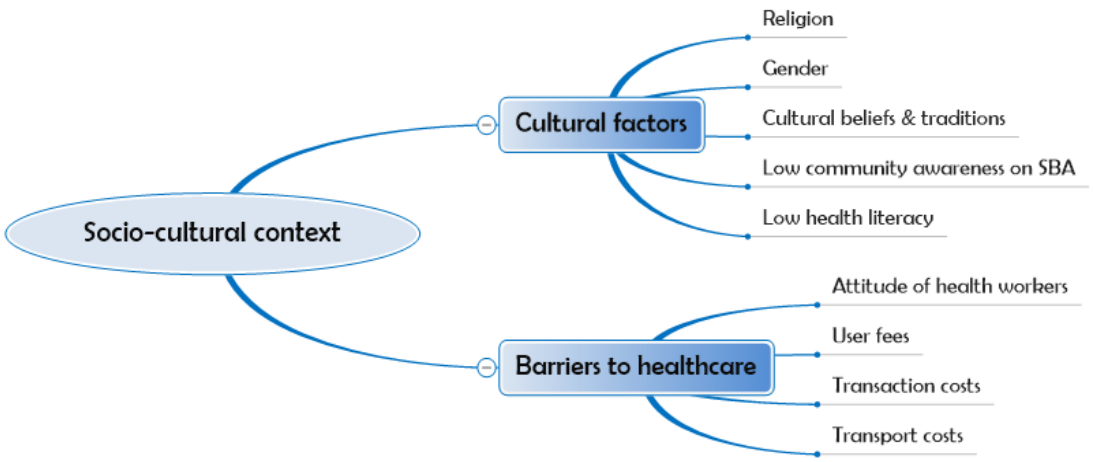
"Kenya gets external financing supports about 5% of its total budget. But when it comes to the health sector, donor funds up to a 3rd of the total health budget. What naturally the Ministry of Finance and National Treasury looks at is, which sectors are not receiving donor financing so they can compensate and make sure that those sectors are not neglected." (KI-3, a national participant from a multilateral organisation)

The government is expected to take more ownership to sustain their interventions they pledged to support within existing capacities and country resources. Besides, **practical challenges** were not considered when adopting new health financing policies and initiatives, such as the capacity of the health sector to comply with the new financing policies (such as user fees abolishment and free maternity services, FMS), and the feasibility and appropriateness of vehicles for mobile clinics in places with limited accessibility (for Beyond Zero campaign).

5.2.2 Socio-cultural context

Figure 21 illustrates key themes highlighting the importance of the sociocultural context as interview participants believed that **cultural factors** still play a significant role in the current health system posting some **barriers for** community **access to health care** without adequate information. Each sub-theme is described below.

Figure 21: Sociocultural context



Participants from all categories highlighted the importance of sociocultural issues regarding care-seeking patterns of women within the communities. Cultural factors such as **religion and gender** still dictated health seeking behaviour of maternal and newborn health. Husbands, mothers-in-law or elderly aunts were influential decision makers affecting the uptake of delivery and family planning services. The following quote from a participant from a bilateral organisation exemplifies this observation.

> *"Here it's not the decision of the mother where she delivers, is the decision of the husband or the mother in law, or the aunt… other community members who are like TBAs...who have a lot of influence… because normally they are elderly women who are respected...the remote areas and this is the only person who they consult." (KI-4, a national participant from a bilateral organisation)*

Some **cultural beliefs** such as *"traditional birth attendants take care of women better than health workers in a facility"* were still prevalent. Communities still believed that facility-based nurses were younger and perhaps less qualified to care for women, as suggested in this quote from a multilateral organisation participant:

> "*They don't go to the health facility because they think those girls, small girls who are not supposed to assist them when they are delivering. You see how the culture was and the complications and then when they bring them to the health facility they are told to pay something, and that discourages them even more." (KI-1, a national participant from a multilateral organisation)*

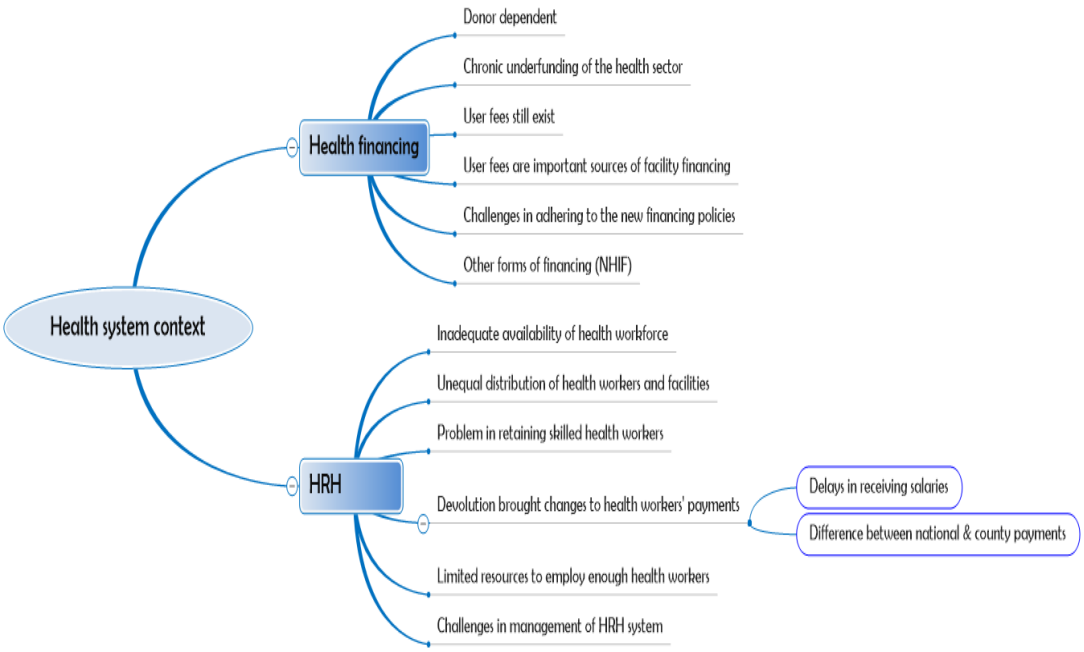
Therefore, health workers felt that community preparedness and **awareness on the use of skilled birth attendants** is not sufficient. Seeking care from trained healthcare providers was further discouraged by the **attitude of health workers**, **user fees** (were not abolished) and other **transaction costs**. The following quote extracted from an interview with a facility participant illustrates this observation:

> *"So, if the man decides that they are not going or they cannot provide the transportation, they cannot provide finances…if it is delivery, the mother would prefer to deliver in the village where there are people who know her and she knows them. So, they can give social-emotional care while in the hospital, they regard the hospital workers to be rude, to be harsh and not to be accommodative enough." (KI-9, Health worker)*

5.2.3 Health system context

Participants discussed two aspects of the health system relating to health financing and HRH. **Figure 22** Illustrates two key themes describing how financing influences the way the health system is governed, how the HRH issue could create grounds for patronage and corruption. Each theme is described below.

Figure 22: Health system context



5.2.3.1 Health financing

The interview questions did not touch on health financing *per se*, yet many participants were keen to discuss this and emphasised that inadequate health financing had been a critical stumbling block to health system progress and caused the health system vulnerable to embezzlement. Indeed, long-standing problems in health system financing can affect the

way the health system is governed. Participants across health system levels discussed two aspects of health financing: user fees and insurance contribution such as National Hospital Insurance Fund (NHIF).

Previous sections have described how the health sector was *"**donor-dependent**"* as that there were insufficient resources to fund the health system and health financing has been one of the bottlenecks of the health sector. Facility participants highlighted that despite the FMS policy in public health facilities, **user fees still exist**, stressing that *"the patients have to pay"* and *"there is no free medication"*. **User fees** continued to be an i**mportant source of financing for health facilities** as "*a system for this health facility to survive, it needs some little contributions to make the hospital run*". User fees ensure that facilities can continue to provide services even when facilities have no other source of income, for instance, when facilities do not receive timely disbursements from the government. On the other hand, user fees can become catastrophic expenditures for households. This is why the government abolished user fees for all public facilities at primary care level and introduced FMS in public facilities. To encourage public facilities to provide FMS, they receive reimbursement from the national government based on the types and numbers of deliveries after providing the data.

Participants perceived that the country would only benefit from abolishing user fees if facilities adhered to the policy, received timely reimbursement for services provided and if there was a strong monitoring system. In reality, there have been **challenges in adhering to the FMS policy** at public health facilities due to the complicated nature of the refund mechanism resulting in delayed disbursements from national to county level. The following quote from a MOH participant exemplifies this observation:

> *"…that money was being delayed. Because it was the facility to provide the services and then they get reimbursement after providing us with the data or of the women were delivered. But you know, get those reports and all those things are usually lengthy and some delayed." (KI-5, a national participant from the MOH)*

There was no mechanism to monitor implementation, including how funds have been managed, when the policies were first introduced. The situation became complicated when the funds given to reimburse a facility for maternity services were not used for the intended purposes; similar findings have been reported in the comprehensive assessment conducted

by the MOH in 2015 (Ministry of Health, 2015). As a consequence, some public facilities were still charging user fees, and some of the maternity services were not free. The following quote from a facility participant illustrates this point:

> *"Government facilities are supposed to be free. They are charging the patients…it is not free. [Patients] pay, they pay some money. I have been to some government facilities, they [the patients] have to pay. There is no free medication" (KI-11, Health worker)*

In addition to user fees, transport costs were also key barriers to seeking care for communities in places where health facilities did not have functioning ambulances. Facility participants recounted their experiences when patients did not comply with their referral advice because they had to pay for services. The government rushed the implementation of the FMS policy without understanding a proper assessment of the health sector capacity. Some county officials felt that there were gaps in the new financing policy as they had difficulties with the reimbursement arrangement. Hence, health financing policy should not be planned in isolation without considering the socioeconomic situation of the population in the relevant county. The following quote from a county participant illustrates this observation:

> *"If we look at health in isolation, the best alternative would be to get everybody into a form of cover actually the whole nation. Ideally, if we can get them into a form of cover where every individual who is working contributes… But now as a county, if we were to address it then probably we need to look outside health and try and see how we can create wealth. But we can have the majority of the people at least earning." (KI-27, a county official)*

Nevertheless, according to national participants, the government was well aware of the problems with the FMS policy and acknowledged its limitations. Thus, the government tried to integrate **other forms of financing** such as the NHIF. Participants from multilateral organisations believed that if maternity services were reimbursed within the NHIF scheme, it would be more systematic and avoids unnecessary parallel state-centric reimbursement process.

5.2.3.2 HRH

This study did not make a specific inquiry on HRH, yet almost every participant raised concerns and mentioned the current challenges with regard to HRH in the country. Challenges related to HRH deterred the progress of the health system, its governance and creating grounds for patronage and corruption. Challenges included the inadequate availability of health workers with problems in retaining them due to poor infrastructure, lack of incentives with delays in receiving salaries and poor remunerations under the devolved government.

Inadequate availability of HRH has been a critical, long-standing problem in Kenya prior to health system devolution. The MOH participants were aware of the situation including the **unequal distribution of health workers** and *"skewed distribution of health facilities"* with fewer resources available particularly in hard-to-reach areas. **Retention of skilled health workers** has been an issue as they received little remuneration but worked despite the poor infrastructure, inadequate supplies and equipment. **Devolution** of the health system has also **brought changes to health workers' payments**. Different payment scheme between national and county governments are described in Section 5.1.2.3. This discrepancy caused tension among medical staff who felt demotivated working under the county government. For example, medical interns who remained under the central MOH were paid more than medical officers who were paid by the county government. The following quote from a facility participant exemplifies this point. The participant was explaining that remuneration from the county government was lower than that from the national government:

> *"In the national government, it was 1200 dollars, so they hacked it and in fact, it is less. In fact, an intern who is paid by the national government is earning more than a medical officer, it is that bad, if I show you the pay slip you feel like an intern earns 90 something thousand, a medical officer earns 47 thousand…The county remunerations are poor, and it is demotivating, most of the allowances have been cut off." (KI-36, Health worker)*

This was compounded by **health workers' receiving late salary payments** from county governments due to the delay in disbursements from the national government. This has affected the lives of health workers as their basic needs have not been met causing periodic health workers strikes. Even in health facilities where health workers were in attendance,

they failed to deliver the required services as suggested in the following quote from a facility participant:

> *"…other things are also in the healthcare workers. Some of the healthcare workers in some institutions because of lack of motivation, lack of good pay and nowadays we go slow. They don't want to work because they have not been paid. So, they go to work, but they are just there, they are not attending to patients. A patient can come, and they are told today we are not working, so there is that go slow." (KI-11, Health worker)*

National participants from multilateral organisations perceived that it was difficult to address the shortages of health workers as counties **did not have the capacity to employ enough health workers** due to their tight fiscal space. County officials also commented that they could not realise their plans due to the limited resources allocated by the national government as described in previous sections. Continual transfers of health workers were also a problem.

Interestingly, while almost every facility participant was complaining about their workload, one participant provided a different perspective as his facility sometimes received twice their current workloads. The following quote illustrates this point. The participant is explaining that they could still handle the increased workload as a result of proper management of health workforce within that particular facility:

> *"There are rotations, and we can handle even double, the workload we have now a double because most of the times we are not very overworked at this point, we have that room of having to review more cases." (KI-24, Health worker)*

One of the long-standing **challenges in** the health system was inefficient **resource management** as some of the recruitment was not based on identified needs, and a certain proportion of the health budget went to non-essential staff causing gaps in critical positions. The following quote from a bilateral organisation participant exemplifies this observation:

> *"The second area is efficiency in that resource utilisation, because when the little resource available is not used efficiently, then we have wastage…Now again coming back, to health workforce, the government spends about 70% of its budget*

> *worth of wages, salaries…And then you go back and realise almost 70% of these workers are non-essential staff. For instance, we have drivers, watchmen, cleaners; you see my point who pick up a big chunk… If 70% BUDGET is going to that and 70 of them are not essential, then you have critical shortages of critical staff that are why they are few, but the money available is not used for them." (KI-4, a national participant from a bilateral organisation)*

5.3 Chapter summary

The chapter begins with devolution describing how devolution presents opportunities for good governance but compromises the capacity at county level government. The process of devolving the health sector in Kenya has begun since 2013, and hence, the context is shifting from centralised to the decentralised health system. The chapter details how the transfer of responsibilities to lower levels in the health sector has impacted the way health facilities are governed, and the feasibility of operationalising good governance principles more widely. The findings highlighted differing views on devolution from three levels of the health system. For instance, county level participants viewed the devolution of the country health system positively that devolution allowed them to respond to the needs of their population and they could allocate resources efficiently. On the other hand, national level participants highlighted the need to strengthen the capacity of the county government to handle the now devolved functions as devolution compromised the capacity of the county health system. However, county and facility level participants felt that the national government was not willing to devolve functions to county governments.

The chapter then illustrates the context of governance highlighting how political; socioeconomic and cultural context shapes the way people interact within the health system in Kenya. Participants from all health system levels perceived that maternal health was recognised as a priority within the current political context as evident from the free maternity services policy and Beyond Zero Campaign. Participants from all health system levels also acknowledged the importance of socio-cultural context as it influenced the health seeking behaviour of the communities. Finally, the chapter ends by describing the two crucial aspects of the health system: limited health financing and bottlenecks in managing human resources for health (HRH).

CHAPTER 6

6. Perception of key stakeholders on health system governance

The preceding chapter presented the context influencing the governance of the Kenyan health system in regards to one of the major influencing factors, devolution at the background. In so doing, the chapter sought to contribute towards answering the first research question: Which factors influence the governance of the health system in Kenya? In this aspect, the themes developed from participants' description on different aspects of devolution on governance with macro-contextual factors such as political, socioeconomic and health system factors.

This chapter follows the above to further contribute to answering the second research objective: to explore the perspectives of key stakeholders on health systems governance. In other words, Chapter 5 attempts to explain which factors influence the governance of the health system while this chapter focuses on how key stakeholders in Kenya viewed health system governance particularly in relation to specific operational principles of governance: participation, the rule of law and strategic vision, accountability, equity and control of corruption. Hence, Chapter 5 explores "macro" institutional factors while this chapter focuses on the gaze on the "meso" and "micro" factors, offering a holistic account of health system governance under study. This chapter presents information collected from interviews with key stakeholders using the governance assessment framework adopted in this study (Chapter 4 Methodology).

The chapter presents the key five themes identified in the study based on participants' characterisations of operational principles of governance. The themes were identified through the thematic analysis approach laid out in the methodology chapter. These themes were then interpretively analysed to gather data describing governance. They are presented in Figures 23 to 27 where different sub-themes and categories have been identified across five key themes of the governance principles: accountability, control of corruption, the rule of law and strategic vision, equity and participation.

6.1 Understanding governance

National and county participants perceived governance as being useful for the health system while some facility participants seemed to be struggling to put governance into a broader context. Few facility participants perceived governance as the responsibility of the government.

Facility participants perceived governance to be a function of government management systems and regarded governance as the Ministry of Health's responsibility. To them, governance was synonymous with "*oversight*"; provision of supervision in the field to ensure that the policies and standards set by the government were implemented. Therefore, they felt that they were not involved in setting the rules of the game, but were involved only to ensure the rules were followed.

National and county participants described governance as one key pillar of the health system which had a mechanism to produce the type of outputs that the community required. Some national and county level participants explained health system governance in their own terms, and their definitions included "*quality health services"* provided by "*accountable staff"* and resources managed in ways to allow for "*equitable access to services*" and equity in health outcomes. Other national and county participants explained that governance implies that *"services respond to local needs"* through transparent decision making and implementation processes that involve service users as well as staff.

A participant from multilateral organisation noted that good governance improved performance of a health system as good governance ensured efficient use of available resources using appropriate monitoring systems. This, in turn, led to better health outcomes as the health system was *"becoming more responsive to the people and their expectations"*. Another national participant perceived that they *"will not see an impact in [the] health sector if the governance issues are not properly sorted"*. They believed that with time there would be differences among counties because of the quality of governance. Other national and county participants highlighted that there was a need to build the capacities of county governments in areas of management, leadership and governance. The following quotes from national and county participants illustrate this point. They were explaining that the county governments who were new to their positions required technical support to ensure good governance.

> *"Instead of focussing more on buying equipment, making sure the infrastructure is there making leadership and management at the county and the national level is something very key we need to support the counties that they become better leaders, better managers." (KI-14, A national participant from a multilateral organisation)*
>
> *"…for good governance within the county, we need to really train the county managers on governance and how to be able to interpret things and overcome challenges. Because you have brought people, you have brought politicians, and you have brought technical people, but they haven't been trained on governance. So, they just read the Constitution on their own, they read the acts on their own, but they may not have that general governance approach of doing things..." (KI-27, A county official)*

In addition to the overall understanding of governance, this study can unpack specific operational principles of governance described by the participants during interviews. Indeed, by applying the framework described in Chapter 4, this study can elucidate how principles of governance have been operationalised in the Kenyan health system. The following section presents findings on those principles: accountability, control of corruption, the rule of law and strategic vision, equity and participation.

6.2 Realising accountability

Accountability was the most frequently discussed principle of governance during interviews. A national participant defined accountability as a process which ensured the "voices" of beneficiaries were heard in the "decision making" process. Accountability was defined, in the traditional sense, as the obligation or willingness to accept responsibility or to account for one's actions. It was also a synonym for "citizen's voice", i.e. a process which ensured that the opinions of beneficiaries were heard and had a place in any decision making process. In the discussion of accountability mechanisms, the idea of holding government agents responsible for acts, behaviours and results did emerge strongly.

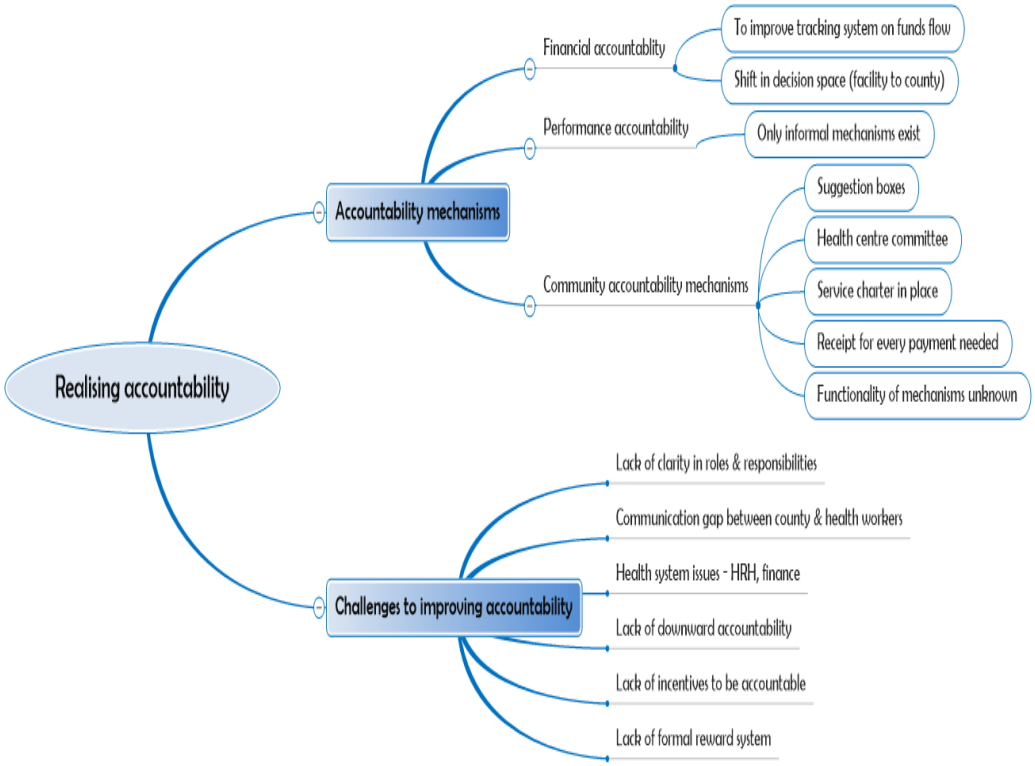
In general, different accountability mechanisms exist in Kenya. Unfortunately, some citizens demanded services to which they were not entitled, trying to benefit from the system. The

following quote from a national participant from a multilateral organisation exemplifies this observation:

> *"If I make noise, I know that I will get certain benefits out of the system. So, I am making noise, not because I want to improve services but because I want to be shut up. So, you see a bit of that going on. Which is not the kind of accountability that we are looking for." (KI-2, A national participant from a multilateral organisation)*

Indeed, there were even some civil society organisations which tried to leverage patron-client relationships to obtain services or public resources for their own benefit, rather than improving community ownership and social justice. Therefore, in cases where individual elected officials might be willing to improve the situation, some patron-client relations posed a contextual challenge for good governance. Hence, two sub-themes have been identified in realising accountability: accountability mechanisms in place and the presence of challenges to improve the accountability. (**Figure 23**)

Figure 23: Sub-themes emerging from the theme "realising accountability"



6.2.1 Accountability mechanisms in place

Three main accountability mechanisms were identified: financial accountability, performance accountability and community accountability. Regarding **financial accountability**, national and facility participants highlighted the importance of developing a good tracking system to report on the flow of funds from the national to the county governments. The interest in such a tracking system was particularly motivated by stories about the misappropriation of funds. The following quote from a national participant from a multilateral organisation illustrates this point:

> *"…from the newspapers, the counties are still not as good in terms of accountability. And…with the time and as the law takes its course arresting some who misappropriate and things like those people will now be serious, following the guidelines and the rule of law." (KI-1, A national participant from a bilateral organisation)*

County governors had limited experience in financial management and did not have the mechanisms to administer funds properly and this was perceived as an underlying vulnerability. Yet, they were asked to manage resources and conduct procurements. The following quote from a multilateral organisation participant illustrates this point:

> *"Quite a lot of counties [because they] were not very much exposed to management of huge funds. Before they were districts and these things they never got managed that huge funds, so we expect a lot of misappropriations here and there especially through procurement things like those." (KI-1, A national participant from a bilateral organisation)*

In relation to **performance accountability**, there was no objectively set system to improve the performance of public sector staff. There was no system of providing feedback within the county system, and facility participants complained that they had repeatedly requested feedback from their county governments on a regular basis. The presence of patronage further complicated the situation, and lack of enforcement of rules as performance accountability depended on individual institutional arrangements which, in turn, depended on the fairness of those who did not abuse their authority. For instance, sending a health worker to attend a course or conference for appraising one's performance might depend on

favouritism and the individual caprice of managers, not necessarily reflecting the outstanding performance.

As a measure to improve **community accountability**, community complaint mechanisms such as suggestion boxes, health centre committees, service charter and providing receipts for every payment were reported. Participants from different levels mentioned that Kenya already had such accountability mechanisms at both community and facility levels, even before devolution. They described structures such as the *village health committee* which governed the operations at the community unit, *facility management teams* (including health centre committee) at the facility level, *sub-county management* and the *county health management teams (CHMT)* were all thought to facilitate accountability at different levels of the health system, respectively. A county participant nominated them as "*organs*" critical to providing oversight to make the best use of resources. However, the level of functioning of those organs was variable, and some depended on external funding to function such as funding the organising of regular meetings. There were also cases when the management was not willing to have a governing board in place or where there was collusion between management and governing boards. The following quote from a national level participant from a bilateral organisation exemplifies this observation:

> *"If the management is not willing to have a board in place, may be issues of accountability, it becomes very difficult to establish one because they can influence who is coming into the board. They can influence what decision they make. Sometimes we have very weak boards, you may find someone who is very strong politically and very vocal in the community but he is not a good leader, and he is heading the board. At that level, they are at the mercy of the hospital technical team. In some cases, you find that the board and management team being together." (KI-4, A national participant from a bilateral organisation)*

6.2.2 Challenges to improve accountability

The lack of clarity in roles and responsibilities, communication gap and lack of incentives to be accountable were key challenges to improving accountability. Resistance to being held accountable, the presence of patronage, nepotism and tribalism in the system were also challenges to improve accountability as a national participant noted: "*it became very difficult to implement some of the disciplinary measures*". Competitions and professional silos were

other recognised challenges undermining the accountability among key actors due to the lack of role clarity and responsibility. The following quote from a national level, multilateral organisation participant, illustrates this point:

> *"There are a lot of stepping on each other's toes. You are entering my area this and my area that. People look at it as an empire, not as a service." (KI-2, A national participant from a multilateral organisation)*

The **communication gap between county and facility staff** also posed challenges in the improving of bureaucratic (internal) accountability. The situation created tension as facility participants stated that they did not trust their county government and felt that the county government personnel would not act without political gain. Particularly, facility participants from one county perceived that their county government was not responsive in meeting the needs of the population and they perceived the county governors as "just politicians and [who] did not know much about the health system".

There was a perception that there was a willingness to improve accountability towards citizens in the current environment. However, a participant from a bilateral organisation perceived that accountability could only be ensured if leadership (either county or hospital management) was willing to be held accountable as people made use of their positions once they came into power. The same participant commented that there were occasions when the leadership was not sure that they would be selected again after their current term and they abused their power while they had an opportunity. The following quote from a national participant from a multilateral organisation exemplifies this observation:

> *"If I have a devolution system and election system that gave me leadership that is fixed over five years, if that leadership is not interested in coming back after five years, then they can do whatever they want irrespective of what the end user says… The member of the country assembly and so on, some of them know that they will not come back. So, they see no reason why they should respond to the needs." (KI-2, A national participant from a multilateral organisation)*

There were also instances where the accountability mechanisms were not fully implemented due mainly to health system issues such as shortages of funds or human resources even though the resources needed to implement the mechanisms have been identified.

Therefore, one of the challenges in realising accountability was a **limitation of resources within the health system**. Facility participants shared their frustration regarding the difficulty of being able to adhere to the FMS policy within the context of a limited resource situation. Under such circumstances, they had to write prescriptions for patients due to shortages of medical supplies and equipment in their own facilities despite the promise of their provision as part of FMS policy.

As described in Chapter 5 (Section 5.2.3.2), the health system challenges relating to HRH also compromised the accountability of health workers. The situation could not provide enough technical and administrative oversight to identify and improve the conditions of health workers' absenteeism and embezzlement in the workplace. Health worker shortages and poor management also favoured patronage practices as health workers needed to "*negotiate*" with their managers to undertake "*private practices*" during public office hours. The following quote of a national participant from a multilateral organisation illustrates this point:

> *"All the doctors are doing personal consultancies…Like in Nairobi, our main referral hospital is Kenyatta national hospital, it is the biggest government hospital where all the sophisticated equipment is. And doctors are there, seeing patients a few hours, they leave, they go to their personal practice…I tell you this afternoon, around 3, I am going to see a doctor. Doctors come around at three o'clock, and they see private patients, but before then this doctor is working in a government hospital. All of them are doing that. They are in the government facility; they have their salary, and in the afternoon, they go to their own private clinics...They must be having an arrangement with the employers that I am coming here to serve you at this time." (KI-1, A national participant from a bilateral organisation)*

Lack of downward accountability was another challenge to improving accountability. Facility participants believed that county governments should have the political will to be accountable, but the interests of some county officials were politically driven and far from the reality on the ground. Participants highlighted the lack of downward accountability as most people were concerned with upward accountability (the accountability towards their managers or higher level). This has been illustrated by a facility participant below. The

participant stated that the governor visited only when there were important political events, and he ensured that there were enough medical supplies only in advance of the visit.

> *"The top governance should be able to learn to come low to the level of people that are working under them, the employees. They should not remain at that level and govern at that level without coming low to know our struggles to know our problems. He [the governor] only comes when there is a political function. That is when they bring drugs as a show-off." (KI-36, Health worker)*

From the perspective of this facility participant, the governor showed only upward accountability neglecting the needs of the facility. Another participant from the same facility also experienced inadequate commitment from their county government as the officials did not show interest or make efforts to understand the challenges of health workers. This situation was seen to be more common among appointed officials, not those who were elected as they only showed accountability to those who appointed them; however, they did not feel a need to be accountable to the population they served. The following quote from a multilateral organisation participant exemplifies this observation:

> *"When you come to the appointed one because those are not elected and appointed by the elected officials, the loyalty of that appointed official is to those whoever has selected him, not to the people." (KI-2, A national participant from a multilateral organisation)*

Another challenge to improving accountability is the **lack of a formal reward system** and performance management. The appraisal should be linked to a reward system creating incentives for both intrinsic and extrinsic motivation such as recognition, career progression, promotion and an increase in salary. However, every county and facility participant in the study perceived that there was a **lack of incentive to be accountable** as there was no attractive formal reward system in place and the existing performance appraisals did not form an important component of the career development of health workers. The promotion was not based on performance but the number of years in service. Regarding disciplinary action, there were situations where actions had been taken without any repercussion or consequences. Yet, participants from one particular county highlighted how county government misused their power and threatened health workers who disagreed or argued with them. The following quote from a facility participant exemplifies this observation:

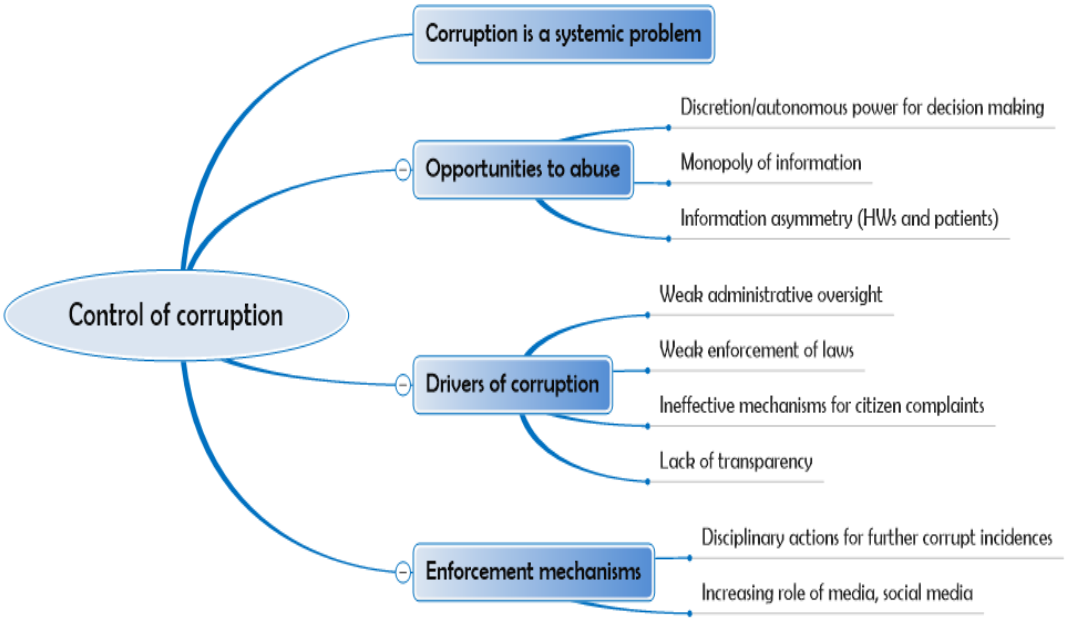
> *"These people are always on the defensive side; they want to defend themselves. The leadership of the county, and again let me tell you: my brother, when you start talking and demanding for these things, next day you are on transfer, so you really get tired." (KI-37, Health worker)*

Therefore, different accountability mechanisms exist in the current health system. However, to fully realise those mechanisms, the willingness of key stakeholders is required together with adequate resources and capacity.

6.3 Control of Corruption

The governance principle, control of corruption, was not directly inquired in this study as it was not included in the topic guide. However, participants highlighted how the current Kenyan health system was vulnerable to embezzlement as there were different drivers of corruption within the system. These are described below (**Figure 24**).

Figure 24: Sub-themes emerging from the theme "control of corruption"



Corruption was repeatedly highlighted as **a systemic problem,** and hence, it was important to engage non-health sectors and civil society organisations in the control of corruption. Participants reported different corruption control measures such as health facility service

charters or the need to provide receipts for any payment made within a facility although their effectiveness has not been measured.

Within the current health system there were various **opportunities for abuse**. This included discretion (autonomous power for decision making); monopoly of information/information asymmetry; weak enforcement of rules and lack of accountability among public servants. Some county and facility participants expressed their opinion that health workers may feel pressure to abuse due to the delay in receiving their salaries. There have been cases where facility staff took advantage of information asymmetry by charging the patients using the previous user fees rate. There were also service providers who sometimes charged informal payments without the knowledge of other staff and the user fees ended up with that particular provider. The following quotes from facility participants illustrate the situation:

> *"He was a health staff from the theatre. He used to take advantage of these patients. So now a patient is coming, for CS, so you are now in the theatre to set the theatre. So, surgical spirit, betadine, so now the health staff can tell the relative, go and buy me the surgical spirit, betadine, before we operate on your patient, or you give me five hundred shillings, but the things are there, he just wants to exploit." (KI-24, Health worker).*
>
> *"…some of them are not aware that they are not being paid for. So, it is easy for somebody to charge them without this knowledge. For example, somebody may say, 'Your wife had a Caesarean Section, and you are supposed to pay for this amount'. If the man says I don't know or I do not have, they will say, 'Okay, how much do you have?' So, if they produce a less figure than that, this person can still take…You do not know how to tell this one to pay and this other one not to pay. But since there are some services which are being paid for, there is a leeway for someone to ask for extra money." (KI-9, Health worker)*

Nevertheless, the existence of functioning accountability mechanisms deterred the incidence of embezzlement as the staff who abused the system were subjected to disciplinary actions such as oral warning, transfer or dismissal of the duties. Unfortunately, some facility participants experienced abusive practices by county officials and how they had made use of their power and official positions to transfer staff who disagreed with them or suggested anything critical of the county government.

Hence, different **drivers of corruption** were weak administrative oversight, ineffective mechanisms for citizen complaints and lack of information. In the current system, administrative oversight was weak and inspection of health facilities was inadequate. Government regulators were also poorly trained or otherwise incapable of doing their jobs properly. In addition, unlicensed health workers and establishments exist in the health system as illustrated by this quote from a facility participant:

> *"So, there are quite a lot of people who have opened clinics, pharmacies, chemists and monitoring of such facilities is not very consistent...people land into different hands of people who are not nurses or doctors, they are just health workers or health professionals but not trained in nursing and medicine." (KI-9, Health worker)*

Access to the correct information and transparent information dissemination were crucial for each group of individuals involved (citizens, healthcare providers, managers and county officers). During interviews, participants highlighted the existence of information gaps among citizens, healthcare providers and even county officials. Facility participants complained about this limitation as they **could not access information such as new policies and guidelines**. Apart from a politically promoted policy like FMS, access to policies and guidelines for health workers was limited. The following quotes from a facility participant illustrate this observation:

> *"Now you see like those big policies, those wonderful or amazing policies; you know it is a very big thing, a very big step you have to be told. That one you will know definitely in one way or another. It will be all over the news; it will be everywhere. But that is very minimal, like for us, like those policies, reproductive health policy, how are you supposed to offer family planning method, how are you supposed to do this you see those policies, those guidelines on how to provide services."*
>
> *"Nowadays there is technology. We have email addresses. The county has the master register of all the health workers at the county, they can easily send the information to every individual, but I don't think [they did]". (KI-24, Health worker)*

The media has played an important role especially in the disclosure of different forms of embezzlements within the public sector. This ranged from small forms of corruption (misappropriation of funds by a health worker) to abuse of office by parliamentarians and governors. Although formal complaint mechanisms were present, health workers were reluctant to use them due to potential backlash or consequences. Instead, the use of social media to disclose mistreatment from the higher authority has increased as presented in Chapter 5. Section 5.1.1.1.

Some national participants believe that media could also play a more positive role in policy dissemination instead of limiting coverage to revealing wrong-doing. The media could disseminate information about important policies such as the FMS policy which have a direct positive effect. Indeed, participants believed that the media should play a more positive role by raising awareness as indicated by a national participant from a multilateral organisation below:

> *"Media could play a more positive role. There are a lot of good things that are happening in the counties, and it is not coming out, and then the media could play a very big role, a more positive role, in really bringing out what are the rights and what are the responsibilities of the duty bearers. Those are the things that we can be informing the mothers the status of health, the things they can play very well...They can play a big role in social mobilisation; they can play very positively and contribute very positively to the health of the citizens of Kenya which we don't see happening much." (KI-14, A national participant from a multilateral organisation)*

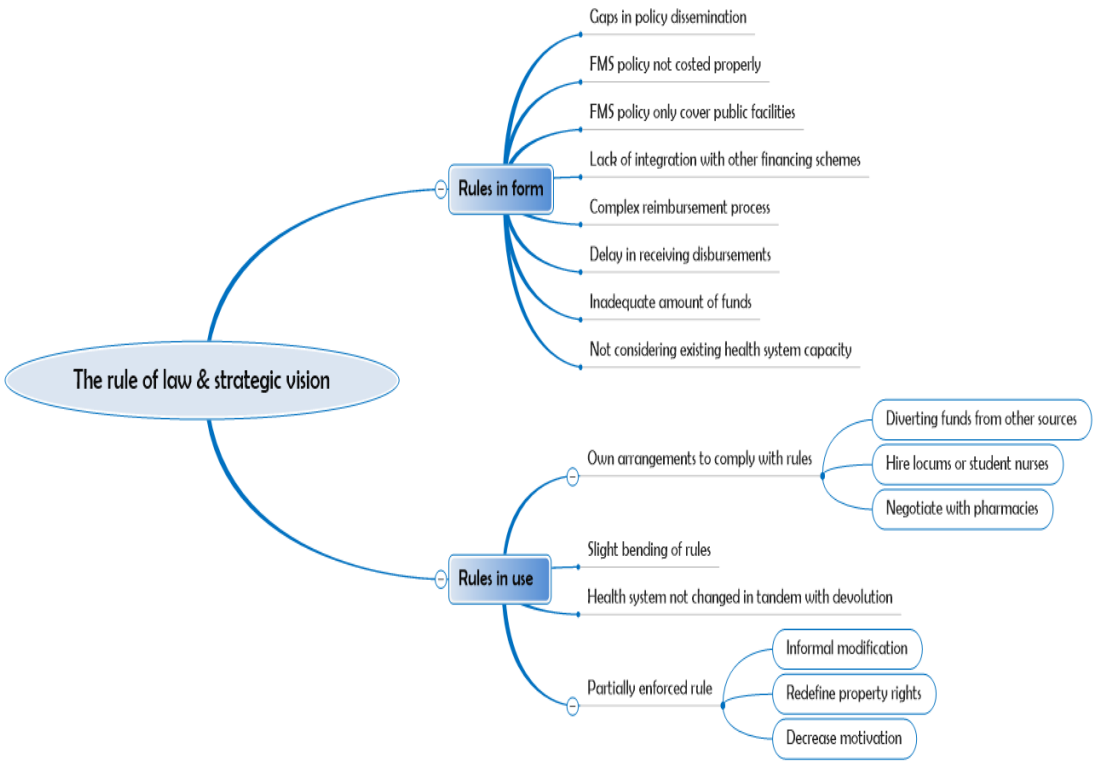
In summary, the participants were aware of and reported that within the current health system, there were different opportunities to abuse. They commented the need to improve the situation through taking disciplinary action when needed and by putting in place functioning accountability and information mechanisms. Most importantly, they have highlighted how corruption impeded formal regulatory mechanisms which were too weak to be enforced.

6.4 The rule of law and strategic vision

In the absence of effective mechanisms for citizen to logde complaints and the enforcement of the rule of law, citizens cannot hold public agents accountable. Hence, the rule of law seems to be the most challenging governance principle. Although certain policies and laws were set up with an ambitious strategic vision, enforcement and monitoring were weak. Participants highlighted the significance between the two forms of rules influencing the current health system: rules in form and rules in use (**Figure 25**). Participants felt that multi-sectoral involvement would be needed to remedy the situation.

To explore whether the policy makers had a broad and long term vision on health; how health-related laws were initiated; translated into rules, regulations and procedures; whether key stakeholders were consulted for laws/regulations relevant to health; and enforcement of laws and regulations, this study has used free maternity services (FMS) policy as an example. Therefore, the majority of responses in this section relate to the FMS policy implementation.

Figure 25: Sub-themes emerging from the theme-"The rule of law and strategic vision"



6.4.1 Rules in form

President Kenyatta announced the abolition of user fees for maternity services in public facilities on the 1st of June 2013. Subsequently, the MOH issued a circular about the abolition of user fees and the FMS policy. The objective of the FMS policy was to remove financial barriers for using maternity services with the goal of reducing maternal and neonatal mortality. Participants from all health system levels agreed with the importance and usefulness of the policy and described how the implementation process had been put into effect. The FMS policy was introduced simultaneously with devolution which significantly influenced the implementation of the policy.

Participants from all health system levels highlighted that there were **gaps in the policy dissemination** when it was first introduced, particularly during 2013. Therefore, different facilities interpreted the policy differently in terms of the amount to be reimbursed depending on the type of facilities and maternity services covered. Facility participants described how it was difficult when the policy was first introduced. Therefore, there was no standard interpretation across the country regarding what should be included as part of the FMS provision. The following quotes illustrate this situation:

> *"For the free maternity, specifically, at the beginning it was more of a Presidential declaration, it didn't have a policy backing it so interpreting it became a challenge for the first few months because at the hospital level where they used to be having the user fee, and this user fee is what they are using to procure some drugs supplies, to employ some casuals, it is what they use to pay some of the utilities to improve their facility. So, when now you remove this and maternity services are, especially at the hospital level, the highest contributor to the revenue of the facility … But this became clarified later by a circular from the ministry of health so even right now as we speak there is no policy which has been endorsed." (KI-15, A national participant from a multilateral organisation)*
>
> *"We have not seen a written circular about it, so it became even difficult for the whole of 2013 to know what [was supposed] to be free. We have had a lot of problems with the public even today as I am speaking. We still have a lot of problems with the public. The public expects that when they walk through the gate, everything that is done to them should be free." (KI-9, Health worker).*

The FMS was not costed appropriately as it took only healthcare costs into account, but not the administrative, investigation and other support costs. Therefore, some facilities lost their income when a woman presented with complications after a caesarean section as the guidelines for FMS did not cover the cost of the treatment of complications. As indicated by a facility participant:

> *"It only covers delivery and the care just for three days after delivery when the mother is in the hospital. It does not cover antenatal, because ultrasound you must pay, blood test you must pay, visits for consultations you must pay and if you come to deliver it is free, when you go home, and you come back and say the baby is sick, the mother is sick now that you must pay, as the time when you are in hospital it is free." (KI-16, Health worker).*

A facility participant perceived that the FMS policy was limited as it **only covered public facilities** although a significant proportion of health care in Kenya was provided by non-public (faith-based and private) organisations. The Ministry of Health acknowledged the limitation and interviews with participants from the MOH confirmed that the government has been trying to find ways to integrate with other forms of financing mechanisms such as the National Health Insurance Fund (NHIF) scheme and the means to include private facilities under the FMS policy.

The other limiting institutional arrangement was the **reimbursement process** due to the **complexity of the procedures involved**. Facilities submitted the request through the county health department who compiled data from every facility within the county which was then sent to the National Health Treasury for reimbursement. The National Health Treasury verified the requests by triangulating the data with District Health Information System (DHIS) data after they received the requests from different counties. The funds were then transferred to relevant county health treasuries where further processing took place before the funds reached to every facility.

Participants at all levels of the health system had encountered challenges because of inefficiencies in the reimbursement processes including delays in receiving the payment and receipt of insufficient funds. These challenges then affected planning at the health facility level as indicated by a facility participant:

> *"You cannot give everything for free…and if the government abolishes user fee, then they must support the hospitals and give them money to run, but as it is now, money does not come, our hospital received money only once, and it was last year in January, since 2013 when the President started this policy he has never given [our hospital] any money, and maybe it is not his fault, maybe he doesn't even know, but the people below him are sitting on that money." (KI-16, Health worker).*

6.4.2 Rules in use

Some **counties made their own arrangements** such as diverting funds from "*the county budget*" to cover the payment under the FMS policy. They also encouraged facilities to promote the use of NHIF to alleviate the burden of FMS implementation constraints. However, NHIF coverage was not very promising as coverage was very low due in some counties to the level of poverty. According to an assessment conducted by the World Bank, the NHIF covered approximately 18% of the country in 2010 (Ramana et al., 2013). Women under the NHIF scheme were also reluctant to pay as they questioned why they should pay for insurance while the services were free for all. The following quote from a facility participant illustrates this point:

> *"They are using the NHIF, and maybe they are given the prescription to buy the drugs, it is a challenge because somebody tells you I am using the NHIF card, and you are telling us to buy the drugs, so it is hard to convince that person to tell him to go and buy the drugs, but at times they used to buy because there is nothing else you can do." (KI-39, Health worker)*

Counties and facilities made their own arrangements to overcome the challenges of operating the FMS policy within the context of health system constraints. These included **hiring locums or post-graduate doctors** (whose overtime work was not compensated) to cover the shortage of medical doctors and **part-time nurses or student nurses** to cover the shortage of nurses. Regarding shortage of medicines and supplies due of late disbursements, informal arrangements with suppliers were made to refund them after receiving the funds as noted by a county participant below:

> *"What is happening, for example, the hospital has a lot of debts, you see like we have to buy things for them, non-pharmaceutical, you need to buy the gloves, the syringes, cotton wool, all those.So, when you ran out of those, you have to borrow from the suppliers and promise to pay when you get the money." (KI-21, A county official)*

Some **facility participants** admitted that they **had to write prescriptions for patients** due to shortages of medicines and supplies at facilities. In some facilities where there were severe shortages, patients were asked to buy everything "*including cotton wool and gloves*". The following quote from a facility participant illustrates this situation:

> "*Actually, we tell them to buy everything…we should have just told them to pay [us] and [we] use that money to buy whatever we need. It could have been better than us telling them it is free and we are not able to provide them good quality services*." (KI-36, Health worker)

Facility participants also discussed media as an important enforcer playing the role of watchdog for accountability of health facilities. The staff at some facilities were concerned about the potential loss of reputation and scathing media reports if they were found to be charging for maternity services:

> "*We cannot charge because we are in Nairobi and if we charge there will be a lot of noises, they will know immediately, the media will come immediately, so we cannot charge, so we just run the hospital with the little we have until [maybe] it closes.*" (KI-16, Health worker)

Hence, there was a perception among county and facility participants that the **health system had not changed "*in tandem with devolution*"** and introducing the FMS policy in this context stretched the existing resources as there was an increased demand for services after removal of the user fees. This included HRH, supplies and equipment as there was no significant improvement in these aspects after devolution. This was further compounded by delays in the reimbursement of funds leading to frequent shortages in supplies of medicines and consumables. The situation affected the already stretched health workers who were frustrated by their increased workloads.

The implementation of new policies was dependant on the timely reimbursement by the national government to the health facilities through county governments. Strong monitoring and supervision mechanisms were also essential to ensure facilities comply with the new policies especially facilities in remote places which required more stringent third party enforcement mechanisms. Hence, some counties arranged *"impromptu supervision*" in addition to the scheduled supervision to ensure the provision of FMS across the county. The following quote from a county participant exemplifies this observation:

> *"The rural facilities sometimes are a bit distant. We cannot monitor them on a day to day basis, so once in a while, you will have a mother coming to deliver, and they are asked to pay. We are aware that happens in some areas, but the way to avoid that or the way to mitigate that is to have supervision…they [managers] have scheduled supervision visits to those facilities that is one, they also have impromptu supervisory visits at the facilities, the suggestion boxes in the facilities, service charter." (KI-26, A county official)*

This new **partially-enforced rule** (policy) with informal modifications, which key stakeholders introduced to cope with the situation, also **redefined the property rights** (decision making and earning rights) of health workers. For instance, healthcare facilities used to have their own account under the health sector services fund (HSSF) or the hospital management fund (HMF) which allowed them to manage their own budget. In the devolved system, budgets are managed by the county health treasury, which allocates funds to healthcare facilities within their catchment area. Income generated at the health facilities is transferred back to the county as county revenue. Hence, health facilities have **lost the decision making power** to manage their own budget under the devolved system, and including the procurement of medicines, supplies and equipment. Some facilities have closed their HSSF or HMF accounts. Some healthcare providers perceived the new set up as "centralization within a decentralised system" while others felt that "everything is meant to be done at the county level."

The property rights of the health workers are now diminished because **a source of funding was lost** and not sufficiently compensated, with consequences on the supply of drugs and informal charges to patients. Hence, health workers' incentives are not well aligned with the Ministry of Health. This results in a loss of motivation among health workers and therefore performance, as well as a series of critical negative consequences for the health system.

If stakeholders in charge of implementing the policy (counties and health workers) have doubts about its impact and sustainability, the policy will not leverage their intrinsic motivation to improve the health of the population. This, coupled with the **decreased** extrinsic **motivation** (i.e. the policy does not provide financial incentives for them to implement it and expand quantity and quality of care), shows why the policy struggles to work in practice. Policy implementers also remarked that the policy makers did not understand the practical, on-the-ground situation and hence did not anticipate or appreciate the operational challenges. The following quotes from a county and facility participant exemplify the observation:

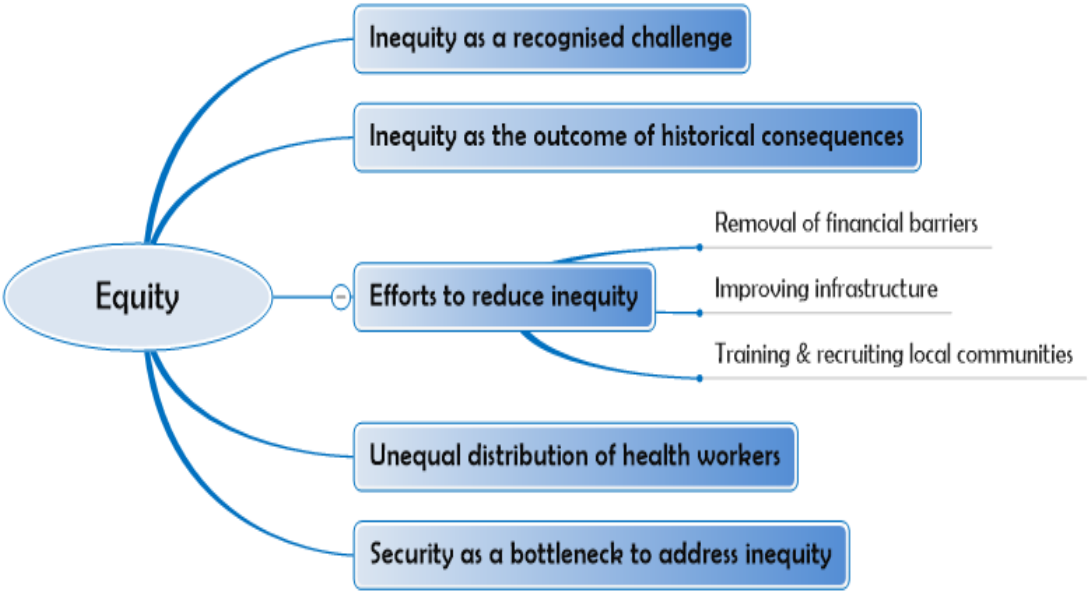
> *"And we have started experiencing that because in this county for example for the past one year, we have delivered mothers and we have not been reimbursed. One hospital like Makindu hospital, which is very busy, is owed around 20 million by the national government. I think [it] is a challenge because of this thing of just giving money and we know the resource purse is very limited, might not be sustainable." (KI-21, A county official).*
>
> *"The President just woke up one day, in one of the National Celebrations, he decided there is free maternity care." (KI-10, Health worker).*

In summary, participants believed that the country had the strategic vision to improve the healthcare of its population, and it had good policies and rules in place, but when it came to implementation, there were significant gaps due to the operational reality on the ground which undermine the existing health system challenges. Besides, participants were not satisfied with the level of political commitment to enforce the existing rules.

6.5 Inequity is acknowledged as a problem

Equity is an essential indicator of good governance in a functioning health system. It is even more important in a country such as Kenya which is undergoing devolution, as this reform can itself lead to inequity if not managed well. **Figure 26** illustrates key themes highlighting the existence of inequity across different counties due to historical consequences, how there have been efforts to reduce inequity and the main challenges such as security and health workers' distribution.

Figure 26: Sub-themes emerging from the theme "equity"



National participants defined equity as a measure of ensuring that previously "*marginalised groups*" were not left out. A facility participant defined equity in the health system as *"everyone should get quality health care regardless of the class, gender and where they come from"*. Inequity was a recognised challenge as inequity existed in other sectors in addition to the health sector. With devolution, inequity across counties has not improved due to **historical socioeconomic and cultural factors** such as poverty, infrastructure and the availability of resources. The following quote from a participant from a multilateral organisation illustrates this point:

> *"We have like 15 counties, which are contributing to almost 80% of maternal deaths. The focus now is concentrating on those 15 counties which hopefully with addressing the equity gap. These are counties which have been marginalised for a while, a lot of inequities in terms of high vulnerability, there are more exposed to conflicts, there's less development." (KI-14, A national participant from a multilateral organisation)*

Inequity in healthcare access has also been recognised as a problem by the national government, and there have been **efforts to reduce inequity**. During interviews, national participants from multilateral organisations present me with a copy of communique signed by the 15 counties with the highest burden of maternal and neonatal mortality in Kenya. Other efforts of the government included the **removal of financial barriers**, allocation of

specific funds, improving infrastructure and training and recruitment of local communities. Indeed, the government has been trying to remove financial barriers, one of the most important determinants of access to healthcare, with two new health financing policies (user fees abolishment and FMS). The following quote from a participant from a multilateral organisation exemplifies this observation:

> "*The free maternity services policy is an initiative of the current government as per their pledge when prior to the elections of 2013 so this in some places has doubled the access, so the financial barrier which was there at the facility level is no longer there so there has been that increase." (KI-15, A national participant from a multilateral organisation)*

However, adherence to those policies require functioning administrative and financial management mechanisms; effective technical and administrative oversight; and strong monitoring and regulatory systems none of which are currently in place. A further factor was the **unequal distribution of healthcare workforce** as it has been difficult to retain health workers. In other words, fewer healthcare workers were ready to work in poor areas as indicated by a county participant:

> *"There are areas which are very disadvantaged in the sense that a very few health facilities are areas which are not popular with people, you want to post people to work, and people are reluctant because they are a bit hard to reach and so the turnover of the work is very high. People are not willing to work in some of that neighbourhood." (KI-31, A county official)*

Security was also a bottleneck, particularly in hard to reach areas. Thus, some temporary measures, such as contracting of services by assigning health staff from another region of Kenya to work in poorer areas. However, this was difficult to sustain. National participants recommended long-term solutions such as developing cadres of human resources from the same community as it was difficult to retain health staff from different communities.

In summary, inequity is a recognised challenge reported by participants from all categories, and there have been several attempts by both national and county governments to address this. However, participants acknowledge the fact that it will take the time to improve equity.

6.6 Participation of stakeholders

Participation in decision making is an essential principle of governance. In principle, both citizens and healthcare providers should engage in the decision making process with national government actors. According to the current Constitution of Kenya, citizens must be consulted widely in both policy making and implementation. Participants from different levels of the health system describe who participates, what are the opportunities to participate and what are challenges for participation (**Figure 27**).

Figure 27: Sub-themes emerging from the theme "participation"

6.6.1 Who participates?

All interview participants unanimously agreed that key policy makers were: the Government Secretary, Principal Secretary Department of Medical Services, the National Treasury, National Parliament at the national level; and the County Governor, County Minister of Health, County Chief Officer for health and County Directors at the county level. In addition to the Ministry of Health, other ministries such as the Ministry of Education, Ministry of Finance, Ministry of Devolution, Ministry of Transport, Ministry of Environment, and Ministry of Urban Planning were also important stakeholders. There were also other organisations such as the professional associations (the doctors' association, nursing council, drug regulatory agency and patient associations). According to county participants, international organisations including the UN and NGOs also participated in health policy making. However,

as one national participant noted in the accountability section, it was not clear whether these NGOs represented beneficiaries and spoke on their behalf.

6.6.2 What are the opportunities to participate?

For participation at the national level, Kenya is quite open with regard to policy making as policy documents are available in the public domain where citizens can provide their opinions. According to the new Constitution, it is a legal requirement that citizens should be consulted widely before a policy is approved into law. However, some county and facility participants did not think that "*consultation was ever done for free maternity services as it was just announced and rolled out*". Indeed, some participants had reservations as they felt it was not true participation due to the level of engagement and lack of opportunities to participate. The following quote from a multilateral organisation participant illustrates the observation:

> *"The policy making process has been quite open. I think the government has been fairly open in terms of the kind of engagement it has with stakeholders. Now it can engage, but it does not necessarily mean to take up everything that people want. Those are two different things. So,* ***for some stakeholders, they perceive engagement as government doing what they have told****. Meanwhile, for me,* ***I will look at engagement as an opportunity to be part of the discussions.*** *I think those opportunities exist both in the sector and legislatively in the Constitution. You cannot pass any policy or any government direction when there is no evidence of engagement of stakeholders. It is illegal by now." (KI-2, A national participant from a multilateral organisation)*

Regarding participation in county-level policy making and implementation, most facility participants felt positive about the devolved roles of county health departments as they had **opportunities to get involved** and their suggestions were incorporated. However, some counties seemed to have communication problems with their healthcare providers as facility participants perceived that even senior management from their own health facility were not consulted for county health planning. County governments were viewed as not understanding health workers' difficulties, nor inviting them to participate in the planning process. Therefore, facility participants were not sure whether their voices would be considered or get addressed. On the other hand, a different picture was portrayed by the

county participants stating, that since devolution, the communication gap had reduced with increased feedback from the communities. The following quotes exemplify these statements:

> *"…they say they want to reduce maternal death in XX county and they don't come to maternity the people working here or in the hospital who really know what is the cause of this and this and the people with experience they meet with all these challenges every day then you know they can just go and imagine their own things there." (KI-37, Health worker)*
>
> *"The success now is that the health systems, this is being addressed closely and the leadership is around whenever there are issues, we know who to address immediately not like the old system… That gap is reduced, it is easier to communicate and get information from the community…They have moved the leadership closer to people, so the services are slightly closer. [When] drugs have a shortage, if you are told this thing is missing, the guy who is supposed to provide the missing gap is closer." (KI-35, A county official)*

6.6.3 Challenges in participation

County participants described how the current Constitution provided various opportunities for stakeholders' participation in policy development forums where they could discuss within their constituencies. These were public meetings or *"barazas"* which were organised at county and sub-county levels where the public could discuss the proposed policies and provide suggestions to the policy makers. However, information regarding the level of public engagement could not be obtained from interviews with county participants. The health facility management board was another opportunity where communities could participate in health-related policy implementation. However, according to some facility participants, management boards were not as engaging as they should be. In their experience, the management boards rarely listened to voices from the communities in situations where the board members represented the hospital. The following quote from a facility participant illustrates the situation:

> *"According to their functions they are supposed to be also actively participating, but I don't think they are active. Because I have not heard of many issues from the community. I don't believe they go to the community or to the opinion leaders to look for these things that they feel they can bring. Because if the community chooses them, it means they represent the community, so they should be at least actively or on periodically report on what has not been done, but I am not sure…I have not heard of any issues they have raised about what they think we should do to their community to meet their health needs if we are not meeting them. So, I think it is the board which should be very actively participating and also interacting a lot with the community, going to the community to the people asking their opinion about the hospital, but I don't think they actively participate as they should." (KI-24, Health worker).*

Despite the different opportunities to participate, facility participants felt that, in reality, participation was not meaningful and **policy making was "top-down"**. The systems were still state-centric or county-centric and provided very little scope for individual citizens to be empowered to participate in the decision making processes. The actions of civil society groups were either limited or led by a few **civil society brokers** who **abused the system**. The following quote from a multilateral organisation participant exemplifies this observation:

> *"We have many people who are becoming professional civil society people; they earn a good living from that. Whenever I want to make money, I just go and make a bit of noise and then somehow, I get something out of it. So, you got a lot of those merchants, the civil society merchants from the system." (KI-2, A national participant from a multilateral organisation)*

There were also county officials who were not satisfied with their level of engagement in health policymaking and the way they were asked to get involved. They perceived that policies were made at the central level and hence, constant coordination and consultation with the counties were essential because "*if a policy was made in Nairobi without considering the uniqueness of the counties, then it became un-implementable*". Thus, **citizens do not have enough information and power** to participate in policy making and implementation processes. A dominant view among facility participants was that the communities did not

know their rights and what they should ask for. The national government was aware of the situation, and hence, there have been civic education programmes within different counties. In summary, there were several opportunities to participate in policymaking and implementation of the health system. However, this requires awareness of the citizens and their initiative with the opportunities to participate in these processes.

6.7 Chapter summary

This chapter illustrates how key stakeholders in Kenya viewed health system governance particularly in relation to specific operational principles of governance: accountability, control of corruption, the rule of law and strategic vision, equity and participation. Participants noted challenges in realising accountability which were strongly related to two other principles namely control of corruption and the rule of law. Regarding financial accountability, national and facility participants felt that a good financial tracking system was crucial for the devolved system. Regarding performance accountability, there was a unanimous view among both county and facility participants that the current health system lacked incentives for accountability. Indeed, the current health system has opportunities for abuse as citizens have limited information and there are power differences and weak enforcement of rules. In particular, county and facility participants perceived that health workers were pressured to abuse due to the delay in receiving salaries and the different arrangements under the county health systems. Regarding the rule of law and strategic vision, two forms were highlighted: rules in form and rules in use. Participants from all health system levels acknowledged the importance of FMS policy (rules in form) and gaps in its policy development. On the other hand, county and facility level participants made their own arrangements to implement the policy (rules in use) set by the national government by assigning additional health workers, establishing agreements with medical suppliers and diverting funds from other departments. There was a prevailed view among facility level participants who perceived that the health system did not change in tandem with devolution. Participants from all health system levels acknowledged that equity has not improved after the first few years of devolution. While national level participants perceived that there were more opportunities to engage in the policy development process, county and facility participants felt that there was not enough stakeholders engagement in policy development at national level. In particular, facility level participants felt that policymaking was still state-centric or county-centric.

CHAPTER 7

7. Are there any differences in governance between fully functional and not fully functional facilities?

The preceding chapters (Chapter 5 and 6) presented the context influencing the governance of the health facilities and key stakeholders' perspectives on governance. Chapter 5 illustrated the "macro" context influencing governance such as devolution, political, socioeconomic and health system factors. Chapter 6 described the operational principles of governance: accountability, control of corruption, strategic vision and the rule of law, participation and equity offering a holistic account of health system governance under study.

This chapter covers the third research question: "Are there any differences in governance between fully functional and not fully functional facilities?". To do so, facilities included were grouped according to their level of functionality using the UN criteria (nine signal functions). This has been described in Chapter 4 (Section 4.4.1). Using the UN criteria, if a facility performed all designated nine signal functions of a CEmOC, it was regarded as a fully functional facility. Similarly, facilities performing fewer than nine signal functions were considered to be not fully functional. Of the ten healthcare facilities included in this study, six were not fully functional while four were fully functional.

This chapter starts by describing how the two groups of health facilities (fully functional and not fully functional) differ in terms of the availability of equipment or if staff have been trained to provide signal functions from the secondary data collected under the "Making it Happen" (MiH) programme. The aim is to gain an understanding of these two health system factors by comparing them with the participants' accounts. For the assessment of the governance of the two groups of facilities, institutional analysis approach described in Chapter 4 (Section 4.4.3.2) was used.

7.1 How were fully functional and not fully functional facilities different?

In the six facilities that were not fully functional, two signal functions were not available: signal function 5 (removal of retained products of conception) and signal function 6 (assisted vaginal delivery). The data available through the MiH programme allowed me to explore the availability of supplies (medicines, medical equipment and consumables) and human resources. However, it was impossible to identify information regarding health financing as the MiH programme did not collect that information. Hence, only two health system factors; availability of supplies (medicines, consumables and equipment) and human resources were considered.

Regarding supplies, it was impossible to identify the specific medicines and consumables required to perform each signal function as some medicines or consumables could be used to perform more than one signal function (e.g. oxytocin). However, it was possible to identify specific equipment required to perform two signal functions (signal functions 5 and 6). Availability of equipment to perform signal function 5 (removal of retained products of conception) was not different between the two groups of facilities. But, there were differences in the availability of equipment to perform signal function 6 (assisted vaginal delivery). Fully functional facilities had at least one of the equipment sets (vacuum or forceps) required to perform signal function 6, while this was not the case for non-fully functional facilities (**Table 12**).

Table 12: Availability of equipment to perform signal function 5 and 6

	Signal Function 5 – removal of retained products			Signal Function 6 – assisted vaginal delivery		
	MVA set	**D&C set**	**At least one**	**Vacuum**	**Forceps**	**At least one**
Fully functional facilities						
Hospital 2 (Nairobi)						
Hospital 1 (Kitui)						
Hospital 2 (Kitui)						
Hospital 2 (Nakuru)						
Not fully functional facilities						
Hospital 1 (Nairobi)						
Hospital 1 (Machakos)						
Hospital 1 (Makueni)						
Hospital 1 (Narok)						
Hospital 2 (Narok)						
Hospital 1 (Nakuru)						

Source: MiH database

Legend:

Available
Not available

The other possible influence on signal function performance, for which there was data was the availability of human resources to perform signal functions. Medical staff performed an average of 25 to 70 deliveries per year, meaning one staff member conducted 2 to 6 deliveries in a month, except in three facilities (PGH Nakuru, St Mary's and Narok). In those three facilities, staff from both PGH Nakuru and Narok conducted approximately 10 deliveries a month while staff from St. Mary's conducted 44 deliveries a month, meaning there was at least one to two deliveries a day (**Table 13**). Hence, some facilities could achieve fully functional status even with relatively few staff.

In summary, although facilities that were not fully functional had staff capable of performing those two signal functions, the facilities did not have the equipment to conduct signal functions.

Table 13: Staff availability and workload

Facility Name	Facility deliveries (annual)	Staff maternity delivery total	Staff delivery ratio
Fully functional facilities			
Hospital 2 (Nairobi)	8877	17	522.2
Hospital 1 (Kitui)	2044	81	25.2
Hospital 2 (Kitui)	1874	36	52.1
Hospital 2 (Nakuru)	8496	74	114.8
Not fully functional facilities			
Hospital 1 (Nairobi)	15821	307	51.5
Hospital 1 (Machakos)	5572	80	69.7
Hospital 1 (Makueni)	1875	44	42.6
Hospital 1 (Narok)	3010	24	125.4
Hospital 2 (Narok)	1150	19	60.5
Hospital 1 (Nakuru)	618	24	25.8

Source: MiH database

The following section explores whether the status of governance differs between fully and non-fully functional facilities using the "institutional analysis" theory of North (1990) as the theoretical framework (Chapter 4 Methodology). Findings are presented thematically based on the three constructs of the theory: institutional arrangements; enforcement mechanisms; incentives and motivation. These interdependent constructs of the theory are not mutually

exclusive. For example, creating incentives for extrinsic motivation enforces individual health worker to comply with certain institutional arrangements.

7.2 Institutional arrangements

"Institutional arrangements" are the ways by which the health system has been arranged to deliver healthcare services in Kenya, in order words, how Kenyan health system has been governed. These can be either formal arrangements (in the form of political or legal rules such as constitutions, contracts and property rights) or informal (such as codes of conduct, behavioural norms and conventions) (North, 1990; Aoki, 2001). The institutional arrangements in this study composed of arrangements to improve four principles of governance: accountability, control of corrupt practices, participation and equity.

The sections below start with institutional arrangements for accountability, then the exploration of the control of corrupt practices, followed by opportunities to improve equity and participate in policymaking or implementation.

7.2.1 Institutional arrangements for accountability

Two main types of accountability exist in the literature: internal accountability (the interactions of facility participants, their managers, the county department of health and county government) and external accountability (accountability towards communities). Discussions of facility participants focussed mostly on internal accountability such as measures to improve the performance of health staff (performance accountability); availability of adequate resources; and on understanding of the roles and responsibilities to be accountable. **Table 14** summarises key differences in institutional arrangements for accountability between the two groups of facilities.

Table 14. Institutional arrangements for accountability

Institutional arrangements for accountability	Fully functional facilities	Not fully functional facilities
1)Performance accountability Formal: appraisal for performance	Absent	Absent
Informal: recognition for performance	Present (training, conference, annual staff party, etc.)	Present (training, conference, annual staff party, etc.)
Informal: sanction against non-performance	Absent	Present (early retirement for 50+ staff, transfer of younger staff)

Institutional arrangements for accountability	Fully functional facilities	Not fully functional facilities
2)Availability of adequate resources (HRH)	Absent except one participant	Absent
3)Understanding roles & responsibilities, clear line of accountability, availability of standard operating procedures	Present and followed	-Absent or not followed -Unclear roles & responsibilities with the lack of accountability led to a maternal death & a fresh stillbirth.

Formal institutional arrangements to improve performance such as a **performance appraisal system did not exist** in both types of facilities regardless of functionality. Participants across all health system levels commented about the lack of an objectively set system of appraisal to improve the performance of public sector staff. In the current devolved system, promotions were handled at the county level, and there was a perception among facility participants that "*they [the county] didn't know who was doing what at the facility, so it was just the system that after every three years you get promoted*". Hence, facility participants felt demotivated due to 'stagnation' and the lack of opportunity to progress in the role as they did not trust their county governments and public service commission responsible for staff promotion. They felt that the responsible authorities were very new to their positions and did not understand the health system. Hence, they perceived county governments and public service commission were far from operational reality. The following quote from a not fully functional facility participant illustrates this point:

> *"The reward system is rather demotivating. Because you find someone has worked for a long time, somebody works very well, and you find she has stagnated all years, she has stagnated in one job group… So, these are things which need to be streamlined because now if you are to wait for the public service commission to create positions, how would the public commission know that there are people stagnating unless they come to the ground." (KI-19, Health worker from a not fully functional facility)*

Facility participants also perceived that after devolution, promotion became different among counties due to a "*lack of uniform standards*" and the difference in performance among county service boards. Hence, the existing reward system was "*demotivating*" for some participants as rewards were not based on performance and "*the appraisal was not very*

transparent nor objectively set" while they "*just gave it for the sake of a requirement*". The following quote from a not fully functional facility exemplifies this observation:

> *"You want to be promoted, or your friend in another county has been promoted, and you have not been promoted. Previously you'd all be promoted, but now you find your friend a doctor like you in another county has been promoted and you have not been promoted, because the county service board for Kisumu is different from the county service board of Nairobi, so the one of Kisumu has sat and the one of Nairobi has not sat even for two years they have not sat, so there are no uniform standards."(KI-16, Health worker from a not fully functional facility)*

Informal institutional arrangements emerged when there were gaps in the formal arrangements for rewards or performance appraisal. For instance, facilities set up their own form of informal appraisal mostly at their own discretion such as organising an annual staff party; sending individual staff members to a conference or workshop; awarding certificates or trophies, or words of appreciation from the managers. Participants from both groups of facilities appreciated that informal appraisal was as an explicit recognition of their management.

For **sanctions against non-performance**, some not fully functional facilities had informal institutional arrangements such as management asking staff who were over 50 years of age to retire while younger staff received an order for transfer as a penalty for not performing. There were also instances where "*health workers' salaries were stopped if there was any failure in roles and responsibilities*".

Availability of adequate resources particularly adequate numbers of health staff in a facility was another enabling institutional arrangement for facility participants to be accountable. Participants from both types of facilities complained about challenges due to human resource shortages except for one participant from a fully functional facility who noted that their facility could receive double the existing workload. In other cases, despite staff availability, lack of staff who were trained to perform signal functions was another challenge as not everyone was trained to perform certain signal functions such as manual vacuum aspiration, assisted vaginal delivery and newborn care. Frequent staff rotation and staff transfer were common challenges in both types of facilities. The following quotes from the participants illustrate this observation:

> *"Emergency Obstetric Care, as far as the training is concerned, there are still many people who have not been trained; there are about less than 50% who have been trained. But you see we are having continuous transfers; so you train somebody who is transferred and takes that knowledge to somewhere else. So not many people have been trained, and also, people go for the training, and you are not in the department where you can practice, then anything that is not used is wasted, isn't it?" (KI-9, Health worker from a not fully functional facility)*
>
> *"…the medical officers are not trained because of the high turnover, so we have 60% of the nurses trained but less than 5% of the medical officers, so because of that there is discrepancy so that is why." (KI-18, Health worker from a fully functional facility)*

The third institutional arrangements for accountability were **understanding roles and responsibilities**; a **clear line of accountability**; availability of protocols or standard operating procedures and proper documentation. Such arrangements were either absent or not followed in not fully functional facilities. The quotes below illustrated tragic examples resulting in the losses of lives. In the first example, a participant from a not fully functional facility highlighted a case of "*system failure*" when the facility staff lacked accountability due to unclear roles and responsibilities among different departments in the facility. In the second example, another participant from a different facility highlighted an incidence of fresh stillbirth due to a lack of accountability and responsibility: compounded by the tension between two health cadres: nurses and intern doctors.

> *"We had mortality, maternal mortality of which an audit, our conclusion was the system failed the patient and not the other way around…this was a patient who followed everything as was advised but the system failed her. She came to the hospital, she had a low Hb, we talked to the lab who told us they had blood, so we started transfusing. Other patients came who needed blood. Those patients were given the blood then blood was over. They did not inform us, we wanted three pints because one pint would sustain the patient. The patient went into labour. We had a black out the generator was not working. So, the patient delivered in the dark, the placenta was not completely out. The person who was taking care of the patient at that point did not know, because they were using their own torch,*

but other than that when the patient kept bleeding. This person kept on doing what she thought was supposed to be done which was half right because they did not know exactly what they were supposed to do. So, at that point when I was called in to see the patient we needed blood. There was no blood. We needed a vehicle to refer the patient; there was no fuel. We had just got a new medical superintendent, the nearest petrol station where we get the fuel they did not know this new medical superintendent. So, they were like they don't know who they are dealing with and they will not give free petrol, and basically, we were resuscitating a patient we know was dying, so there was nothing we could do." (KI-38, Health worker from a not fully functional facility)

"I can give an example. There's a mother [who] comes, and there is foetal distress, and this patient may need a CS. But then the nurse sees the doctor's plan of management. She says she gives syntocins in the next four hours. This intern doctor does not have the experience, but the nurse has. The nurse says "well she is a doctor, she should know" and just moves on with her work and doesn't say anything then. When we deliver a fresh stillbirth, the nurse says, "I knew, but I couldn't tell her because I expect her to know as she is a doctor." (KI-36, Health worker from a not fully functional facility)

7.2.2 Institutional arrangements to control corrupt practices

Despite the presence of formal rules and procedures to discipline public health staff, there was a reluctance to do so as the procedures were perceived to be long and complicated. There was a common perception that public servants took advantage of the situation where the formal procedure to dismiss them was long and complicated and no action could be taken against them even if an individual staff committed some form of embezzlement. This was made by the presence of impunity as the system for sanctions or non-performance was compromised due to corruption or political affiliation. **Table 15** summarises the differences in institutional arrangements to control corrupt practices between the two groups of facilities.

Table 15. Institutional arrangements to control corruption

Institutional arrangements to control corrupt practices	Fully functional facilities	Not fully functional facilities
Formal: rules & procedures to sanctions for non-performance	Present	Present but impunity exists
Informal norms to sanction	Present (facility-driven disciplinary action)	Not mentioned
Informal norm to charge patients under FMS	Not mentioned	Present, *"charging patients under FMS is not corruption"*

A participant from not fully functional facility recalled how staff was exempt from punishment which further "*discouraged from disciplining another person*" in future. Another participant from the same facility echoed how disciplinary action could be blunted. The participant recounted how the proposal of disciplinary action was corroded by the hospital management due to the fear of potential consequences or backlash. The following quotes from two participants of a not fully functional facility illustrate this point:

> *"I have never seen anybody going home because of a problem. Instead, they are transferred to another place. So, you transfer the problem to another place. Because there was another relationship with the accused, whether you are relative or you are relative to their husband or something like that. You never know you can be compromised. Also, we are human beings. So, you have done somewhere like an incentive; an action is not taken by your senior. As a result, you get discouraged from disciplining another person next time.*"(KI-9, Health worker from a not fully functional facility)
>
> "*We may recommend at the lower level, but at the higher level, it may be disapproved… We kept quiet… The backlash will be there. That is called impunity, will now start doing things with impunity that can happen. Well, I may mention only one…a certain doctor has failed to come for duty and in the event, a patient has died because there was no doctor to attend. Then, we do a disciplinary committee and recommend that doctor's license be suspended and the recommendation goes higher and they refuse to suspend his license. It worked negatively for the hospital*" (KI-16, Health worker from a not fully functional facility)

Some informal institutional arrangements such as confusing norms and practices were also present in some not fully functional facilities as charging patients to cover FMS was not regarded as corruption so long as the money "*went into the hospital account*". It was regarded as corruption only if the payment went to an individual health worker's pocket. The following quote from a participant from a not fully functional facility exemplifies this observation:

> *"You see, now we are talking about charging a mother for delivery where it is supposed to be free and this money we are saying some hospitals are charging goes into the hospital account, does not go into individual pockets. So, I will concur with the staff who has told the mother to pay, because the money has gone to the hospital account to assist the same mother." (KI-16, Health worker from a not fully functional facility)*

Thus, conditions such as the difference in position and power provided the health staff with an opportunity to misuse their public positions for private gain. However, in fully functional facilities where staff had been involved in corrupt practices, there was evidence that **facility-driven disciplinary actions** had been taken. The following testimony from a participant from a fully functional facility provides evidence where a casual worker has tried to charge patients using previous user fees payment:

> "**Participant:** *last year I had an incidence and we took it up to the office, it was a casual worker.*
>
> **Interviewer:** *So, can you explain a bit more of this case?*
>
> **Participant:** *A casual worker you know in the evening, now she was going around and telling them [the women] "have you been discharged? You want to go home tomorrow give me money." Actually, it was two thousand at that time and the mother was a bit in doubt, why has she asked for money and these are free services, so she kept quiet and called the nurse later.*
>
> **Interviewer:** *She paid?*

> **Participant:** *She did not pay, she told the casual I will give you in the morning, but she waited till the casual went and asked when the nurse came "how much am I supposed to pay?" The sister was like "for what?" It is free. So, she explained there was this girl, she described because she did not know the name, she described and she was asking me for two thousand, she was telling me I was supposed to pay. It was a CS mother, so she was using the charges that we used to. So, she was telling her it's five thousand but if you can look for two, I can help you to go home.*" (KI-25, Health worker from a fully functional facility)

7.2.3 Institutional arrangements for participation

Participation and consensus orientation are other important institutional arrangements to actively engage key stakeholders in health policy implementation and development. According to the new Constitution of Kenya, it is a legal requirement that citizens must be consulted before a policy has been enacted into a law. **Table 16** summarises the institutional arrangements for participation in both groups of facilities.

Table 16. Institutional arrangements for participation

Institutional arrangements	Fully functional facilities	Not fully functional facilities
Participation in policy making Formal: legal requirement	Present	Present
Informal	Absent because *"decisions are made at Afya house"*	Absent because policy making was *"top-down"*

The country has formal mechanisms for inviting different stakeholder groups to strategic planning meetings. However, in practice, participants from both groups of facilities perceived that policy making was "*top-down*" as they were not given opportunities to participate in the decision making process. They only received information after the decision had been made at the central level as "*donors came and discussed with the Ministry people; it was all at Afya House [where the Ministry of Health is]*". There was a perception that private and faith-based organisation should have been involved in policy dialogue as the faith-based organisations provided a significant proportion of health service provision in the country. The following quote from a participant from a fully functional facility illustrates this point:

> *"The amount of health care that is provided by the Faith-based organisations; but we are hardly represented, even on the medical board. I think we need to have a voice because we really are on the ground and there are communities where it is really the faith-based organisations that provide the health care." (KI-10, Health worker from a fully functional facility)*

7.2.4 Institutional arrangements to improve equity

Table 17 summarises differences in institutional arrangements between the two groups of facilities.

Table 17. Institutional arrangements for equity

Institutional arrangements for equity	Fully functional facilities	Not fully functional facilities
Barrier in access to care due to distance	Present	Present
Barrier in access to care due to finance	Present	Present
Capture of local elites	Present (politicians wanted to influence county department of health)	Present *"county government was partial in providing the best services to their relatives"*

The barrier in access to care due to the **long distances necessary to travel to health facilities** or financial reasons were present in both types of facilities. Both groups made their own arrangements for people with disabilities in order to improve access to care. The following quotes from a participant from a not fully functional facility exemplifies this observation:

> *"The hospital receives everybody and even we are disability friendly, even for the disabled there is a bed which is low enough which a disable can climb, we have even trained staff on sign language." (KI-16, Health worker from a not fully functional facility)*

However, facilities in remote counties had challenges in getting health staff to provide healthcare to different population groups as it was difficult to recruit health staff who understood e.g. sign language to communicate with disabled women. The following quote exemplifies this observation:

> *"In my catchment area, we do not have someone with sign language, so I would say the policy is saying for all Kenyans and even people with disability. But here, this is a patient with disability and I am not able to serve them fully." (KI-25, Health worker from a fully functional facility)*

The other barrier to access care was user fees as **economic reasons were still a barrier** for target populations from both groups of facilities. The following quote from a not fully functional facility participant highlighted this point:

> *"In terms of equity, we have three groups of Kenyans, the upper class, the middle class and the lower class. So now the upper class do not come [to] public hospitals, they have their own hospitals, the rich and the middle class they don't come to public hospitals, they go to private hospitals because they have insurance which pays for them, there the health system is fantastic. Everything is fantastic, the equipment is good, there is no crowding, there is good food, there are a good ambulance system and everything. So, we are talking about the public hospitals… Your maid, your house girl, your house boy, your relative from the rural area who do not have money are the ones we have been talking about." (KI-16, Health worker from a not fully functional facility)*

Furthermore, "**capture of local elites**" was present in both types of facilities. A fully functional facility participant recalled how politicians wanted to interfere with the management of health workers within their county department of health (Also discussed under Chapter 5. Section 5.1.3.4. Threat to equity). Another participant from a not fully functional facility similarly experienced that their county government provided "*the best services for their relatives*" while they ignored the requests from health facilities. When health workers failed to comply with the county's request, the county has used their power to take action against health workers. Hence, facility participants felt that equity should also exist within the county health system. The following testimony from a not fully functional facility participant provides evidence for this observation:

> ***Participant:*** *"Politics play a very big role when it comes to management nowadays management of clients in the hospital you can imagine if it is a politician's relative, he would want the best for that relative they even make a follow-up. But once you*

go to complain that we need this and this in the hospital because we have patients suffering from this and this, they will not bother. But the day they will have their own relatives wanting the same services, they will come in very first. They will come in very first.

Interviewer: *And if you don't have these materials?*

Participant: *They want it done.*

Interviewer: *Failure to do that?*

Participant: *Failure to do that, we have had cases where people have been given letters to show why you should not be disciplined just because of ABCD. There is a day, we had a very bad road accident, we did not have so many things in the hospital so were referring everybody to Kenyatta. Even small fractures cut everything. So, it happened we had one of the relatives of the people in the county, they just called there and big people came and started saying why don't you have this and this. We told them, we don't have. They rushed to town to buy, this time they bought because they had a client. But when we have a problem with people, they don't know, it is not a big thing to them, they just tell you to refer, manage or do what you want to do. You know that is not equity. It should be equity for all, if you don't have, let us buy for everybody." (KI-37, Health worker from a not fully functional facility)*

7.3 Enforcement mechanisms

Enforcement mechanisms for good governance ensure individuals and organisations adhere with and abide by the interest of the institutions (Aoki, 2001) (Bertone and Meessen, 2013). This can occur via self-enforcement such as common beliefs, reputation, kinship or via third party enforcement such as legal sanction, contracts, rules, laws or policing (North, 1990). Reviewing the makeup of institutions, observing their adherence and understanding motivation could also enforce institutional arrangements (Bertone and Meessen, 2013).

In this study, self-enforcement were initiatives by facility participants for service delivery despite limited resources while third party enforcement comprised supervision, strengthening existing regulatory systems and enforcement across other sectors outside health.

The section below starts by explaining how facility staff used their own initiative to improvise with the available resources, then highlights the situation of the existing third party enforcement mechanisms such as supervision and regulatory system in place. (**Table 18**).

Table 18. Enforcement mechanisms between the two groups of facilities

Enforcement mechanisms	Fully functional facilities	Not fully functional facilities
Self-enforcement To perform	Present and initiatives to -Improvise with available resources -Overcome policy dissemination gap	Not mentioned
Third party enforcement Supervision	Present	Present
Existing regulatory system	Present but weak	Present but weak
Cross-sectoral actions	Require as corruption is "*systemic*"	Require as corruption "*exists in other sectors outside health*"

7.3.1 Self-enforcement

Participants from fully functional facilities demonstrated **self-initiative in performing** their duties as they improvised with the available resources to provide health services even though the equipment and supplies required to perform certain procedures were insufficient. The following quote from a fully functional facility participant illustrates this point:

> "*We also do the emergency CS or deliveries at night. This is even a bigger challenge even if you want to send the patient for the drug which is not available in the facility and even if you send the patient to go and get the drug, they cannot get the drug because most of the pharmacies have closed… [What] we usually do are other measures to control bleeding. Other methods that I do after uterine massage, oxytocin, give the oxytocin at the third stage of labour, then again you can add the oxytocin and go to a limit of 60-80 syntocinon IV. If that doesn't work and we don't have sytotec I usually do the balloon tamponade, which most of the time it sorts me out, the improvised one. You know we don't have the Rouche catheter, the ideal one for tamponade, but I just use the Foley with a condom." (KI-24, Health worker from a fully functional facility)*

Participants from fully functional facilities also took their own initiatives to look for the information within the context of the policy dissemination gap while it was not mentioned by participants from not fully functional facilities. Facilities, both fully functional and not fully functional facilities, set up their own forms of enforcement in agreement with the county department of health to control embezzlement. In some facilities where staff were involved in corrupt practices, there was evidence that facility-driven disciplinary actions had been taken. This was described in the previous "institutional arrangements" section as both formal and informal institutional arrangements were instrumental in avoiding further incidences.

7.3.2 Third party enforcement

Supervision was the most common form of third party enforcement, and facility participants felt supported during those supervisory visits which allowed them to interact with their supervisors and learn from those interactions. The following quote from a fully functional facility participant illustrates this observation:

> *"People from the central government should see how you are doing and what are your challenges. Even that in itself is motivating? So, that it doesn't appear like I have been dumped in some remote corner, somewhere." (KI-10, Health worker from a fully functional facility)*

Participants also highlighted the importance of third party enforcement to control corruption as corruption existed in other sectors, not only health and control measures for corruption were not enforced within the system. The **existing regulatory system was weak** as "*a lot of people tend to think that health care is like a business*". Together with stringent third party enforcement and responsible action, corruption could be eradicated from the current society in Kenya. This includes **cross-sectoral actions going beyond the health sector** as corruption is systemic. The following quotes from a not fully functional facility participant exemplify this observation. In the first quote, the participant highlighted substandard maternity facilities could be allowed to continue to function in a corrupt system. In the second quote, the participant wanted to highlight how corruption was systemic and how it also existed in other sectors outside health.

> "*I believe corruption or money can take anybody anywhere. Some of these things I am sure, they are bought. They are bought as when you want a permit to run*

maternity; if it has a requirement that you should have qualifications for you to run maternity, then what if you give them money, these people may protect you."

"*There is no fairness in anything. That's why we go on. Our system we have problem…like in the education system, you find that a child is not supposed to attend that school because he has not attained the marks that are required to join the school, and then you have another one who has met the requirement to join the school; but the parents of the child who has not attained the marks pays the principal. The result is the one with the requirement will miss joining the school. Those are the things that you will see everywhere either in the health system or the education system.*" (KI-9, Health worker from a not fully functional facility)

There was a perception that third party enforcement such as oversight mechanisms were present in both types of facilities but weak. Under these condition, self-enforcement was also important in remote facilities where third party supervision was a challenge. Indeed, even if a facility had formal rules in place to provide receipts for every payment, enforcing these rules depended on staff's adherence, community awareness and having disciplinary measures in place. In the previous chapter (Chapter 6), participants shared their experiences regarding how people could "*bend the rule*" as there were reported cases of non-adherence of FMS policy such as writing prescriptions to buy medicines under the policy instead of providing them free of charge.

7.4 Incentives and motivation

Incentives and motivation were important for health workers to achieve service delivery objectives. Incentives involved different types of benefits accrued to individuals because of institutional arrangements (Bertone and Meessen, 2013). Two types of motivation were discussed in this study: intrinsic motivation (the health worker adhered to the facility arrangements as s/he valued it) and extrinsic motivation (the health workers expected to benefit something by adhering to the facility arrangements). These two types of motivation were difficult to differentiate as providing extrinsic motivation for health workers might have affected intrinsic motivation as health workers might revise their preferences and choice (Bertone and Meessen, 2013).

In this study, facility participants described two reasons for intrinsic motivation and three causes of extrinsic motivation. Intrinsic factors included a moral mission to save lives as

participants felt accountable to the populations served but demotivated to work due to the lack of opportunities to participate in policy making. Extrinsic factors were meeting their basic needs and supportive working environment, for instance, collaboration/coordination among co-workers and presence of facility-driven staff support system. The section below first describes intrinsic factors followed by extrinsic factors. (**Table 19**).

Table 19. Incentives and motivation between the two groups of facilities

Incentives and motivation	Fully functional facilities	Not fully functional facilities
1)Intrinsic motivation		
Accountability (moral mission to save life)	Present	Present
Participation (voice in policy making)	Absent	Absent
2)Extrinsic motivation		
Basic needs (e.g. receiving regular salaries in time)	Met	Delay in receiving salaries (some facilities for months) (job insecurity)
Coordination among colleagues	Present	Absent
Supportive working environment	Present (facility-driven staff support system)	Absent (facility-driven staff support system)

7.4.1 Intrinsic motivation

Most intrinsic factors were related to health workers' **moral mission and ethical principles to treat** and hence, they felt they were accountable for their work, practised in line with facility arrangements, even in resource-constrained situations and in private facilities. For example, despite the lack of resources to perform emergency obstetric care (the equipment and trained health staff to perform signal functions), participants from both types of facilities continued to providing services. In another example, a fully functional facility participant could act on ethical principles even in the private sector, resisting the temptation to recommend caesarean sections to make more money. The following quotes from participants from each group of facilities exemplify this observation:

> *"In the delivery room, we deliver mothers on a mackintosh. It increases sepsis because another mother has just come from there you delivered a mother over there then you bring another mother. Fine, you have carbolised but it is not sufficient… Delivery packs are never sufficient; they are never enough. Most of the time, even if you went there now, they are delivering with either a blade and that is what they use for episiotomy is what they use for cutting the cord." (KI-36, Health worker from a not fully functional facility)*
>
> *"In private facilities, you know private most of the time is about making money, so where I work I usually tell them I have to review the patient before I do any CS, when they call me for emergencies I review the patient I make sure the indication is there then I perform then do the procedure, but in other areas the intent is just to make money, it could be exploited a bit." (KI-24, Health worker from a fully functional facility)*

Some facility participants were demotivated due to a **lack of opportunities to participate in policymaking**. There was a perception that they were left out of policy development and the decision making process and this "lack of voice" led to demotivation. Participants from both groups of facilities shared similar opinions as they were not invited for the development of important policies. A fully functional facility participant gave an example regarding the "Beyond Zero" campaign and how it was impossible to reach this in some counties. A not fully functional facility participant also highlighted that as the FMS policy did not involve health workers in policy development, this had resulted in significant gaps in payment structures and impeded its implementation. The following quotes of participants from a fully functional and a not fully functional facility illustrate this observation:

> *"Beyond Zero; but think of taking this ambulance to Turkana where there is no road. Then you are called that there is an emergency, how does the ambulance get there, how does it get back. The decisions are being made on the centre without really looking at specific challenges of each [county]." (KI-10, Health worker from a fully functional facility)*
>
> *"The government pegged 5000sh for delivery, and they did not know that there is a difference between normal delivery and a CS… They should have said if you*

> *deliver normal, we give you 5000sh. If you deliver CS, we give you 20,000sh because the two are different, the cost of anaesthesia is different from normal delivery… We were not called to craft the payment structure; we were not consulted, it was just pushed down our throat that you will get 5000 and you cannot say no because it is the government, so you just work with what you have." (KI-16, Health worker from a not fully functional facility)*

7.4.2 Extrinsic motivation

Facility participants seemed to highly value the humanitarian aspect of their work, particularly their moral mission to save lives. This passion was one of their motivating factors though they were working with limited resources. This was observed in both groups as they felt satisfied that their services still benefit women and children. However, those intrinsic factors would only function **when basic needs** of the health staff **were met** (for instance, receiving regular salaries in time). Participants from some facilities (not fully functional) noted that generally, motivation in their workplace was low as their basic needs were not met. This was observed in some not fully functional facilities as some staff who did not receive their salaries on time and in the worst case, salaries were delayed "for months" with no information. Besides, some staff in those facilities felt insecure in their jobs as there were rumours regarding the laying off some health staff. In one of the not fully functional facilities, there were even reports of losses of medical equipment compromising the trusting relationship among the staff. This could be seen from the following example of how working with very limited resources put a strain on health workers.

> *"There was a time when a lot of equipment was getting lost from the hospital, and there was a lot of blame game…And there was a policy, when you are leaving, you are asked to show what is in your bag… There has been a lot of issues concerning salaries, and some county says they want to lay off some people. Some people salaries have not been paid for months, some people have not been promoted, and you see there is a lot of hardship among the people who provide care in the hospital. Especially the support staff, they come to work, but some of them have not been paid for months and months." (KI-38, Health worker from a not fully functional facility)*

A positive working environment such as collaboration/coordination and collective support among colleagues also motivated facility participants to perform. Some participants from not fully functional facilities commented that the lack of both **vertical and horizontal coordination** with insufficient support from the county government were significant barriers to productivity and the accountability of health workers. The following quotes from not fully functional facility participants exemplify this observation:

> *"…because the hospital does not liaise with the county government, so you find that there is a gap, the hospital needs if it is presented to the county government…We get to meet only when there is an issue and even when we meet when there is an issue. Usually, you find there is no unity though most likely if we meet, we call for a meeting usually the medical officer interns, clinical officer interns will come but the nurses may not come. So, you find that still, the meeting is not effective, is counterproductive." (KI-36, Health worker from a not fully functional facility)*
>
> *"…they [the county] have been buying for us, but they are still to bring some of the things that we require, they are yet to respond, but before devolution, actually from the minister of health we used to receive a recurrent funding that we could use to purchase food for patients, fuel our vehicle for such, we used to receive a number of things even equipment's and so we are waiting for the county to do the same." (KI-33, Health worker from a not fully functional facility).*

Another extrinsic motivator was **supportive working environment** as participants from not fully functional facilities highlighted that it was missing in their workplaces. The following quotes from facility participants illustrate this observation as fully functional facilities supported and felt supported by their colleagues while it was not present in not fully functional facilities:

> *"We had someone who was drunk, he was an alcoholic, and the facility was able to enrol them in a rehabilitation centre, and now actually they are back to work. So, I think that is a success, that is an example." (KI-32, Health worker from a fully functional facility)*
>
> *"It is really pathetic. We once had such a staff, when it comes to work he is very perfect but he was an alcoholic, the case was forwarded to the county. Instead of us really having a support system to support this individual, he was transferred to a rural facility, where he went, and he became worse, I think that's our weakness, we need to have such a system in place to help these staff some welfare." (KI-37, Health worker from a not fully functional facility)*

7.5 Chapter summary

This chapter examines how governance arrangements differ between the two groups of health facilities with different functionality. The facility functionality was explored in the form of the availability of signal functions. Governance arrangements were considered from institutional analysis approach looking at what and how institutional arrangements for different governance principles have been enforced and what was the motivation to enforce those arrangements. The findings suggest that staff responded to problems with formal institutions by creating informal arrangements that sometimes circumvented and sometimes supported the goals of the formal system. Fully functional facilities had accountability mechanisms that were self-enforced. By contrast, not fully functional facilities lacked both self-enforcement and effective third party enforcement mechanisms. Norms and practices for controlling corruption were clear in fully functional facilities but confused in not fully functional facilities. Both groups of health workers highly valued the humanitarian aspect of their work. However, staff from not fully functional facilities were demotivated as they could not meet their basic needs and the working environment was unsupportive. Other institutional factors that might have explained the difference between the two groups of facilities did not seem to be significant. All facilities were subject to top-down policy decisions which hindered dialogues between citizens, civil society and government. A general lack of transparency and the absence of structured information dissemination also reduced the chances for accountability to citizens via participation and engagement.

CHAPTER 8

8. Discussion

The aim of this chapter is to position the findings of this study within the body of empirical and theoretical evidence from the literature. To do so, the chapter first briefly recaps the aim and objectives of the study, the methods employed and the theoretical framework used in the study. Following this, the chapter will discuss how the study findings are similar or different from findings from other studies, and how they advance the understanding of health system governance.

The aim of the study is to explore the situation of health system governance at three health system levels in Kenya focussing on health facilities designated to provide comprehensive emergency obstetric care (CEmOC). The following specific research objectives were formulated to achieve this aim:

1. To explore factors influencing health systems governance in Kenya
2. To explore the perspectives of key stakeholders on health systems governance
3. To explore whether the status of health system governance differs with functionality of health facilities

While the subject of governance has been studied across different disciplines, few studies have generated a comprehensive understanding of governance at the operational level. Chapter 3 (Literature review) of this study discussed governance from a cross-disciplinary perspective. It provides an in-depth critique of the frameworks available to assess governance in health systems. There are ten studies in the literature which assessed governance at the operational level. This is one of the very few studies which have assessed governance at health facility level. Specifically, one of the analyses conducted in this study was informed by the institutional framing of governance in which governance is defined in terms of the rules that distribute roles among actors and shape their actions, decisions and interactions.

Considering that governance refers to the rules (both formal and informal) of collective action and decision making in a system with diverse players and organisations, it was important to adopt a suitable framework to guide the exploration of factors that may influence governance. Two frameworks were adapted: the frameworks of Baez Camargo and

Jacobs (2011) and Siddiqi et al. (2009). Three main attributes characterise the framework: in-depth understanding of key operational principles of governance; a focus on institutional analysis and analysis at multiple levels of a health system.

This chapter is presented in five parts as below. The first section of this chapter summarises the main findings of the study. The second section relates the findings to the literature. The third section explores the strengths and limitations of the study. Within the section, key strengths of the study have been highlighted in two key sections: methodological contributions and relevance to Kenya. The fourth section points to the areas for future research in health system governance. The fifth section provides strategic recommendations for Kenya. The final section presents the overall concluding remarks on the study and the topic.

8.1 Summary of key findings

The following section provides an overview of key findings of this study in relation to the research questions described in Chapter 4. (**Table 20**).

Table 20. Summary of key findings

Chapter	Research questions	Key findings
Chapter 5	Which factors influence the governance of the health system in Kenya?	-Devolution has brought the Kenyan health system into a decentralised structure of governance, **presenting opportunities for governance** as the system of elected county government promoted public accountability. Challenges (threats to accountability and equity) outweighed the opportunities of devolution as it **compromised the capacity of county government**. -Rapid "big bang" devolution did not allow Kenya health system and structures to be in place. This was compounded by the **limited capacity of county governments to handle** their newly **devolved functions** and **limited capacity of national government to support** county governments in devolution. -**Health financing** was **still a challenge** to the Kenya health system as public health facilities were struggling to adhere to the new financing policy (FMS). This was compounded by **HRH shortage** and **health workers' strikes** due to health workers receiving late salaries and different payment schemes between the two levels of government.
Chapter 6	How do key stakeholders from Kenya perceive governance of the health system?	-Financial accountability was considered to be essential due to **lack of control mechanisms with different opportunities to abuse** within the Kenyan health system. The current health system **required incentives to improve the performance of public sector** staff due to lack of formal performance appraisals. -Different mechanisms to improve **community accountability existed** although their **functionality was variable**. This was compounded by **limits in citizens' access to the right information** and **weak enforcement of laws**. The country had good policies in place, but **discrepancies existed between the formal and informal rules** due to weak law enforcement, lack of resources, inappropriate costings and problems with reimbursements. -Although the current Constitution allowed stakeholders' participation in policy making, there were **not enough engagement in policy development** due to inequity among different groups and power differences. -**Equity** across counties **has not improved with devolution**. There have been small steps to address it, and it would take the time to improve the equity across the country.
Chapter 7	Are there any differences in governance between fully functional and not fully functional facilities?	-Both groups of facilities lacked formal institutional arrangements for performance appraisal. **Informal rules for accountability and control of corruption** did differ such as understanding roles and responsibilities, following standard operating procedures and coordination among the health workers **were missing in not fully functional facilities**. -In not fully functional facilities, facility **enforcement measures were hindered by influential people,** and health workers felt discouraged or reluctant to discipline other staff. -The presence of incentives and motivation to be accountable was another observed difference between the two groups of facilities. **Participants from some not fully functional facilities felt demotivated** as their **basic needs were not met** in the **unsupportive working environment** such as coordination/collaboration among the colleagues. -Other institutional factors such as participation, transparency and equity between two groups of facilities did not seem to be significant. All facilities were subject to **top-down policy decisions** which hindered dialogues between citizens, civil society and government.

The overall aim of this study was to explore the situation of health system governance in Kenya. Previous studies sought to establish quantitative linkage between governance and health system performance or health outcomes. This study made a departure from that as it sought to understand, in addition to that linkage, how stakeholders perceived governance. To be specific, this study explored each operational principle of health system governance. Indeed, the main contribution of this study to the knowledge on governance is in its exploration of how and why stakeholders are accountable; how they control corrupt practices; how rules have been enforced; and how stakeholders engaged and participated in achieving equity in access to health care.

8.1.1 Factors influencing health system governance in Kenya

Chapter 5 describes how the government of Kenya has supported the improvements of governance, by taking a strong stance against corruption while the country is trying to achieve universal health coverage through different initiatives. Two prominent health financing initiatives introduced in June 2013, the abolishment of the user fees policy and the adoption of the FMS policy, are constitutional milestones for the country. In addition to the political context, the socio-cultural context played a significant role as it influenced and explained why and how individual health workers interacted with their communities and their roles in adhering to health system rules. For instance, it highlighted the importance of social and public accountability mechanisms as socio-cultural norms still dictated how people sought health care. In other words, it highlighted the inadequate use of skilled healthcare providers and power difference between community and healthcare providers.

Simultaneously with introducing new financing initiatives, the country has undergone a process of **devolution** as the majority of Kenyans voted for decentralisation in August 2010. The health sector was one of the public sectors to embrace devolution. Consequently, 47 newly elected county governments became responsible for the implementation of essential health services while the national government provides technical support to the counties, manages provincial general hospitals and drafts health policies. Although a Transition Authority was formed to facilitate the transition period, county governors asked the President to devolve authority more rapidly than initially planned, soon after they had been elected (within a six-month time frame).

Indeed, services have been devolved quickly while several outstanding questions remain unanswered for Kenya's health sector. Participants provided different examples of how

devolution compromised the capacity of county government to deliver care. They perceived that it was "*big bang*" devolution with inadequate support from the national government. Counties have different baseline capacities due to historical development challenges and the limited decision making power (counties can decide but have no resources to realise) received through the devolution. Even though counties can design health service delivery at their own discretion, they receive limited resources from the national government, and very few counties can generate their own revenues. Thus, the **lack of adequate financing** to achieve their vision is a real problem. Another common frustration shared by participants is the **management of the health workforce**, as counties struggled to manage the payroll while human resource management systems and structures were yet to be put in place; compounded by frequent health workers' strikes due to late salary payment. Some participants felt that the health system had not changed quickly enough to respond to the devolution goals.

Nevertheless, this study highlights that **devolution provided opportunities for good governance** as it created opportunities to **improve** different forms of **accountability**. Devolution helped to promote community accountability as local government officials risked not being re-elected if they did not respond to community needs. It also helped to avoid unnecessarily prolonged decision making as counties could respond with a shorter turnaround time. Devolution facilitated ownership and responsibility of county governments as it provided them with adequate decision space to implement health service delivery. The devolved Constitution provided county governments "*a lot of clout*" to implement health policies. Devolution also allowed county governments to think holistically, involving other sectors such as roads, infrastructure and communication to improve the health system.

8.1.2 Perspectives of key stakeholders on governance

Besides devolution, Chapter 6 explored specifically how key stakeholders perceived the governance of Kenya's health system. The study used a governance assessment framework described in Chapter 4 to examine different principles of governance. Participants reflected mainly on five interrelated principles of governance: accountability, control of corruption, the rule of law and strategic vision, participation and equity. Indeed, there were challenges in realising accountability which was influenced by other principles of governance.

Among the three accountability mechanisms (financial, performance and community accountability), **financial accountability** was **considered to be the most important** by national participants as counties became responsible for decision making related to health

service delivery. An additional perceived vulnerability was that county governors had limited experience in financial management with no proper mechanisms in place to manage resources. For facility participants, the current health system **did not have visible incentives for performance accountability** as there was no objectively set system of penalty or appraisal to improve performance while patronage, favouritism and individual caprice could limit performance accountability. Furthermore, **downward accountability** (i.e. accountability towards subordinates or lower levels) was also a **neglected agenda** within the health system hierarchy, as different officials only cared about accountability towards their managers or higher level.

This study found evidence of **community accountability mechanisms** being put in place, including suggestion boxes, health centre committees and facility service charters, although their functionality was unknown. Two commonly cited reasons for using community accountability were to create public awareness and to empower communities despite the existence of accountability brokers and abuse of the system. This was evident from the example of citizens who demanded services to which they were not entitled but were trying to benefit from the system.

The findings seem to suggest that the current health system has **different opportunities for abuse**, some groups had used the power and information to abuse public resources for personal benefit. For example, some facility staff took advantage of the limited understanding and knowledge of clients such as asking women for payments for maternity care, even though user fees had been officially abolished. Participants reported experiencing unfair treatment by some county government officials who made use of their power. Hence, **corruption was** perceived as **a systemic problem** while transparency and the rule of law helped reduce the incidence of possible corrupt practices. Although there were increasing means to make information more available, citizens' access to the right information at the right time was still an issue within the Kenyan health system. Additionally, **weak enforcement of laws** was another key driver to abuse, as citizens could not hold public agents accountable.

This study identified two forms of rules influencing Kenya's health system: rules in form and rules in use. This study was conducted two years after the introduction of two new financing policies: abolishment of user fees and FMS. Therefore, this study used the FMS policy as an example in discussions related to the rule of law and strategic vision. Participants perceived that the **country had very good policies in place**, but when it came to implementation, there

were significant gaps due to weak enforcement of the rules. This was compounded by inefficient policy dissemination, inappropriate costings and a complex reimbursement process. The situation was further complicated by health system challenges such as shortages of staff, supplies and equipment. Sometimes policy implementers (facility and county participants) made their **own arrangements to adhere to the prescribed rules**: for example, slightly bending the rules to provide maternity services by writing prescriptions. This **partially-enforced policy redefined the property rights** (decision making and earning rights) of health workers with a loss of one source of funding which was not adequately compensated. Hence, the FMS policy struggles to work in practice due to discrepancies between the rules in form and the rules in use. One reason for such discrepancy noted by county and facility participants was that they were not invited to participate in developing the policy.

This study considered opportunities afforded to stakeholders to participate in the policy making and implementation process. Although the Constitution allowed for their participation, in fact, participants did not perceive that they could participate in **policy making** which **remained "top-down"** and the **systems were state-centric or county-centric**, allowing little room for participation. Additionally, citizens were not sufficiently empowered to participate in these processes due to power differences and inequities among different population groups.

Participants across all categories acknowledged the existence of **inequity in access to care** and **inequity across different counties** has not reduced after devolution. The national government did put in place measures to reduce inequity, such as the removal of financial barriers by abolishing user fees, equitable sharing of resources among different counties, removing distance and geographic barriers by improving infrastructure and the referral system, and training and recruitment of local communities. On the other hand, participants acknowledged that issues of inequity could not be solved overnight.

8.1.3 Differences in governance between fully functional and not fully functional facilities

Chapter 7 of this thesis answers the third research question: "Are there any differences in governance between fully functional and not fully functional facilities?" UN signal function availability was used to determine the functionality of health facilities designated to provide CEmOC. Among ten purposively selected facilities, four were fully functional, and six were not. Signal function 5 (removal of retained products) and 6 (assisted vaginal delivery) were

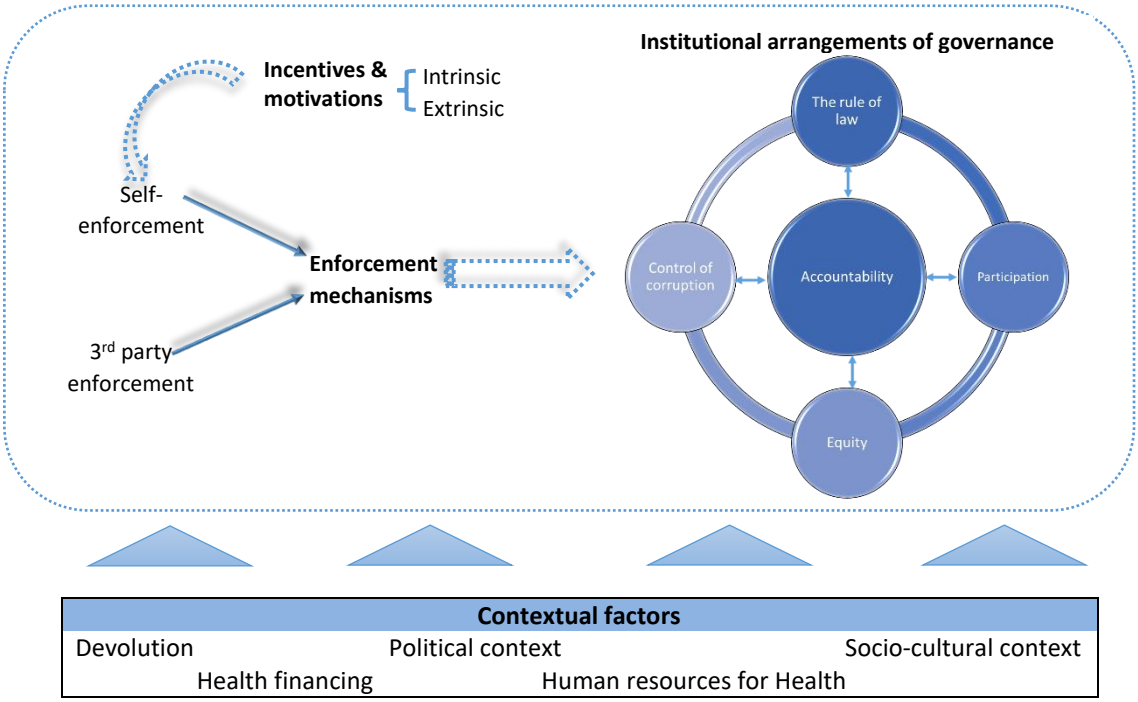
the two signal functions most commonly unavailable. Secondary data highlighted that fully functional facilities had at least one of the equipment sets (vacuum and forceps) required to perform signal function 6, which was not the case for not fully functional facilities. However, there was no difference in the availability of equipment between the two groups of facilities according to the interview participants, as none of the groups had enough equipment. But staff from fully functional facilities improvised with available resources while both groups faced challenges due to a shortage of skilled staff who were trained to provide signal functions, due to frequent staff rotation and transfer.

The analysis adopted in this chapter used the institutional framing of governance as described in Section 4.4.3.2 and directed content analysis (described in Chapter 4). The findings highlighted that staff responded to lack or weakness of formal institutions by creating informal arrangements that may circumvent or support the goals of the formal system. **Fully functional facilities** had **self-enforced** accountability mechanisms; by contrast, facilities that were not fully functional lacked both self-enforcement and effective third party enforcement mechanisms. Furthermore, **norms and practices for controlling corruption** were **clear in fully functional facilities** but confused in some that were not fully functional. Other institutional factors that might have explained the difference between the two groups did not seem to be significant. All facilities were subject to "**top-down" policy decisions** which hindered dialogues between citizens, civil society and government. A **general lack of transparency** and absence of structured information dissemination also reduced the opportunities for accountability to citizens via participation and engagement.

It is important to note that the overall findings presented above modified the framework (**Table 7**) exploring governance which was presented in the Methodology Chapter (Section 4.2). During the analysis process, it became apparent that governance principles were interrelated and the same finding could be classified under different governance principles. Particularly, the two principles: strategic vision and the rule of law have been combined into one as the responses related to strategic vision were mostly related to the FMS policy and how they have been enforced by laws. Besides, there was not enough information on the principle "responsiveness". Instead, there was information regarding the "control of corruption" principle which was not considered initially. Indeed, a modified conceptual framework incorporating the key findings from this study is needed. The revised conceptual framework (**Figure 28**) recognises the importance of contextual factors influencing health system governance such as on-going devolution, political and the socio-cultural context, health financing and human resources for health. It also integrates the institutional framing

of governance, highlighting how different intrinsic and extrinsic motivations of frontline health workers enforce the institutional arrangements for each operational principles of governance.

Figure 28. Revised conceptual framework of the study



8.2 Findings in relation to the literature

This section discusses key findings in the context of the broader literature on health systems governance in four sub-sections according to the revised conceptual framework (**Figure 28**). They are 1) contextual factors influencing health system governance in Kenya, 2) institutional arrangements of governance, 3) enforcement mechanisms and 4) incentives and motivation. In discussing the linkage with the literature, both the health system literature and findings of governance from other disciplines such as international development and new institutional economics are discussed.

8.2.1 Contextual factors influencing health system governance in Kenya

Within the context of devolution, the health system in Kenya faced challenges with limited health financing and resources which did not change in tandem with devolution. The findings highlighted that devolution could be an opportunity to improve county governments' responsiveness to their population due to the emergence of public accountability

mechanisms and stakeholder opportunities to engage in policy development process. However, rapid devolution hindered these opportunities as the counties did not have systems and structures in place. This can be observed in Chapter 5 which highlights how governance is instrumental in shaping the newly devolved (decentralised) health system of Kenya. This is in line with Hope (2014) who highlighted that decentralisation brought changes in governing the health system. Ciccone et al. (2014) also noted that decentralisation improves the responsiveness to local health needs and values.

The central aim of devolution in Kenya was political to respond to 'distributional grievances'; in other words, **inequity** (Ndii, 2010). Two out of the nine stated objectives of devolution in Article 174 of the Constitution were related to economic development: 1) Article 174 f. 'to promote social and economic development and service delivery'; and 2) Article 174 g. 'equitable resource distribution' (Ndii, 2010:6). The implications of devolution on improved public sector performance depends largely on positive collaboration between the two levels of government, the capacities of the two levels of government, and, the accountable use of resources. As the primary purpose of decentralisation was to respond to inequity, participants expressed concern that little progress had been made in achieving equity goals. The lack of progress may not be unusual: evidence linking decentralisation to improvements in equity is scant (Sumah et al., 2016).

Devolution has brought the Kenyan health system into a **decentralised structure of governance**. Chapter 2 (Background) has described how the devolved governance structure transfers the responsibility of financing and managing health service delivery (except national referral facilities) to county governments while the national government is responsible for providing policy, technical oversight and support to county governments. Therefore, a positive collaboration between national and county governments is crucial, and depends on the incentives and motivation of key stakeholders at each of the two government levels. County governments received only a moderate decision space in financing while they received a wide decision space in two other key health system functions: 1) organisation of health service delivery and 2) HRH. **Decision space** is essential in a decentralised governance as it dictates how devolved government could influence or participate in the decision making processes (Bossert and Beauvais, 2002). Allowing wide decision space is often used as a means to hold devolved government accountable (Bossert and Beauvais, 2002). A wide decision space also allows the devolved government an opportunity of "learning-by-doing" as they become increasingly more comfortable in making independent choices (Bossert et al., 2015). The principal-agent theory postulates that the

decentralised units (county governments) with wide decision space may choose not to take advantage of the new powers received if they are entrusted with accountability and responsibility (Bossert, 1998). The agents also tend to innovate by making new choices if their interests are in line with the objectives of the principal (the national government) (Bossert, 1998).

According to a survey conducted in 2002, Kenya was already in the top quartile for five components of decentralisation (political, administrative, financial, upward accountability and downward accountability) among its African peers even before devolution (Ndii, 2010). However, the decision space for those functions, in reality, was restricted by the limited resources the county governments received. This can be observed from interviews of county level participants who shared their frustration that the capacity of county health services was somehow limited due to the "*resource envelope"* received. Under the current system, the national government allocated only 15 percent of its total revenues to county governments. This funding is then divided between different counties based on population, poverty index and land area. Consequently, counties struggled to fulfil their mandates with the limited budgets received. These findings echo Abimbola & Olanipekun et al. (2015), illustrating limited resource allocation does not allow devolved governments to function adequately. Sumah et al. (2016) highlighted a similar observation in their systematic review on the impact of decentralisation, noting that devolved governments were rarely independent.

Together with limited financing, the county governments were also facing another health system challenge, that is, **shortage of health workers** to deliver services at public health facilities. Frequent health workers' strikes since devolution compounded this. The Kenyan government has been struggling to resolve this issue as the numbers of strikes have increased. During the first quarter of 2017, a nationwide strike involving approximately 5000 health workers brought Kenya's public health system to a halt. Medical staff from the public health system protested to the national government as the government failed to fulfil their 2013 commitment to raise health workers' salaries, provide adequate resources (equipment, medicines and supplies) and opportunities for training and professional developments. The situation was compounded by health workers receiving late salary payments. This highlighted the national government's failure to successfully decentralise its health care to county governments related to the lack of distribution of the needed financial resources to implement this.

In Kilifi county, Tsofa & Goodman et al. (2017) similarly observed that delays in the payment of health workers' salaries resulted in increased health workers' strikes and resignations after devolution. Some of the health workers from Kilifi county asked for re-centralisation as they did not experience any positive effects from devolution (Tsofa & Goodman et al., 2017). On the other hand, improvements have been observed in the supply of essential medicines and commodities after devolution (Tsofa & Goodman et al., 2017). Unfortunately, the improvements focused on publicly visible commodities like ambulances rather than investing in essential medicines required for primary health centres (Tsofa & Goodman et al., 2017). Similarly, previous analysis of decentralisation in developing countries had unintended effects on HRH (Abimbola & Olanipekun et al., 2015; Scott, 2009). Abimbola & Olanipekun et al. (2015) documented the attrition of primary healthcare workers in Nigeria which was influenced by the consequences of decentralisation as the primary healthcare governance falls under the weakest and least powerful level of the government, the local government.

Most importantly, frequent health workers' strikes jeopardised civilians' lives due to the lack of services at public health facilities as many of these were unstaffed during the strike period (Kenya's nurses strike takes its toll on healthcare system, 2017). This was due to the consequences of devolved governance arrangements under the existing health system. Njuguna (2015) conducted secondary data analysis using service utilisation data from hospitals within Mombasa county and highlighted that two-week health worker strike in August 2014 resulted in a 26.3% increase in patient deaths, 53.5% decrease deliveries at health facility level, 57.8% decrease in inpatient admissions, 64.4% decrease in outpatient admissions and 74.2% decrease special clinics attendance. In such occasions, Kenyans had to choose private service providers which the majority of the population were unable to afford (African Research Bulletin, 2017; Kenya's nurses strike takes its toll on healthcare system, 2017).

The other challenge highlighted by this study was how the **limited capacity of county governments** (to manage the newly devolved health system functions) undermined health system governance. Unclear roles and responsibilities in devolved systems limit accountability and threaten equity. Similar findings were reported in Kilifi county, Tsofa & Molyneux et al. (2017) highlighted the lack of clarity in roles and responsibilities among different health system levels, compromising accountability of the country health system. Regarding capacity of county governments, existing reports are in line with the views expressed by the participants in this study. For instance, Williamson & Mulaki (2015) highlighted that county governments had limited legislative experience and lacked the

required systems to manage resources efficiently. Tsofa & Molyneux al. (2017) also spotlighted the lack of capacity at county government level (Kilifi county) with re-centralisation of financial management under decentralised government. Therefore, the World Bank (2017) commented that Kenya's devolution is "*one of the most ambitious implemented globally*" (World Bank, 2017). Williamson & Mulaki (2015) also noted that capacity gaps within decentralised units were an issue in many developing countries. Kenya is no exception as only a few counties had the administrative capacity to absorb the limited funds available and plan for effective use of these funds. There was also no plan in place for training or mentoring to close the capacity gaps, although the national government had originally planned to use the three-year transition period for capacity building (Williamson & Mulaki, 2015).

This study identified how devolution enhanced different forms of accountability (another key principle of governance). Chapter 12 of the Constitution on Public Finance required open financial accountability mechanisms (Hope, 2014). Mitchell and Bossert (2010) highlighted that decentralisation could be used to improve accountability of public policy especially downward accountability. Similar findings were observed in this study as participants highlighted the increased accountability of the county government to their health departments or health workers. This was considered to be due to officials at county government level being concerned about re-election.

Mills (1990) noted that in any decentralised system, there should be **a balance between** different forms of accountability such as **upward accountability** (county government to national government), **downward accountability** (county government to health workers) and horizontal accountability (among the same levels of the health system). Although county governments in Kenya still depend on the national government, they are accountable to both national government and citizens including the health workers under their management. This is highlighted by facility participants on how downward accountability of health workers was compromised in order to comply with the orders from their managers (upward accountability).

8.2.2 Institutional arrangements for good governance

The findings in Chapter 6 and 7 described the institutional arrangements for governance by from the perspectives of key stakeholders, highlighting the key principles of governance.

8.2.2.1 Accountability and control of corruption

Participants highlighted how **accountability** of key health system actors was **influenced by inadequate resources and capacities** which in turn created a lack of clarity in roles and responsibilities among key stakeholders. This finding echoes the critical factors outlined by Cleary et al. (2013) which influence health workers' accountability: resources and capacities of key stakeholders; attitudes and perception; and values, attitudes and culture. Participants in this study described various challenges in improving accountability such as poor communication, lack of incentives to be accountable and resistance to being held accountable, patronage, nepotism and tribalism. Competition with resistance to coordinated and integrated work were other recognised challenges undermining accountability among key actors in Kenya.

This study also identified one crucial aspect of the health system, that is, the regulatory capacity of the Ministry of Health. As discussed in Section 6.3. (Control of corruption), participants highlighted two regulatory weaknesses: licensing and regulation of health workers within the Kenyan health system. Sheikh et al. (2013) termed this situation as "regulatory capture" as professional medical associations were reluctant to take action against their own members due to conflict of interests, power differences and unclear roles and responsibilities.

Other literature on corruption highlights that individuals sometimes used their public position to pursue their personal objectives or interests (Vian, 2008). This was observed in cases of health workers (KI-24, KI-9 in Section 6.3; KI-25 in Section 7.2.2), as the facility staff perceived that they had opportunities to manipulate or influence patients who sought to receive services from them. **Asymmetry of information and power**, and **monopoly** (i.e., being the only organisation providing care, so patients could not choose alternatives to signal their discontent with services) provide **opportunities for the public officials to abuse their power** (Vian, 2008). This was highlighted in this study when health workers illustrated how county officials assumed that health workers (according to their positions in the health system hierarchy) had no means to voice the unfair treatment received from the managers and the system.

Access to information is crucial for a well-governed health system (Vian, 2008). Between the two parties in the health system, when one party has more information than the other, it creates a difference in power that can provide an opportunity for the party with more information to exploit the other (Bloom et al., 2008). In this study, participants highlighted the existence of information gaps among citizens, health workers and even county officials. Improving social accountability requires increased opportunity to listen to its citizens. This is in line with the literature. For example, Bjorkman and Stevenson (2009) conducted a randomised field experimental study on community-based monitoring of primary health workers in Uganda. The study showed that through improving information and community participation, citizens made health workers accountable for their performance.

On the other hand, Booth and Cammack (2013) argue that **social accountability** and the voices of citizen **will be powerful only if** there are **complementary mechanisms in place**, such as top-down pressure, opportunities to integrate social movements into political parties, and interest from professional organisations. Therefore, interventions to improve accountability and fight against corruption should be complemented by such activities. Even though individuals may disapprove of corrupt practices and are aware of the consequences for the society at large, they have few incentives and motivation to fight against it (Booth and Cammack, 2013).

At the facility level, the findings from Chapter 7 showed that both groups of facilities lacked **formal institutional arrangements** to improve performance accountability such as performance appraisal for health staff. Alande (2014) conducted a study on the role of human resource management in five technical areas (recruitment and selection, training and development, change management, human resource policies and procedures and performance management) in Mombasa district of Kenya which highlighted that human resource development was a neglected area for which there was no system for developing county officers to further the agenda of devolution. The county also lacked a performance management system and some of the county staff were hired not based on their capacity but due to political affiliations (Alande, 2014).

Despite the lack of formal institutions, the two groups of facilities had different **informal institutional arrangements** for accountability and the control of corruption. These included understanding roles and responsibilities, following standard operating procedures and coordination among the health workers. These arrangements were absent in facilities that were not fully functional. Other studies conducted in Nigeria reported the consequences of

poorly defined roles and responsibilities together with the lack of coordination among the co-workers. This compromised accountability among health workers and affected the achievement of health system objectives (Erchick et al., 2017; Garuba et al., 2009).

Informal institutional norms, such as charging patients to recover fees for the facility, were not regarded as corruption in facilities that were not fully functional. While there was confusion as to which components of the FMS were free and which could be charged for, the informal institutional norms further confused the health workers and patients, providing health workers opportunities to abuse the situation. In a similar vein, Mkoka et al. (2014) highlighted the importance of institutional arrangements in implementing an emergency obstetric care programme in a rural district of Tanzania. The authors pointed to the lack of accountability arrangements such as clear roles and responsibilities with minimal inclusion of health workers in policy development which hampered the successful implementation of the programme.

8.2.2.2 Strategic vision and the rule of law

Section 6.4 of Chapter 6 pointed out to the **discrepancies between the rules in form and the rules in use** with a specific example of the FMS policy implementation. Participants believed that the FMS policy was prescribed in 2013 without ensuring that the necessary preconditions for its success, including financing, were in place. The FMS policy superimposed a functioning health insurance programme called the NHIF, even though in practice, the coverage of NHIF was limited to the formal sector and covered only 18% of the total population. The FMS policy also ignored the fact that user fees had been an important source of facility income for non-salary funding; the new policy had no provisions for replacing this revenue source with other sources of funding. Lack of adequate resources to realise the FMS policy frustrated health workers in their workplaces which, in turn, fuelled health workers' strikes.

When the FMS policy was introduced in Kenya, health workers felt that they were given an opportunity to be part of an important mission: to help reduce maternal and neonatal mortality and morbidity. However, many facility participants perceived the arrangement of reimbursement mechanisms for the FMS policy as a disincentive, as health facilities lost their property rights (i.e., decision making rights and earning rights). Thus, the FMS policy was met with resistance at both county and health facility levels. Some were concerned with the operational challenges while others felt uncertain due to the lack of clarity regarding the content of the maternity services package. Some health workers also did not see any

incentives to participate as they were already working at full capacity. Both facility and county level participants had doubts regarding the impact and sustainability of the FMS policy, as they encountered many operational challenges. A recent study of Gilson et al. (2017) conducted in Kilifi county of Kenya reported how facility managers re-introduced user fees in response to funding shortfalls. Olivier de Sardan et al. (2011) made similar observations in Niger during a period when the country introduced the free primary health care policy for children under-five in 2006. The study Olivier de Sardan et al. (2011) found that the free primary health care policy weakened the functioning health insurance mechanism as health facilities lost significant health workers' incentives in the public health sector. At the same time, health facilities lost their reliable source of non-salary funding due to "*policy-induced institutional incoherence*".

Booth (2011) also spotlights how the "*institutional shortcomings*" of local and sub-national governance were associated with inadequate provision of public services in a multicountry research programme in seven African countries (Malawi, Niger, Rwanda, Uganda, Senegal, Sierra Leone and Tanzania). These shortcomings were due to "*policy-driven institutional incoherence*" where some policies were prescribed based on political popularity but without considering the capacity of organisations and institutional arrangements (Booth, 2011). On the other hand, Booth (2011) described the success story in Rwanda when the country introduced a new health insurance policy due to institutional coherence (**synergy between the rules in form and rules in use**). Because the reform incentives were consistent with clear mandates from all line ministries and there was intense political pressure to comply with the reform process, those institutional factors facilitated the reform process. However, institutional coherence in introducing the FMS policy was not observed in this study from Kenya.

Another "*institutional incoherence*" identified in this study was **inconsistent formal and informal institutional arrangements** for public health staff working at private facilities. Informal institutions tend to emerge when there are problems with formal institutions (Bertone & Witter, 2015). Participants in this study highlighted how health workers negotiated with their managers (informal institutional arrangements) to work at private facilities during public working hours. Blundo & Le Meur (2009) and Olivier de Sardan (2008, 2015) described such arrangements as "*informal privatisation*" of public services because of institutional incoherence between the public and private sectors. Informal privatisation results from a lack of coordinated efforts among key health system actors and policy makers to develop consistent incentive structures (Blundo & Le Meur 2009, Olivier de Sardan 2008,

2015). This highlights a gap in the stewardship role of the government to protect the public interest, as there is no clear boundary between the two sectors (Balabanova et al., 2008).

8.2.2.3 Participation in decision making

Section 6.6 of Chapter 6 highlighted how current context provides citizens with different opportunities to participate in policymaking and implementation. Participants described different opportunities to participate in policy implementation such as barazas, health facility management committees (HFMC) and hospital management board. However, citizens' engagement in these processes requires awareness and initiatives to participate. Similar findings were observed in studies conducted in Kenya (Lipsky et al., 2015; Barasa & Molyneux et al., 2017). In the study of Lipsky et al. (2015), the authors did not observe any involvement by citizens or civil society organisations in county policy and programme selection processes. Similarly, Barasa & Molyneux et al. (2017) did not observe participation and transparency in budgeting and priority settings in their case study hospitals. Indeed, although county participants mentioned that they had public hearings or barazas where the public could provide suggestions to the country government on a proposed policy, actual public opportunities to provide such suggestions were varied. Among three counties studied by Lipsky et al., only one county held such an event to receive feedback from citizens, while in another county, a single official developed the health sector budget without additional input.

Similarly, some facility staff who participated in this study did not believe that the hospital management board represented their community, as they did not ask for feedback from the communities. This finding is in line with the results of Lipsky et al. (2015) as the selection of HFMC among their study counties was politically driven, with little representation from the communities. Their study highlighted the "*capture of local elites*" in facility management, as most HFMCs were powerful bodies able to make staffing and operational decisions. This supports the position of Booth and Cammack (2013) who argue that participation without other complementary measures will not result in improved social accountability.

8.2.2.4 Equity

Participants in this study pointed out that equity has not improved after devolution and different counties had different socioeconomic baselines. This was compounded by the counties' limited capacities to generate their own revenue and dependent on national government while the current formula to determine the distribution of resources does not consider specificities of the counties and health system functions. Equity is operationalised

as improving access to healthcare services with reduced socioeconomic and geographic barriers in accessing care. Facility level participants pointed out that the remoteness of some areas make it difficult for users to access services. The shortage of staff to provide services was another barrier to access care. The situation was worsened by "skewed distribution" of health workforce as counties in remote places did not have resources to attract and retain health workers. Similar findings were reported by Wakaba et al. (2014) through statistical analysis of secondary data from the Kenyan health workforce information system. Wakaba highlighted the public-sector nursing densities were positively associated with urbanisation (p value=0.376), immunisation rates (p value= 0.0018) and health expenditure per capita (p value=0.0028).

8.2.3 Enforcement mechanisms for good governance

The outcomes of a system depend on how these rules/institutional arrangements are enforced and hence, "institutions without enforcement are not institutions at all" (Gustafsson, 1998: 18). This was evident at operational level as observed in Chapter 7 as the difference in **enforcement mechanisms** was observed in the two groups of facilities. As noted by participants from not fully functional facilities, some of the facility enforcement measures were hindered by influential people and that participants felt discouraged or reluctant to discipline other staff. Similar findings were reported by Nigerian government officials involved in a routine immunisation programme as they highlighted that enforcement for non-performance required supportive environments to function properly (Erchick et al., 2017).

Similar findings are highlighted in the study by Cammack (2011) showing how law enforcement resulted in improved service delivery (public safety and safe deliveries) in Malawi. Enforcement of rules such as imprisonment or heavy punishment to rule breakers deters individuals and groups from committing crimes (Cammack, 2011). Cammak (2011) provides another example regarding the introduction of a policy to ban the use of traditional birth attendants (TBAs) in Malawi in mid-2009. The Malawi government also created other measures to improve the use of skilled birth attendants instead of TBAs. Yet, TBAs were found to be active in all research sites (Cammack, 2011). Cammack (2011) argued that even though the intention of the policy reform was right, officials were unwilling and unable to enforce the policy; and other socially rooted factors compounded this failure, including the attitude of health workers themselves.

On the other hand, the introduction of an institutional delivery initiative in Rwanda was successful due to more rigorous enforcement of the rules (Cammack, 2011). The Rwandan government used a combination of financial penalty and social mobilisation to achieve public compliance with the new rule. Those activities were complemented by disciplinary actions against staff engaging abusive practices towards women (Booth, 2011). These complementary efforts (institutional arrangements being enforced and sanctions which were backed up by the political pressure) resulted in the fruitful and widespread adoption of institutional delivery in Rwanda.

8.2.4 Incentives and motivation for good governance

Though governance includes arrangements set out at national and county level, everyday practices of key health system actors dictate how a health system is governed (Gilson et al., 2017). Hence, the incentives and motivation of frontline health workers are instrumental as they enforce the institutional arrangements on good governance (for instance, accountability and control of corruption). This was observed in Chapter 7 as there were differences in the **incentives and motivation** to be accountable between the two groups of facilities. Health workers from both groups of facilities appreciated informal recognition for their performance and held ethical values and professional moral principles in high regard. In contrast, conditions such as patronage and favouritism demotivated health workers from not fully functional facilities: they did not feel motivated in the fight against corruption, as participants felt that "*there was no fairness in everything*" which they "*see everywhere either in the health system or the education system*".

Some participants from not fully functional facilities were demotivated to work as their basic needs were not met. This coupled with the decreased extrinsic motivation as the FMS policy did not provide financial incentives. Under such constraint conditions, they could not create a supportive working environment such as coordination/collaboration among the colleagues. Erchick et al. (2017) reported similar comments from Nigerian government officials working in a routine immunisation programme as they highlighted two factors of motivation: the presence of incentives for high-performers, and, a supportive working environment. Erchick et al. (2017) emphasised that just ensuring the basic needs of health workers (receiving sufficient salaries in time) was crucial to motivating health workers to carry out their responsibilities. Gilson et al. (2017) also pointed to the importance of a supportive working environment and the everyday resilience of health workers at Kilifi county in Kenya. The authors highlighted that frontline health workers should be trained and

supported on how to manage unpredictable staff as they had to work within the context of unstable responsibilities, challenging community expectations and the ever-changing policy environment in Kenya (Gilson et al., 2017).

8.3 Strengths and limitations of the study

8.3.1 Strengths of the study

This is the one of a few studies in Kenya to assess governance with an in-depth exploration of factors influencing health system governance at the macro (national), meso (county) and micro (health facility) levels. In so doing, this study effectively used different conceptual frameworks of governance and different theories of governance (from various disciplines) to develop a robust way of assessing and analysing governance in a health system and at an operational level, under the field of health systems and policy research.

Beyond its specific findings, this study contributes to the current knowledge on how to conceptualise and assess governance at both the national and operational level in resource constrained health systems. This contribution is not only consistent with but also expands the existing theories of health system governance. While I was working on this study, some governance studies have been conducted (for example, Petersen et al. 2017, Abimbola & Olanipekun et al. 2016, Erchick et al. 2016, Abimbola & Ukwaja et al. 2015). Moving beyond the traditional approach to assessing governance, those new studies also considered the process (the interactions between the rules and players of a system), including the operational level of a health system. Thus, this study of governance in Kenya was timely and consistent with those at the forefront of this field.

This study in Kenya contributes to the knowledge of governance in health system, theoretically and empirically. Theoretically, this study uses institutional analysis approach to interpreting findings on health system governance which confirmed the usefulness of this theory and extends its use/application to the field of health system governance. Empirically, the findings of this study provide relevant recommendations for the Kenyan health system and health policy by testing a validated governance assessment framework. The study also identifies areas for future research, not limited to Kenya. Hence, the sections below describe two key areas of strength of this study: 1) methodological contributions 2) relevance to the current Kenya health system.

8.3.1.1 Methodological contributions

This study identified a range of frameworks to assess governance of a health system and critically evaluated these in a systematic review (subsequently published) which is useful for health system research (**Appendix 1**.). Hence, one main strength of this study is its use of a theoretical framework to assess health system governance at the county level and below in Kenya. As the concept of health system governance is complex, all-encompassing and context-dependent, this study has used a theory-driven approach to health system governance. In doing so, this study provides a methodological contribution to health system research through 1) the development of a new integrated framework (**Figure 28**) to assess governance which was then applied in Kenya, and 2) assessing health system governance using the institutional analysis approach.

The framework used in this study is based on two frameworks which originate from the new institutional economics and international development. Indeed, as explained in Chapter 3 (Literature review), the framework used in this study is a combination of Baez-Carmago and Jacobs (2011) and Siddiqi et al. (2009). The framework of Baez-Carmago and Jacobs (2011) draws on the "institutional analysis" theory of North (1990), originally derived from the discipline of new institutional economics. The institutional approach to governance helps shed light on the formal and informal rules set by organisations and health system actors. Through institutional analysis, it is possible to identify power distributions between the main stakeholders who influence major decisions within the health system.

The traditional approach to assessing governance focuses on indirectly assessing the performance of the Ministry of Health, based mostly on the essential public health functions (Siddiqi et al., 2009). Direct assessment of health system governance requires a different approach using an analytical framework based on the operational principles of governance (Siddiqi et al., 2009). This is the approach adopted in this thesis. Other methods to directly assess governance have been limited to quantitative as the assessment focuses on ranking or scoring governance principles which are usually presented as summary measures (for instance, World Bank Global governance indicators, UNDP, Ibrahim Index). The quantitative approach has received criticism as ranking governance scores does not bring insight into a system unless specific findings highlight the strengths and weaknesses of governance in a system (Fryatt et al., 2017; Siddiqi et al., 2009).

There are a growing number of frameworks adopting qualitative methods (interviews and focus group discussions) to provide an in-depth explanation of the governance (for instance, Mikkelsen Lopez et al., 2011). This study confirms the value of qualitative research methods used in the exploration of health system governance as also highlighted by other governance studies (Abdulmalik et al., 2017; Marais & Petersen et al., 2017; Mugisha et al., 2016; Petersen et al., 2017; Hanlon et al., 2017; George et al., 2016; Abimbola et al. 2014).

An increasing number of frameworks also borrow concepts from other disciplines outside health systems research such as the concept of new institutional economics (e.g. Abimbola et al., 2017, 2016, 2015; Baez-Carmago & Jacobs, 2013; Brinkerhoff & Bossert, 2008, 2013). Adopting the institutional analysis approach in this study highlights that the health system is complex and includes both "hardware" and "software" (Abimbola et al., 2017). Sheikh et al. (2011) defines "hardware" as the approach used in international development, key building blocks such as HRH, financing, supplies and equipment and "software" as the approach used in new institutional economics such as formal and informal rules which are enforced through self-enforcement and third party enforcement because of motivation of individual key stakeholders.

The framework of Siddiqi et al. (2009) originates from development studies which tend to unpack the different operational principles of governance, rather than assessing governance in general. This is the approach adopted in this study which makes the study distinct, as it explores specific principles of governance in Kenya. Applying qualitative research methods with pre defined principles of governance allowed for the collection of rich contextual data on governance principles. The approach used in this study highlights how each principle of governance operates at different levels of the health system.

Ostrom (2005b: 28) stated that a "framework" is an analytical tool which can be used to identify elements and relationships among those elements that can be considered in an analysis. The intentions of using a framework in this study were two-fold: 1) as a thinking guide in developing the topic guides for key informant interviews, and 2) as a conceptual guide to the analysis of governance. Therefore, in analysing interview data in Chapter 5 and Chapter 6, inductive analysis (i.e. the analysis did not use any prior formulated theory or hypotheses as codes and themes could emerge freely from the data) was used. During the institutional analysis of data from facility participants (signal functions performance and interview data) in Chapter 7, a deductive approach (guided by the theoretical framework) was carefully used. Despite the use of the theory, the analysis ensured that the theory did

not hinder the emergent themes which were pertinent to the study, allowing for inductive coding within the predetermined themes (deductive coding).

Developing a comprehensive framework to assess governance of a health system remains a challenge to the health system and policy research as there is no universally agreed framework and governance is a diffuse and context-specific concept. While other approaches to assess health system governance may be developed in the future, this study contributes to the methodological approach of the assessment of governance of a health system. This study adds to the knowledge of health system governance by confirming the value of qualitative research methods and by borrowing approaches from other disciplines.

8.3.1.2 Relevance to the current Kenya health system

Despite slow progress in maternal health outcomes within the last decade, there has been no study on governance focussing on maternal health care in particular. This study is the first to explore the views of key stakeholders from maternal health care settings using a multi-disciplinary framework.

To put this research in sociopolitical context, it is important to mention that field work for this study was conducted during 2015 two years after devolution. Indeed, Kenya had started devolution of the public sectors including health in June 2013. This influenced the way in which the Kenyan health system was governed, and it was essential to explore the effect of devolution on health system governance in Kenya. Chapter 5 contributes to ongoing discussions of devolution in Kenya, and, more importantly, to decentralisation of health systems across the world.

Devolution in Kenya is an ongoing process and systems and structures have changed over time. For instance, the health workers' strikes became more frequent and intense, crippling the public health system of Kenya. Citizens who cannot afford private health care were mainly affected by the strikes (Kenya's nurses strike takes its toll on healthcare system, 2017). Health workers strikes in Kenya not only affected health service delivery, but it also caused increased absenteeism at health facilities and low morale among health workers (Njuguna, 2015). Although peer-reviewed publications on the impact of health workers' strikes on mortality and morbidity are not yet available, the local media reported instances of women in labour being left stranded in front of hospitals (Elszasz, 2017; Africa Research Bulletin, 2016). Recent strikes in early 2017 gathered much attention as the strikes were national and reported to involve approximately 5000 health workers (Elszasz, 2017). Therefore, managing the health workforce has increasingly become a political agenda at both

national and county levels. This challenge county and national governments in providing health service delivery in addition to the challenge of devolution.

The situation was further complicated when health workers were asked to provide free maternity services when they did not have the means to do so. This study points to the importance of a broader consideration of implementing a health financing policy to ensure that the system is ready to achieve health system objectives. This study highlights the implications on health system governance because of implementing a new financing policy within the context of devolution.

It is important to capitalise on the lessons learnt from this study to put in place a proper rearrangement of devolution and review of essential national policies such as abolishing user fees and FMS policies. To do so, the findings regarding FMS policy implementation and its implications on governance have been arranged for dissemination through publication as the manuscript is now under review in a peer- reviewed journal.

8.3.2 Limitations of the study

The section below presents important limitations of this study with measures to mitigate them. They are grouped into different research phases: conceptualisation and design; data analysis and data interpretation.

8.3.2.1 Limitations related to conceptualisation and design

There is no universally agreed way to define, measure or assess health system governance. However, a comprehensive systematic review was conducted and published which identified suitable frameworks to assess health system governance. Based on the review, this study chose a widely, but not universally, accepted definition and frameworks for assessment. The frameworks adapted in this study have been applied/validated in eight low- and middle-income countries (**Table 5**). Topic guides to assess governance were also based on the framework which were pilot tested with non-participating respondents before field data collection.

There are different ways to determine the functionality of a health facility using different criteria. This study has used the functionality of a facility based on the presence of the signal functions of comprehensive emergency obstetric care (CEmOC). This assumes that a facility designated as a CEmOC facility would be fully functional in service provision if it has all the preconditions for functionality (in this case, signal functions). This limitation was explicitly

acknowledged since the conceptualization of this study. The choice was determined for the pragmatic reasons that this research was embedded within the Making it Happen programme which focused on competency based training of health workers' capacity to deliver EmOC. The UN signal functions are biased against health facilities with the capacity to provide EmOC services. The facility which does not perform one signal function can be due to: lack of trained staff, lack of equipment, low facility attendance and/or distance and costs. Hence, some challenges might relate to health facility leadership, management and governance but some were beyond the control of the health facility staff. Identification of these factors on signal function availability was beyond the scope of this study. Most importantly, this study has used UN signal functions only to group facilities into different functionality group. The analysis adopted in this study did not aim to attribute facility functionality with governance.

Purposeful sampling of key informants in this study has some limitations. The samples are limited to ten facilities and six counties with the inability to generalise findings outside the six counties in Kenya. However, the primary aim of adopting the qualitative research methods is to gain in-depth insights of governance that can be considered in similar settings. Interviews were conducted with at least two facility level participants from each facility, giving at least three to four participants per county. Interviews were also conducted with national level participants which allowed the researcher to examine country-wide issues when interpreting the findings from the six counties included in this study. In addition, although the findings of governance in this study are from maternal healthcare settings, the insights are transferrable to other health programmes as governance is systemic and cross-cutting.

In addition, the inclusion of six counties and ten facilities could be critiqued as a broad-brush approach as it did not allow more in-depth analysis by including all facilities from one county. However, it was believed to be the most suitable approach despite its limitations. The decision to include six counties and ten facilities was inevitable as the sampling started from CEmOC level facilities supported by the Making it Happen programme. A CEmOC level facility was a minimum district level facility which could provide caesarean section and blood transfusion for maternal health complications. Hence, there were not many CEmOC level public facilities supported by the programme. Within each county, every effort was made to include at least one fully functional and one not fully functional facility. However, it was not always possible. Hence, the sampling resulted with ten CEmOC level facilities within six counties.

The other limitation is that the sampling did not include community representatives, users or beneficiaries of the Kenyan health system. While including community groups was beyond the scope of this study, it would have enriched the findings particularly regarding their experiences of community accountability and participation.

8.3.2.2 Limitations related to data analysis

Directed content analysis was employed to analyse data to explore how governance differed with the functionality of health facilities (Chapter 7). This theory-driven analysis has limitations as the researcher approaches the data with an informed bias (Hsieh and Shannon, 2005). It has been argued that theory can blind researchers to contextual aspects of the phenomenon under study, influencing neutrality and trustworthiness (Hsieh and Shannon, 2005). Nevertheless, the analysis allowed for inductive coding within the predetermined themes (deductive coding). An audit trail of the analysis and transparent approach to reporting has been carried out throughout the analysis process to mitigate these limitations. These include explanations of the theoretical constructs of the framework to increase the accuracy of predetermined categories. Furthermore, as explained in Section 4.6, reflexivity was exercised throughout the research process.

8.3.2.3 Limitations related to data interpretation

The findings of this study may not be generalisable to other low- and middle-income countries beyond Kenya. However, the results are certainly valid within the context of the counties studied in Kenya and the insights are transferable. In particular, the findings are transferrable within the health system in Kenya, regardless of the medical specialities as findings related to the governance of a health system could be applied to maternal health or other specialities. For instance, accountability challenges due to lack of role clarity as highlighted by maternal healthcare providers could also happen in other health specialities.

In qualitative inquiry, the goal of the analysis is "inferential generalisability", "transferability" or "naturalistic generalisability" which is different from conventional (representational) generalisability used in the quantitative inquiry (Ritchie and Lewis, 2014). The insights gained from this study might provide insight on health system governance in other contexts if they have similar structure. This study described the context in detail (Chapter 5) so that readers can judge the transferability of the findings to similar settings. This study also provides "rich" description on different operational principles of governance by offering inferential generalisation to draw out potential lessons for policy development elsewhere. Indeed, the

health system and governance situation will not be substantially different from those in other low- and middle-income countries (Ensor & Witter, 2001).

The focus of the study was on the governance of a health system in an ongoing process of devolution; the situation may change over time. This study was exploratory, providing a snapshot of the governance situation in Kenya adopting a descriptive, qualitative approach.

Hence, the findings of this study would require considering those practical limitations in mind.

8.3.3 Areas for future research

This study highlights the importance of and need for a clearly defined framework to assess governance of a health system and to monitor governance over time, particularly in a context such as Kenya where there may be rapidly changing political, social and economic circumstances. However, the focus of this study was limited to six counties (and ten facilities within those counties). Extension to other counties within Kenya using the same framework would be helpful to strengthen or refine the conclusions of this study. Using mixed methods research may allow for representational generalisation. This can be achieved by national-level governance assessment using a quantitative approach by assessing key public health functions with county level process descriptions and perceptions. The insights gained from this study might provide insight into the health system governance in other low-and middle-income country contexts considering the similarities of how the health system in Kenya is organised.

It will be useful to include the private sector when assessing Kenyan health system governance as private service providers play an important role in Kenya. A recent Kenyan healthcare sector analysis reports that 38% of all officially registered health facilities in Kenya were owned by private-for-profit and an additional 14% by private not-for-profit organisations while only 48% belong to the public sector (Netherlands Enterprise Agency, 2016: 32). Public health staff are working in both the public and private sectors. An institutional analysis to assess how the private health sector has been enforced and monitored would be useful for the MOH to find a means to maximise its public health impact by effectively engaging with the private sector.

It is also important to conduct studies on how devolution influences retention of public health workers in particular after several health workers' strikes have occurred in Kenya, given the fact that devolution has changed HRH management, including salary, incentives

(financial and career progression) and service delivery arrangements. According to a local newspaper, 24 health workers' strikes had taken place by March 2017 since the country underwent devolution in 2013 (Elszasz, 2017). Hence, it will be necessary to understand the push factors (factors that encourage health workers to leave) and pull factors (factors which attract health workers to stay in the post). Future studies may benefit from the insights of public health workers and policy makers to better understand those push and pull factors influencing health workers' retention and their motivation to work in the Kenyan public health system.

It is timely and crucial to conduct a national scale evaluation of the implementation of the FMS policy including economic evaluation as the policy directive has been in place for four years (since 2013). Although different small-scale evaluations in purposively selected counties exist (Lang'at et al.,2015; Kenyan Ministry of Health, 2015; Chuma et al.,2014; Bourbonnais, 2013), a nationally representative evaluation of the FMS policy adherence will be strategic for Kenya. Using a mixed methods approach, comprising representative samples of counties and facilities with purposive samples of key stakeholders including service users will provide a comprehensive understanding of if and how the FMS policy is effective in Kenya. It is also timely to conduct a social cost analysis, particularly social return on investment to measure the true cost of implementing the policy to the population that incorporates social, environmental and economic impacts (Banke-Thomas et al., 2015).

The findings related to institutions governing the health system in Kenya highlight the importance of context in implementing health system devolution. Similar assessments in other low-and middle-income countries could use the "rich description of context" obtained in this study to assess whether the findings apply to their own settings and make judgements on the transferability of findings to their settings. A common assessment approach using one framework could potentially provide a cross-country comparison of governance (Siddiqi et al., 2009, Brinkerhoff & Bossert, 2013). The Emerald project funded by the European Union has proved the feasibility of cross-country assessment of governance in six low-and middle-income countries in Africa and South Asia by adopting the frameworks of Siddiqi et al. (2009) and Mikkelsen-Lopez et al. (2011).

8.4 Recommendations

8.4.1 Strategic and national level

Devolution:

1. Devolution is best implemented using a phased approach and ensuring adequate capacity at a devolved level.
2. Establish a monitoring system to ensure that county governments commit the allotted budget to health. This study highlighted that county governments had different priorities in addition to health. Even when county governments had initially prioritised health in their budgets, they focussed on the infrastructural development while other areas such as HRH, commodities and maintenance of existing facilities were neglected (Bigmore et al., 2012).

FMS policy implementation:

1. Lack of participation in policy formulation can be one reason for non-adherence to the FMS policy implementation in Kenya. A "bottom-up" approach to policy development that ensures that health workers, facility management committees and county health management teams are engaged throughout the process involved in policy formulation, and implementation is likely to be more successful.
2. Define the components of the main policy initiatives (for instance, the FMS policy) by specifying the amount received, facility level and type of services provided which public facilities are supposed to receive by providing free maternity services.
3. Integrate FMS policy into other health financing strategies such as NHIF and HSSF so that financing components do not contradict each other.
4. Review the details of the FMS policy elements and consider how they might need to be reformulated to strengthen their links with the aim of health system performance and improved health outcomes. To ensure that the policy is in line with the country context, the prevailing institutional arrangements may need to be aligned with each other. It is evident from this study that poor policy design and dissemination process are significant barriers to adhering to a new policy initiative. This is complicated by other operational challenges leading policy implementers to modify at their discretion to suit their settings. Effective information dissemination and public awareness raising to overcome attitudes that may not be conducive to successful policy implementation.

Underlying/pre-existing socioeconomic inequity:

1. Support county governments in developing and implementing strategies to improve socioeconomic conditions for development across different counties. This will subsequently improve maldistribution of the health workforce and health service facilities.

8.4.2 Operational level (county and facility)

Capacity:

1. County governments should assess the capacity of their health sectors regarding the availability of key resources such as HRH, infrastructure, medicines, supplies and equipment. This will help them redefine strategies to improve readiness to provide services and highlight the need for capacity building, availability of infrastructure, medicines, supplies and equipment.
2. Strengthen leadership and management capacity of county and health facilities managers as it is now acknowledged to be instrumental in the Kenyan health system strengthening (Gilson et al., 2017; MOMS/MOPHS, 2008-2009).
3. Strengthen the capacity of county and health facility managers in supply chain management so that they could efficiently forecast, quantify and manage medical commodities.

Incentives and motivation:

1. County governments should develop incentive schemes to attract and retain health workers by simply ensuring their salaries are paid on time. Incentives should not only motivate the health workers but also cater to the needs of their families (education and housing facilities for their children and work opportunities for their spouses).
2. Institutional arrangements can be strengthened by specifying enforcement characteristics, for example, the incentives to comply with the rules should be more pronounced.

Accountability:

1. The county department of health should support hospitals in developing and following procedures, guidelines and standard operating procedures to improve accountability through clarifying roles and responsibilities among different staff.
2. Strengthen existing formal rules by enforcing sanctions for the abuse of power or neglect of duty and identify locally adapted reward system to motivate the best performing staff. It is also critical to identify informal norms which support improvement in performance by cultivating ownership through a supportive working

environment and collaboration among colleagues with clear roles and responsibilities.

Resources:

1. Study participants highlighted that one reason for non-adherence to the FMS policy is a lack of sufficient medicines, supplies and equipment. Hence, county governments should ensure continuous and sufficient supplies of commodities.
2. County governments should actively look for collaboration with different partners to create opportunities for development of their counties.

8.5 Concluding remarks

This study contributes to the field of health system research, particularly health system governance in low-and middle-income countries, by providing an in-depth exploration of what factors influence institutional arrangements for good governance and how these were enforced or not. Specifically, the study enhances the understanding of governance at different levels of a health system in a lower-middle income country context. This is one of the few studies in Kenya which has used a theoretical framework to assess health system governance at the county level and below since devolution in 2013. This study highlights, in particular, the perspectives of key maternal health stakeholders in Kenya. Despite slow progress of maternal health in Kenya within the last decade, there has been no study of governance focussing on maternal healthcare settings, and this was the first one to explore the views of key stakeholders on maternal health.

The study highlighted different approaches to assess governance and the potential of the institutional analysis approach which enforces rules (formal and informal) to improve the performance of health facilities and achieve health system goals. The analytical framework developed and applied in this study has been useful for providing information on composite institutional arrangements and specific principles of governance at the operational level. This approach has also helped integrate the findings of governance within wider bodies of knowledge highlighting the need to look at governance across disciplines. A theory-guided analysis of a diffuse concept with strong emphasis on context is an essential contribution to the existing evidence on governance.

This study has explored a broad range of possible contextual factors influencing the governance of the health system at both policy formulation and implementation levels in Kenya. Understanding governance at the policy implementation level, that is, facility level is imperative as it provides a better understanding, not just policy formulation level which does

not capture the essence of how a health system functions. The findings of this study highlight that there is no single or uniform approach to assessing governance, given that contexts differ in each setting. However, there are broad principles of governance which drive towards different forms of governance.

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10. Appendices

Appendix 1. Publications based on the PhD work

Appendix 1.a. Frameworks to assess health systems governance: a systematic review

Health Policy and Planning, 32, 2017, 710–722
doi: 10.1093/heapol/czx007
Advance Access Publication Date: 3 March 2017
Original Article

OXFORD

Frameworks to assess health systems governance: a systematic review

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Accepted on 16 December 2016

Abstract

Governance of the health system is a relatively new concept and there are gaps in understanding what health system governance is and how it could be assessed. We conducted a systematic review of the literature to describe the concept of governance and the theories underpinning as applied to health systems; and to identify which frameworks are available and have been applied to assess health systems governance. Frameworks were reviewed to understand how the principles of governance might be operationalized at different levels of a health system. Electronic databases and web portals of international institutions concerned with governance were searched for publications in English for the period January 1994 to February 2016. Sixteen frameworks developed to assess governance in the health system were identified and are described. Of these, six frameworks were developed based on theories from new institutional economics; three are primarily informed by political science and public management disciplines; three arise from the development literature and four use multidisciplinary approaches. Only five of the identified frameworks have been applied. These used the principal–agent theory, theory of common pool resources, North's institutional analysis and the cybernetics theory. Governance is a practice, dependent on arrangements set at political or national level, but which needs to be operationalized by individuals at lower levels in the health system; multilevel frameworks acknowledge this. Three frameworks were used to assess governance at all levels of the health system. Health system governance is complex and difficult to assess; the concept of governance originates from different disciplines and is multidimensional. There is a need to validate and apply existing frameworks and share lessons learnt regarding which frameworks work well in which settings. A comprehensive assessment of governance could enable policy makers to prioritize solutions for problems identified as well as replicate and scale-up examples of good practice.

Keywords: Evaluation, frameworks, governance, health systems

Key Messages

- Health system governance is one of the neglected agendas in health system research.
- There is currently a lack of evidence with regard to how governance can and is assessed at both national and sub-national level.
- Existing frameworks can be adapted to assess governance overall or specific components of governance.

Appendix 1.b. Implementation of the free maternity services policy and its implications for health system governance in Kenya

Research

BMJ Global Health

Implementation of the free maternity services policy and its implications for health system governance in Kenya

Thidar Pyone, Helen Smith, Nynke van den Broek

To cite: Pyone T, Smith H, van den Broek N. Implementation of the free maternity services policy and its implications for health system governance in Kenya. *BMJ Glob Health* 2017;**2**:e000249. doi:10.1136/bmjgh-2016-000249

Handling editor Seye Abimbola

Received 18 November 2016
Revised 19 September 2017
Accepted 25 October 2017

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ABSTRACT

Introduction To move towards universal health coverage, the government of Kenya introduced free maternity services in all public health facilities in June 2013. User fees are, however, important sources of income for health facilities and their removal has implications for the way in which health facilities are governed.

Objective To explore how implementation of Kenya's financing policy has affected the way in which the rules governing health facilities are made, changed, monitored and enforced.

Methods Qualitative research was carried out using semistructured interviews with 39 key stakeholders from six counties in Kenya: 10 national level policy makers, 10 county level policy makers and 19 implementers at health facilities. Participants were purposively selected using maximum variation sampling. Data analysis was informed by the institutional analysis framework, in which governance is defined by the rules that distribute roles among key players and shape their actions, decisions and interactions.

Results Lack of clarity about the new policy (eg, it was unclear which services were free, leading to instances of service user exploitation), weak enforcement mechanisms (eg, delayed reimbursement to health facilities, which led to continued levying of service charges) and misaligned incentives (eg, the policy led to increased uptake of services thereby increasing the workload for health workers and health facilities losing control of their ability to generate and manage their own resources) led to weak policy implementation, further complicated by the concurrent devolution of the health system.

Conclusion The findings show the consequences of discrepancies between formal institutions and informal arrangements. In introducing new policies, policy makers should ensure that corresponding institutional (re) arrangements, enforcement mechanisms and incentives are aligned with the objectives of the implementers.

Key questions

What is already known about this topic?

- Reports on the introduction of the free maternity services (FMS) policy in Kenya describe either the implementation (including the perspectives of health workers) or health system outcomes (provision of free maternal health services or increase in use of the service).

What are the new findings?

- Our study explores how the FMS policy affected the way in which the rules governing health facilities are made, changed, monitored and enforced.
- Our analysis and interpretation was informed by the institutional framing of governance, in which governance is defined by the rules for distributing roles among key players and shaping their actions, decisions and interactions.
- To our knowledge, no other studies have examined implementation of the FMS policy and how the rules governing health facilities in Kenya have been enforced, monitored and changed.

Recommendations for policy

- The findings highlight discrepancies between formal institutions and informal arrangements, and their consequences. Therefore, in introducing new policies, policy makers should ensure that corresponding institutional (re)arrangements, enforcement mechanisms and incentives are aligned with the objectives of the implementers.

INTRODUCTION

User fees are an important source of income for most health facilities in low- and middle-income countries,[1 2] and introducing a health financing policy into a health system, particularly one which directly affects user fees, is not straightforward.[2 3] Removal of user fees can have consequences for health facilities and the way they are governed. For example, the extent to which health facilities comply with the new policy (formal rule)—that is, choose to discontinue levying user charges, may be influenced by the extent to which the policy is in line with existing norms and practices at the health facilities (informal rules). Despite its importance, this rules-based approach to studying health system governance has not been widely adopted in health policy and systems research.[4]

In Kenya, several policies to reduce the financial burden of healthcare have been introduced since independence in 1963 (figure 1). In 1996, the National Hospital

Appendix 2. Search strategy used in literature review

Search set	Medline (search fields)	Scopus	EBSCOHOST (CINAHL, Global health database)	Cochrane library	Popline
1	Governance (ab,hw,kw,sh, ti,tw)	Governance	Governance	"Governance" (ti, ab, kw)	Governance
2	Leadership (ab,hw,kw,sh, ti,tw)	Leadership	Leadership	"Leadership" (ti,ab,kw)	leadership
3	Accountability (ab,hw,kw,sh, ti,tw)	Govern*	Accountability	Accountability	1 OR 2
4	Stewardship (ab,hw,kw,sh, ti,tw)	Stewardship	Stewardship	Accountabilities	Health system
5	1 OR 2 OR 3 OR 4	1 OR 2 OR 3 OR 4	1 OR 2 OR 3 OR 4	Stewardship	3 AND 4
6	"Health system*" (ab,hw,kw,sh, ti,tw)	"health system*"	Health system*	1 OR 2 OR 3 OR 4 OR 5	Limit to English language
7	"Healthcare system*" (ab,hw,kw,sh, ti,tw)	"health care reform*"	Health system agenc*	Health system*, agency	Limit from 1994
8	"Healthcare industry*" (ab,hw,kw,sh, ti,tw)	"health care system*"	Health care system*	Health system*, community	
9	"Healthcare reform*" (ab,hw,kw,sh, ti,tw)	"health delivery system*"	Health delivery system*	7 OR 8	
10	"Health system strengthen*" (ab,hw,kw,sh, ti,tw)	"health system* strengthen*"	Health system* strengthen*	6 AND 9	
11	6 OR 7 OR 8 OR 9 OR 10	"health care sector"	Health care sector	Framework	
12	5 AND 11	6 OR 7 OR 8 OR 9 OR 10 OR 11	Healthcare reform	Model	
13	"Framework*" (ab,hw,kw,sh, ti,tw)	5 AND 12	6 OR 7 OR 8 OR 9 OR 10 OR 11 OR 12	Indicator	
14	"Model*" (ab,hw,kw,sh, ti,tw)	Framework	5 AND 13	Definition	
15	"Indicator*" (ab,hw,kw,sh, ti,tw)	Model	Framework	measurement	
16	"Definition*" (ab,hw,kw,sh, ti,tw)	Indicator	Model	11 OR 12 OR 13 OR 14 OR 15	
17	"measure*" (ab,hw,kw,sh, ti,tw)	Definition	Indicator	10 AND 16	
18	13 OR 14 OR 15 OR 16 OR 17	Measurement	Definition		
18	12 AND 18	14 OR 15 OR 16 OR 17 OR 18	Measurement		
19	Limit to English language	13 AND 18	15 OR 16 OR 17 OR 18		

Search set	**Medline (search fields)**	**Scopus**	**EBSCOHOST (CINAHL, Global health database)**	**Cochrane library**	**Popline**
20	Limit to after 1994	Limit to English language	14 AND 19		
21		Limit to after 1994	Limit to English language		
22		Limit to subject area "health sciences"	Limit to after 1994		
23		Limit to research areas "social sciences & humanities"			

Abbreviations of search fields used in Medline

ab = abstract
hw = subject heading word
kw = key word
sh = MeSH subject heading
ti = title
tw = text word

Appendix 3. Quality assessment of included studies

No.	Author, year	Aim of study	Study participants	Methods used	What did they measure or document?	Study design	Participants selection	Measurement (valid & reliable)	Analytical methods description	Meaning findings b/o appraisal of methods	Potential bias	Attempts to validate/ verify the findings	Generalisable results?	Policy, practice/ research implications	Quality
1	Abimbola, Olanipekun et al (2015)	To explore how decentralization influences the retention of PHC workers in rural communities in Nigeria	PHC workers & community members	Cross-sectional, focus group discussions, in-depth interviews	How decentralization influences health worker's retention in rural Nigeria	Appropriate	Criteria ++	Valid & reliable	Clear description (quotes included)	Answer the study objectives	Yes (selection bias)	Yes	No	Improving health system governance to mitigate attrition of health workers	Peer review, High
2	Abimbola et al 2015	To use the concept of transaction costs and their implications for access to healthcare & health system governance in Nigeria	Patients who received first time anti-TB treatment	Cross sectional survey	To estimate transaction costs of access to healthcare incurred by the patients during care seeking for anti-TB	Appropriate	Criteria ++	Valid & reliable	Clear description & statistical analysis	Answer the study objectives	Yes (recall bias)	Yes	Yes	Finding alternative governance arrangement	Peer review, High

No.	Author, year	Aim of study	Study participants	Methods used	What did they measure or document?	Study design	Participants selection	Measurement (valid & reliable)	Analytical methods description	Meaning findings b/o appraisal of methods	Potential bias	Attempts to validate/ verify the findings	Generalisable results?	Policy, practice/ research implications	Quality
3	Abimbola, Olanipekun et al (2016)	Abimbola's multilevel framework was used to identify factors influencing policies of posting and transfer of public health workers.	PHC workers, community members	Cross-sectional, focus group discussions, in-depth interviews	In the absence of national policies, to examin how the posting & transfer of PHC workers	Appropriate	Criteria ++	Valid & reliable	Clear description	Answer the study objectives	Yes (recall bias)	Yes	Yes	Finding alternative governance arrangement	Peer review, High
4	Avelino et al 2013	To understand the relationship between health governance institutions & incidence of corruption	Audit data from health municipal councils	Cross sectional analysis of audit data	To provide objective evidence of corrupt practices in randomly selected municipalities for an audit	Appropriate	Criteria ++	Valid & reliable	Clear description & statistical analysis	Answer the study objectives	Nil	Yes	Yes	Finding alternative governance arrangement	Peer review, Medium

No.	Author, year	Aim of study	Study participants	Methods used	What did they measure or document?	Study design	Participants selection	Measurement (valid & reliable)	Analytical methods description	Meaning findings b/o appraisal of methods	Potential bias	Attempts to validate/ verify the findings	Generalisable results?	Policy, practice/ research implications	Quality
5	Baez-Carmago and Kamuju ni 2011	To assess governance of Ugandan public sector drug supply chain	Non-state stakeholders of the Uganda health system including patients, service providers, advocacy group	Cross-sectional, focus group discussions, in-depth interviews	To identify formal & informal institutional arrangments for public sector supply chain	Appropriate	Not mentioned	Valid & reliable	Yes (quotes included)	Answer the study objectives	Yes (selection bias)	Unknown	Yes	Finding alternative governance arrangement	Non-peer review, medium
6	Balabanova et al. (2008)	To identify how key actors from private sector of a health system interact	Afghanistan, India & Uganda	Cross-sectional	To illustrate how differences in context affect the nature of the governance function focussing on stewardship	Not known	Did not mention	Not known	Did not describe	Answer the study objectives	Yes	Unknown	No	Identification of context specific private-public interactions to understand different forms of governance	Not peer review, weak

No.	Author, year	Aim of study	Study participants	Methods used	What did they measure or document?	Study design	Participants selection	Measurement (valid & reliable)	Analytical methods description	Meaning findings b/o appraisal of methods	Potential bias	Attempts to validate/ verify the findings	Generalisable results?	Policy, practice/ research implications	Quality
7	Huss et al 2011	To document governance & corruption in KLA experience	Representatives from CSO, public institutions, health professionals & citizens	Cross-sectional interview based study	To document the governance particularly corruption in health sector in KLA	Appropriate	Criteria +	Valid & reliable	Analytical methods did not describe but quotes were used	Answer the study objectives	Yes	Unknown	No	Usefulness of assesing governance at different levels in a health system	Peer review, Medium
8	Mutale et al, 2013	To validate & apply new tool for assessing governance at health facility level	Health facility management teams Community members	Cross-sectional, survey, focus group discussions, in-depth interviews	To measure governance at health facility level	Appropriate	Criteria +	Valid & reliable	Analytical method described but quotes were not used.	Answer the study objectives	Yes	Yes	No	Feasiblity of measuring governance practices at health facility level	Peer review, Medium
9	Siddiqi et al, 2009	To present the HSG framework developed	Key stakeholders in national & subnational levels from Pakistan	Cross sectional, interview based study	The applicability of health system governance assessment	Appropriate	Not mentioned	Valid & reliable	No	Answer the study objectives	Yes	Unknown	No	Raise awareness of governance among policy makers & health providers	Peer review, weak

No.	Author, year	Aim of study	Study participants	Methods used	What did they measure or document?	Study design	Participants selection	Measurement (valid & reliable)	Analytical methods description	Meaning findings b/o appraisal of methods	Potential bias	Attempts to validate/ verify the findings	Generalisable results?	Policy, practice/ research implications	Quality
					framework										
10	Smith et al, 2012	To examine arrangement of leadership & governance in 7 developed countries	Key stakeholders from Australia, Germany, Netherlands, Norway Switzerland, Sweden, UK	Cross sectional, interview based study	Leadership & governance arrangement in 7 developed countries	Appropriate	Not mentioned	unknown	No	Answer the study objectives	Yes	Unknown	No	Importance of leadership & governance role	Peer review, weak
11	Vian & Bicknell, 2013	To design & test a methodology for measuring implementing the PBB reform in Lesotho	Key stakeholders from hospitals & national level of Lesotho	Cross sectional, interview based study	The applicability of framework in evaluating PBB reform process in Lesotho	Appropriate	mentioned	Valid & reliable	Analytical methods described & quotes were used.	Answer the study objectives	Yes	Unknown	No	Requirement of less complex & context specific budget reform	Peer review, Medium

No.	Author, year	Aim of study	Study participants	Methods used	What did they measure or document?	Study design	Participants selection	Measurement (valid & reliable)	Analytical methods description	Meaning findings b/o appraisal of methods	Potential bias	Attempts to validate/ verify the findings	Generalisable results?	Policy, practice/ research implications	Quality
12	Erchick et al., 2017	To explore the perspectives of government officials involved in routine immunization programme in Nigeria	Government officials from national, state & facility level	Cross sectional, interview based study	Challenges to internal accountability & barriers to high performance in immunization system	Appropriate	mentioned	Valid & reliable	Analytical methods described & quotes were used.	Answer the study objectives	Yes	Yes	No	Identification of specific areas for accountability to improve routine immunization programme in the country.	Peer review, High
13	Abdulmalik et al., 2016	To identify challenges & opportunities for strengthening the mental health system in Nigeria	Key stakeholders from national, Oyo state and local government level in Nigeria.	Key informant interviews	Assess governance of mental health system in Nigeria	Appropriate	mentioned	Valid & reliable	Analytical methods described & quotes were used.	Answer the study objectives	Yes	Yes	No	A comprehensive assessment of health system governance is required to strengthen the mental health system.	Peer review, High

No.	Author, year	Aim of study	Study participants	Methods used	What did they measure or document?	Study design	Participants selection	Measurement (valid & reliable)	Analytical methods description	Meaning findings b/o appraisal of methods	Potential bias	Attempts to validate/ verify the findings	Generalisable results?	Policy, practice/ research implications	Quality
14	Hanlon et al., 2017	To explore barriers & facilitators in strengthening mental health system governance in Ethiopia	Key stakeholders from national, Sodo district and health facility level in Ethiopia.	Key informant interviews	Assess governance of mental health system in Ethiopia	Appropriate	mentioned	Valid & reliable	Analytical methods described & quotes were used.	Answer the study objectives	Yes	Yes	No	Strengthened leadership & M&E, mobilisation of service users to improve mental health system	Peer review, High
15	Marais & Peterse n, 2015	To identify factors influencing implementation of integrated mental health care in South Africa	Key stakeholders from national, North West Province and Dr Kenneth Kauda district level.	Key informant interviews	Assess governance of mental health system in South Africa	Appropriate	mentioned	Valid & reliable	Analytical methods described & quotes were used.	Answer the study objectives	Yes	Yes	No	Identification of strategies to support integrated mental health care in primary healthcare services.	Peer review, High

No.	Author, year	Aim of study	Study participants	Methods used	What did they measure or document?	Study design	Participants selection	Measurement (valid & reliable)	Analytical methods description	Meaning findings b/o appraisal of methods	Potential bias	Attempts to validate/ verify the findings	Generalisable results?	Policy, practice/ research implications	Quality
16	Mugisha et al., 2016	To assess mental health system governance for integration into the PHC in Uganda	national and Kamuli district in Uganda.	Key informant interviews	Assess governance of mental health system in Uganda	Appropriate	mentioned	Valid & reliable	Analytical methods described & quotes were used.	Answer the study objectives	Yes	Yes	No	Addressing governance issues in a coordinated & intersectoral way to address mental health burden.	Peer review, High
17	Petersen et al., 2017	To identify gaps, challenges and strategies of health system governance to integrate mental health into primary healthcare settings in six Africa and Asia countries	Policy makers at national, provincial and district level of the MOH (particularly PHC and mental health)	Key informant interviews	Barriers associated with implementing mental health in primary healthcare settings	Cross sectional, exploratory	Purposive	Valid & reliable	Analysis methods described & quotes were used.	Answer the study objectives	Yes	Yes	No, context specific	Expanded governance framework allowed for cross-countries comparison.	Peer review, high

No.	Author, year	Aim of study	Study participants	Methods used	What did they measure or document?	Study design	Participants selection	Measurement (valid & reliable)	Analytical methods description	Meaning findings b/o appraisal of methods	Potential bias	Attempts to validate/ verify the findings	Generalisable results?	Policy, practice/ research implications	Quality
18	Upadhaya et al., 2017	To assess mental health system governance to provide recommendations for mental health improvements in Nepal	Key stakeholders from national and district level	Key informant interviews	Assess governance of mental health system in Nepal	Cross sectional, exploratory	Purposive	Valid & reliable	Analysis methods described & quotes were used.	Answer the study objectives	Yes	Yes	No, context specific	Strong leadership & governance mechanisms are required to translate mental health policy into practice	Peer review, high

Appendix 4. Summary table of frameworks identified (grouped by disciplines)

N.	Author, Year	Name of the framework	Characteristics of the framework	Underlying theory if applicable	Purpose of the framework	Analytical focus
New Institutional Economics						
1	Abimbola et al. 2014	"Multi-level" framework	Multi-level framework composed of three levels of a health system hierarchy-operational (citizens and healthcare providers), collective (community groups) and constitutional governances (governments at different levels). Theoretical underpinning borrowed from the concept of "governing without government". Under such situations, communities with similar interest can develop their own rules and arrangement to manage the common pool.	Ostrom's theory of "common pool resources" (governance to manage "common pool resources/health system" & "tragedy of commons")	To assess governance of three levels of a health system (collective, operational & constitutional governance)	-Focuses on 1) essential role where non-state actors can play in governance; 2) rules and institutions can be formed among communities with the same interest -Analyse formal ("rules-in-form") and informal ("rules-in-use") actors of governance. -Focuses on social interactions among different levels of the health system.
2	Baez-Carmago & Jacobs, 2013	Social accountability framework	Using the "principal-agent" theory, the framework consists of two routes of accountability: short (direct) and long (indirect) routes. Direct accountability-where citizens can "voice" their preference or choose other alternatives (exit). Indirect accountability requires institutional capacity and a functioning public system.	Principal agent theory	To assess accountability	-Focuses on 1) incentives what made people accountable; 2) institutional analysis-what are the rules set by the institutions; and 3) power distribution within the institutions
3	Baez-Carmago, 2011	Accountability framework	Similar to above	Similar to above	Similar to above	Similar to above
4	Balabanova et al. (2008)	"Health sector governance and the private	With increasing role played by the private sector, the government should take the stewardship role to protect the	Principal agent theory	To assess the role of private sector in health system governance	-Focuses on interactions among principals (government or donors) and agents (private sector).

N.	Author, Year	Name of the framework	Characteristics of the framework	Underlying theory if applicable	Purpose of the framework	Analytical focus
		sector" framework	public interest by working together with the private sector.			-Focuses on three key principles: the rule of law, participation or rule of engagement and accountability.
5	Brinkerhoff & Bossert, 2008, 2013	"Principal-agent" model of governance framework	Governance is the result of interactions among principals and agents with diverse interests. Agents will provide services to the principals as long as they have some incentives, but they have more information than principals. Principals will find ways to overcome the information asymmetry without much transaction costs.	Principal agent theory	To assess governance of a health system-national level	-Focuses on interactions among principals (citizens) and agents (state and healthcare providers) of a health system. -Using principal-agent relationship, analyse 8 governance principles
6	Cleary et al. 2013	Framework of accountability mechanisms in health care	The framework to assess accountability pathways among principal and agent. The accountability mechanisms are sub-divided into three critical factors responsible for functioning: resources, attitudes and values.	Principal agent theory	To assess accountability in primary care settings	-Focuses on 1) incentives and sanctions for different actors; 2) information asymmetry and power difference among different groups of actors
7	European Commission, 2008	Governance analysis framework in sector operations	The assessment starts with context analysis and stakeholders mapping. Among different principles, the framework focuses on accountability among different stakeholder groups. The framework does not include citizens among its six clusters of stakeholders.	Principal agent theory with predefined principles (Development literature)	To assess governance of a public sector	-Assessment starts with context analysis & stakeholders mapping -Focuses on type of accountability among key stakeholders (except citizens)
Political science and public administration discipline						
1	Berlan & Shiffman 2012	"Health worker accountability" framework	A framework to identify factors which shape the accountability of healthcare providers. Social interactions and norms operating within the system and	No theory identified	To assess factors which may shape accountability of	Accountability

N.	Author, Year	Name of the framework	Characteristics of the framework	Underlying theory if applicable	Purpose of the framework	Analytical focus
			context are prominent features of this framework.		healthcare providers in developing countries	
2	Brinkerhoff, 2004	Accountability assessment framework	Framework to map accountability using components of public accountability: financial, performance and political accountability.	No theory identified	To assess different forms of accountability	Accountability
3	Brinkerhoff & Goldsmith, 2004	Framework to assess patron-client relationship	Framework to identify reasons why clientelistic practices persist and the authors use realist evaluation approach comprising of context, actions (mechanisms) and outcomes.	No theory identified.	-To develop a diagnostic tool to identify patron-client relationship in development assistance -To identify harmful patron-client relationship and identify their trade-offs.	Trust & legitimacy The framework to be used by donor institutions
International development						
1	Islam, M et al., 2007	Governance framework from Health system assessment manual version-1	The framework composed of two components: general governance based on six World Bank governance measures and health sector specific governance which is linked to stewardship in the health sector.	-No theory has used, but the authors adapted WB principles of governance in developing their framework	To directly assess overall governance & health system specific governance at national level	To provide evidence that there is a relationship between governance indices and health system performance or outcomes.
2	Kirigia and Kirigia, 2011	"Health development governance" framework	The framework is intended for use in Africa, comprises 10 principles and 42 sub-functions. Using a similar formula to the one used by UNDP to calculate the Human Development Index, the authors developed their own scoring	-No theory has used, but the authors adapted UNDP principles of governance & Siddiqi's	-To directly assess governance at national level -To provide scoring of governance,	The framework tries to quantify governance using rules-based measures such as the existence of certain policy or guidelines.

N.	Author, Year	Name of the framework	Characteristics of the framework	Underlying theory if applicable	Purpose of the framework	Analytical focus
			from 0% (very poor) to 100% (excellent) for each function.	framework to quantify the functions of governance.	comparison among countries over time -To alert policy makers to areas needing improvement.	
3	Mikkelsen-Lopez et al., 2011	Framework to address governance of health system	The framework uses problem-driven approach and considers five health system building blocks under five proposed principles of governance.	-No theory has used, but the authors used system thinking approach to WHO health system building blocks	To assess governance of a pre-identified problem of a health system filtering through health system building blocks	-To assess all four levels of a health system (national, district, facility & community) using health system building blocks
4	Mo Ibrahim, 2007	Ibrahim Index of African governance	The framework focuses on government centred approach. The Index has 57 variables which can be grouped into 14 categories summarised into the following four dimensions: 1) safety and the rule of law; 2) participation and human rights; 3) sustainable economic opportunity; and 4) human development.	-No theory has been used	To assess governance of the government.	-The original purpose of the framework is to assess governance of a country from a holistic approach. The framework considers every aspect of the development of a country.
Multidiscipline						
1	Baez-Carmago & Jacobs, 2011	"Inputs-processes-outputs" governance framework	The framework starts with stakeholders mapping and power distribution (both formal and informal actors). The framework is presented as a visual process map of causal links between inputs, processes and outcomes to provide better explanations and easier application.	-Institutional analysis theory (North, 1990) from New Institutional Economics -Development literature=predefined principles	To assess governance of a health system with a pre-identified problem in health system performance	-Analyse governance as a result of interactions among different key stakeholders (formal & informal actors) -Assess predefined governance principles in terms of inputs (strategic vision, participation & consensus orientation), processes (accountability, control of corruption, transparency) and outcomes

N.	Author, Year	Name of the framework	Characteristics of the framework	Underlying theory if applicable	Purpose of the framework	Analytical focus
						(responsiveness, equity and efficiency).
2	Siddiqi et al., 2009	Governance assessment framework	The framework aims to directly assess health system governance using the hierarchical approach from national to policy implementation levels. 10 governance components are disaggregated into 63 broad questions under their relevant domains.	-Institutional analysis theory (North, 1990) -Development literature= the authors, adapted UNDP principles of governance in developing their framework	-To assess overall governance of a health system at three levels of a health system (national, district, facility) using governance principles -To provide context specific assessment of governance of health sector	-To assess different players in the health market of a health system (government, for-profit and not for-profit providers, informal networks etc.) -To analyse the context of institutions (incentives, rules that influence behaviour of key actors)
3	Smith et al., 2012	"Cybernetic" framework	A cybernetic model of leadership and governance is a mix of traditional hierarchy, market and network types of governance. The framework includes three governance components: setting priorities, performance monitoring and accountability.	System theory	A system can self-regulate through feedback mechanisms.	-Focuses on how systems use information and how they seek to monitor actions to steer towards their goals. -Focuses on accountability and management of networks.
4	Vian 2008	Framework to identify corruption in the health sector	The framework is based on the assumption that key players in the health system have certain opportunities which are the product of formal and informal rules and constraints set by the institutions. Corruption occurs as a result of taking advantage of opportunities within the institutions.	-Institutional analysis theory (North, 1990)	-To guide policy makers in examining corruption in the health sector -To identify possible ways to intervene	Corruption from the view point of government. The framework also considers other factors such as socio-interpersonal pressures, the rule of law, individual and organisational level influences and interactions and key stakeholder's interests.
5	George et al. (2016)	Accountability framework	Three counterbalancing axes of mutually reinforcing dimensions of accountability: the axis of power (incentives & sanctions), the axis of	-Institutional analysis -Political science	-To understand the perspectives of government officials to	Accountability from the view point of government officials. The framework was developed based on literature review with

N.	Author, Year	Name of the framework	Characteristics of the framework	Underlying theory if applicable	Purpose of the framework	Analytical focus
			ability (formal & informal rules) and the axis of justice (political leadership, community ownership & social equity).		support accountability reforms in Nigeria	consensus obtained through stakeholders' workshop in Nigeria.

Appendix 5. Frameworks applied

N.	Author, year	Framework applied	How frameworks have been applied	Level of analysis	Methods used sources of data	Where has it been applied? Purpose	Findings on quality assessment of empirical studies
Frameworks using principal-agent theory							
1	Avelino et al.,2013	Framework to assess accountability	Principal-agent theory (between citizens and municipals, healthcare providers and Federal government) was used to highlight how governance has improved through local accountability in addition to horizontal and vertical accountability mechanisms.	Municipal level	-Interviews with key stakeholders -Desk review of municipal audit data and reports.	Applied at the municipal level in Brazil. Use for diagnostic purpose	Medium
2	Balabanova et al.,2008	"Health sector governance and the private sector" framework	The authors use their own framework to assess how principal (government) interact with the agent (private sector) in three key forms: regulation, financing & stewardship	National level	Not mentioned	Applied at national level in Afghanistan, India and Uganda	Weak
3	Cleary et al. 2013	The framework of Brinkerhoff and Bossert (2008) was adapted to assess accountability	To identify how factors influencing accountability mechanisms work and the association between different mechanisms.	Different levels	-Review of literature describing relationship between accountability and health systems	A literature review of district health systems in low and middle income counties. Use for diagnostic purpose	Not applicable (not an empirical study)
4	Huss et al., 2011	A variant of Principal-agent model	The principal-agent theory was used at two levels: principal-agent-client and refers the "state" and "collective citizens" as "principal" while "public service providers" are "agents to deliver services for "citizens". To assess the roles and functions of principal & agent and factors affecting	Sub-national (state level)	-Interviews with key stakeholders -Desk review of reports	Applied in a State in India. Use for diagnostic purpose	Medium

N.	Author, year	Framework applied	How frameworks have been applied	Level of analysis	Methods used sources of data	Where has it been applied? Purpose	Findings on quality assessment of empirical studies
			the operations of the health sector in the State.				
5	Mutale et al.,2012	Brinkerhoff and Bossert (2008) framework	The framework was used together with a survey of health workers using self-reporting questions on governance. Interviews and FGDs with key stakeholders on two key elements identified from the survey.	Health facility level	-Survey -Focus group discussions (FGDs) -Interviews with key stakeholders	Applied at facilities in Zambia. Use for diagnostic purpose	Medium
6	Ramesh et al.,2013	Brinkerhoff and Bossert, 2008	Two principal-agent relationships (between citizens & government, between government & healthcare providers, between healthcare providers & citizens) to highlight how governance has shaped historical health system reforms in China.	National	-Desk review of reports	China Use for diagnostic purpose	Not applicable (not an empirical study)
7	Vian and Bicknell, 2013	A variant of principal-agent model	Single principal-agent relationship (state-healthcare provider) to assess governance at facility level in hospital reform process in Lesotho. They explore possible contributory causes in the failure of reform (performance based budgeting/PBB).	Facility level	-Case study approach -Discussions with key stakeholders - Desk review of budgets, financial reports	Applied at public facilities in Lesotho. Use for diagnostic purpose.	Medium
8	Vian et al., 2012	Brinkerhoff and Bossert (2008) framework	Two principal-agent relationships (between citizens & government agencies, between government agencies & healthcare providers, between healthcare providers & citizens) to assess anti-corruption initiatives in Vietnam health sector. The framework was also used to propose anti-corruption approaches.	National	-Discussions with key stakeholders - Desk review of reports	Applied in Vietnam. Use for diagnostic & prescriptive purposes.	Not applicable (not an empirical study)

N.	Author, year	Framework applied	How frameworks have been applied	Level of analysis	Methods used sources of data	Where has it been applied? Purpose	Findings on quality assessment of empirical studies
Frameworks using multilevel governance framework							
1	Abimbola et al.,2015	Multi-level framework for PHC governance	To assess government, communities and intrinsic health workers' factors influencing retention of primary healthcare workers in decentralized health system.	National, state and facility levels	-Interviews and focus group discussions with key stakeholders	Applied at six states in Nigeria Use for diagnostic purpose.	High
2	Abimbola et al.,2015	Multi-level framework for PHC governance	The framework was used together with Williamson's "Transaction costs" theory (1979) to provide recommendations for governance interventions for access to TB treatment.	National, state and facility levels	-Analysis of TB survey data from healthcare facilities in Nigeria.	Applied at one state in Nigeria. Use for diagnostic purpose.	High
3	Abimbola et al.,2016	Multi-level framework for PHC governance	Under the conditions when there is lack of formal national policies to post and transfer health workers in Nigeria, the authors have used their own multilevel framework of PHC governance to identify factors influencing policies of posting and transfer of public health workers.	Four states of Nigeria	-Interviews and focus group discussions with key stakeholders	Applied in Nigeria. No tools included. Use for diagnostic purpose.	High
Frameworks using institutional analysis approach							
1	Baez-Carmago and Kamujuni 2011	Baez Carmago and Jacobs (2011)	The authors used health system governance assessment framework developed by Baez Carmago and Jacobs to assess public sector supply chain. They started assessment by stakeholders and institutional mapping to understand powerful actors and the political context.	National	-Interviews and focus group discussions with key stakeholders -Desk review of reports	Applied in Uganda. Use for diagnostic purpose.	Medium
2	Siddiqi et al.,2009	Siddiqi et al., 2009	Using institutional analysis theory as the conceptual basis, the framework	National and sub-	-Interviews with key stakeholders	Applied at national and sub-national level of	Medium

N.	Author, year	Framework applied	How frameworks have been applied	Level of analysis	Methods used sources of data	Where has it been applied? Purpose	Findings on quality assessment of empirical studies
			was used together with predefined sets of ten governance principles to assess governance of Pakistan health system.	national levels	-Desk review of reports	Pakistan health system. Use for diagnostic purpose	
3	Erchick et al.,2017	George et al., 2016	Three dimensional axes of accountability framework (axes of power, ability & justice) was used to explore the perspectives of government officials involved in routine immunization programme in Nigeria	National, state & facility level	-Interviews with 17 government officials	Niger state, Nigeria Use for diagnostic purpose	High
4	Abdulmalik et al., 2016	Siddiqi et al., 2009	Siddiqi's framework was adapted to assess mental health system governance in Nigeria	National, state & local government level	-Interviews with 30 key informants from three different levels	Applied at national, Oyo state and local government level in Nigeria. Use for diagnostic purpose	High
5	Hanlon et al., 2017	Siddiqi et al., 2009	Siddiqi's framework was adapted to assess mental health system governance in Ethiopia	National, district & health facility level	-Interviews with 17 key informants from three different levels	Applied at national, Sodo district and health facility level in Ethiopia. Use for diagnostic purpose	High
6	Marais & Petersen, 2015	Siddiqi et al., 2009 Mikkelsen Lopez et al., 2011	The authors developed a framework by adapting the two existing frameworks to assess mental health system governance in South Africa	National, province and district level	-Interviews with 17 key informants from three different levels	Applied at national, North West Province and Dr Kenneth Kauda district level. Use for diagnostic purpose	High
7	Mugisha et al., 2016	Siddiqi et al., 2009	Siddiqi's framework was adapted to assess mental health system governance in Uganda	National and district level	-Interviews with 18 key informants from three different levels	Applied at national and Kamuli district in Uganda. Use for diagnostic purpose	High

N.	Author, year	Framework applied	How frameworks have been applied	Level of analysis	Methods used sources of data	Where has it been applied? Purpose	Findings on quality assessment of empirical studies
8	Petersen et al., 2017	Siddiqi et al., 2009 Mikkelsen Lopez et al., 2011	The authors developed a framework by adapting the two existing frameworks to identify barriers of health system governance in integrating mental health into primary health care in Africa & South Asia.	National and sub-national levels	-Interviews with key stakeholders	Applied at national and sub-national levels of Ethiopia, India, Nepal, Nigeria, South Africa, Uganda Use for both diagnostic & prescriptive purposes.	High
9	Upadhaya et al., 2017	Siddiqi et al., 2009	Siddiqi's framework was adapted to assess mental health system governance in Nepal	National and district level	-Interviews with 28 key informants from two different levels	Applied at national and district level in Nepal. Use for diagnostic purpose	High
10	Yuan et al., 2017	Siddiqi et al., 2009	Siddiqi's framework was adapted to assess two health insurance policies in China	National level	-Desk review of policy documents & reports	Applied at national level in China. Use for diagnostic purpose	Not applicable
Others							
1	Smith et al.,2012	Smith et al., 2012	The framework which is composed of three key nodes of governance serves as the guiding principles in assessing hierarchy, market and network governance of seven developed health systems	National	-Interviews with key stakeholders -Desk review of reports	Applied at national level in seven developed health system. Use for diagnostic purpose	Medium
2	Olafsdottir et al. (2011)	Ibrahim index of African governance (2007)	Ecological analysis of two sub-indicators of Ibrahim Index namely RLTC: Rule of Law, Transparency and Corruption and SEO: sustainable economic opportunity.	National	-Secondary analysis of data	46 WHO Africa countries	Not applicable

Appendix 6. Topic guide

General opening

1. How do you characterise the maternal and newborn health (MNH) services in Kenya? (About availability and quality of MNH services nationally. And how about the availability of CEmOC nationally?)
2. What are the main health needs of MNH? How have those needs been identified in the devolved health system?

Strategic Vision

1. Are there clear vision and policies for MNH? If yes, what are they? (Probe into "Free maternity services (FMS) & user fees abolishment policies")
2. Are you aware of how those policies were developed? Who has involved in developing those policies?
3. How do you find the policies in responding to the MNH needs of the population?
4. What have been the challenges after devolution?

(**Probe** into their specific answers if they mention the lack of finance or trained staff or equipment or infrastructure. Ask them "*How do you overcome them?*")

Participation

1. Who are the key stakeholders in MNH policy making?
2. How do those stakeholders share ideas? Are there regular meetings or other ways that they can express their interests (and possibly influence policy or programmatic decisions about EmOC)? Did this change after devolution?
3. Among them, who do you think is the most powerful in MNH policy making in Kenya? Who has the greatest influence in the provision of CEmOC?
4. Tell me about participation in MNH service planning and delivery – who participates and why?

(**Probe**: Types of engagement or participation of civil society or individual citizens, not just in service planning and delivery but perhaps in policy or agenda-setting too. If people are engaging a lot, what factors seem to be associated with this? Do they also engage in groups for self-help outside of EmOC (prior experience)? Are they actively encouraged to engage? Is the engagement positive (a productive interaction) or is it confrontational and adversarial?)

5. What have been the successes and challenges in wider participation since devolution?

The rule of law

1. Are you aware of the rules for free maternity services?
2. How are they enforced? (Probe if he mentions non-enforcement of the rules. Why? Ask if there are procedures in place for addressing grievances of consumers & providers)

Accountability

1. Please tell me about the understanding of roles and responsibilities among key stakeholders in the health system since devolution.
2. What do you think are the consequences of lack of role clarity?
3. Do any complaint mechanisms exist? Do people feel empowered to use them? Why/why not?
4. What are the measures of performance and non-performance?
5. Please tell me about the rewards for those performing well and repercussion for those performing poorly.
6. What have been the successes in relation to accountability? What are the challenges?
7. How might accountability challenges affect the provision of MNH services and CEmOC, and why?
8. What can be done to improve accountability?

Responsiveness

1. What are the challenges to respond to main health priorities in MNH? To respond to CEmOC service provision?
2. How can they be improved?

Equity

1. What do you think about equity in access to MNH services in your country? (Probe-whether devolution has affected equity and responsiveness of government?)
2. Which population groups are mostly using MNH & EmOC services in your county or facility? (only for county or facility levels)
3. Please tell me about any policies in place to ensure fair access of MNH services.

General closing

1. Is there anything else you would like to say about health systems governance? Or anything more relating to the governance challenges and opportunities for MNH services and CEmOC?
2. Is there anyone else involved in MNH policy making that I should talk to about governance?

As the meeting comes to an end, the interviewer reads the notes that she has taken to the participant so that s/he can clarify the points made. The interviewer thanks the participant for her/his valuable contributions and time.

End of the meeting.

Appendix 7. Participant information sheet and consent form

Name of Principal Researcher: Dr. Thidar Pyone

Name of Organisation: Liverpool School of Tropical Medicine

Name of Project: Health systems governance in Kenya: an assessment at national and subnational level

This informed consent form has two parts:

- Participant Information Sheet (to share information about the research with you)
- Consent form (for signatures if you agree to take part)

PARTICIPANT INFORMATION SHEET

BACKGROUND

You are invited to participate in this research project, which is a research study towards the Doctor of Philosophy (PhD) programme at The University of Liverpool, UK in cooperation with Liverpool School of Tropical Medicine (LSTM), UK. This study is part of the on-going "**Making it Happen**" programme in Kenya. The study has been approved by the ethics review committee from the LSTM, UK and the Kenyatta National Hospital Ethics and Research Committee (KNH/UON-ERC) from Kenya. UK-Department for International Development (DFID) funding is being used to support this research.

PURPOSE OF THE STUDY

The study is about health systems governance and functionality of a healthcare facility. As you are an active player in Kenya health system and implementation of health policy, I am interested to hear about your experiences and views on governance. It is up to you to make a choice whether to take part in the study or not; participation is entirely voluntary.

STUDY PROCEDURES AND DURATION

If you do decide to participate, you will be given this information sheet to keep and be asked to sign a consent form. You are still free to withdraw at any time without giving a reason. Your participation would be through an interview which will take about an hour. The interview will take place at your work place or other mutually agreed convenient location.

RISKS AND DISCOMFORTS

During the discussion, if you come across any questions that you do not feel comfortable or do not want to answer, you do not have to; you may also stop the interview at any time. However, we would appreciate an open and honest discussion about the health systems governance in your country, how key stakeholders perceive, practise and interact with governance procedures.

EXPECTED BENEFITS

By participating in this research, you will be contributing towards the improvement of health systems although there will be no immediate, direct benefit to you.

COMPENSATION

No financial incentive will be given to participants.

CONFIDENTIALITY

We hope you will allow us to record the discussion, as it will make subsequent analysis easier. Only the principal researcher will work with the transcripts. The records and transcripts will be destroyed 5 years after the completion of the study. The study is anonymous and you will not be identified in any documents related to the study. However, anonymised direct quotations might be used in the final thesis and peer-review publications. The consent forms will be stored in lockable cabinets and will only be accessible to the principal researcher. Electronic data will be stored on a password-protected computer with only the principal researcher having access to the password. None of the data on the computer will have your name on it.

DISSEMINATION OF RESULTS

Results will be published in peer-reviewed journals and in print and e-thesis format.

PARTICIPATION AND WITHDRAWAL

The choice to participate in this study depends solely on you. You can choose to withdraw from this study at any time during the research without any consequence to you. You can refuse to answer any question you do not want to answer and still be part of the study.

CONTACT

If you have questions regarding the study, please contact **Thidar Pyone** through e-mail at **Thidar.Pyone@lstmed.ac.uk** or by calling **+441517052533**.

You can also contact the Ethics committee regarding any concerns you have about the conduct of the research in the case when you do not want to contact the principal researcher.

Contact Details:

Research and Ethics Committee
Liverpool School of Tropical Medicine
Pembroke Place, L3 5QA, Liverpool
United Kingdom
+44(0)151 705 3100

KNH-UON-ERC
Mbagathi Rd. Nairobi, Kenya
+254 (0)20 2713349, +254 (0)20 2722541, 0722-205901

Please keep this information sheet and should you wish to take part, you will need to sign and be given a copy of the consent form.

CONSENT FORM

The above information was clearly explained to me in English by the administrator of the instrument and I understand that language. I was given the opportunity to ask questions which were answered satisfactorily.

I hereby voluntarily consent to participate and have received a copy of this form.

I am also aware that the discussion will be recorded and I consent to this.

Signature of participant / Date

For administrator,

I certify that all information concerning the research was accurately provided to the participant.

Signature of administrator / Date

A copy of this information will be given when you return the completed form.

THANK YOU

Appendix 8. Interview topics sent to participants

Study title: Health systems governance in Kenya: an assessment at national and subnational level

Thank you for agreeing to help us with this project. Below is a list of topic areas which we plan to cover in our interview.

1. Your department/organization, and your role within it.

2. Governance: Focuses on political ideology considering health system together with other principles which influence the system such as transparent rules governed by effective oversight and strong accountability in place.

3. Strategic vision: Strategy for health policy in your country

4. Participation and consensus orientation: Participation in decision-making process of the country health system, who involves in decision making and community participation in health services provision

5. Rule of law: The legislation process at health facility level; including the interpretation of legislation into regulation and policy and the enforcement of laws and regulations

6. Responsiveness: The efforts of the institution to try to serve the health needs of the population. How does the health system respond to the health needs?

7. Equity: How healthcare resources are allocated and any differences in access to care among different population groups?

8. Accountability: The state of being responsible and answerable for one's decisions and actions.

Appendix 9. Memo on topic guide modification

- The way to ask the interview questions

If the respondent mentioned governance principles from the first question, try to ask them what they mean for each principle.

> "*T; so How do you understand and would define this (governance) especially within, your country health system*
>
> *P: Ok, the government is ensuring that there are accountabilities, transparency and people participation in decision making in the provision of health services.* "(KI-3, p1)

For instance, I should ask "you have mentioned accountabilities, transparency and people participation, can you elaborate a bit?"

- If the respondent got lost with the questions on governance even after giving examples on specific governance principles like in the case of KI-10, ask them how the situation was in their institution.
- When the respondents answered health system issues (HR, financing) as governance, what should I do? Or when the bottlenecks are health system issues, how should I relate that to governance?

- Should I remove the word "**devolved**" from guiding question of my topic guide? I found that the respondents mentioned "devolution" so often in the interviews. Will that lead towards devolution study but not governance? Devolution is on the agenda in Kenya nowadays, so I think they will mention that although I didn't include "devolved" in my guiding questions. But I think I cannot avoid that as devolution is on the agenda in Kenya. People will say even if I don't ask. I think I need to find how devolution has improved or worsened the situation of governance in Kenya.

- Before each group of questions, I used to have those opening statements and explained that what these governance principles are, for instance, *"Let's consider more detail aspects of health system governance and how these could affect MNH service provision and availability of CEmOC. First, let's consider governance inputs, such as a strategic vision, participation in decision making and the rule of law (if needed, give the definitions)."* I thought they are not needed as it complicated the participant. So, I have removed them. I will directly ask the questions.

- Under **general opening section**, I have added "quality" in addition to "availability of MNH services" like this "How would you describe availability and quality of MNH services nationally?" because KI-4 said *"what has happened over time is the facilities initially because they didn't have the money we had so many mothers who came in, and then the care was not good because they didn't have the money at that time".* So, I think I need to add quality in addition to availability.

- Under **strategic vision**, I have replaced the question "Is there long term vision for MNH? If yes, what is it?" With this one "Are there clear vision and policy goals for maternal and newborn health? If yes, what are they?" because everyone mentioned vision 2030 when I asked that question, and that is the vision to become Kenya a middle-income country by 2030. I think I need to be more specific because everyone knows there is vision 2030.

- Under **strategic vision**, I have added some questions to probe after this question "What have been the challenges after devolution?" (Probe into their specific answers if they mention lack of finance or trained staff or equipment or infrastructure). How do you overcome them as I found that almost all respondents gave health system issues? I would like to see specific strategies to overcome them and whether it has any consequences on governance. One example from the interview with KI-4 *"they have this equipment, they don't have the other, they have this health worker they don't have the other supplies."*

- This has been replaced with two health financing policies prescribed in 2013 and asks relevant questions on FMS and user fees abolishment? (addition 27Aug2015)

- Under **participation**, I have added two following questions to probe:
  1. "Processes before participating i.e. how do stakeholders share ideas? Are there regular meetings or other ways that they can express their interests (and possibly influence policy or programmatic decisions about EmOC)? Did this change after devolution?" I got the idea from my interview with KI-2, as he mentioned that there are a lot of constituencies and forums where stakeholders can participate. "*There are such a lot of forums. So, if you want to engage, and come together with constituencies and raised your issue for engagement*." (KI-2, p7)

  2. "Types of engagement or participation of civil society or individual citizens, not just in service planning and delivery but policy or agenda-setting too". Public engagement includes a spectrum of activities from passive to very active, i.e. being a recipient of information from regulators, providing input through public opinion poll, submitting complaints about poor service, joining an advisory board, or conducting a social audit. Literature sometimes refers to categories of public communication (least active), public consultation, and public participation (most active). "If people are engaging a lot, what factors seem to be associated with this? Do they also engage in groups for self-help outside of EmOC (prior experience)? Are they actively encouraged to engage? Is the engagement positive (a productive interaction) or is it confrontational and adversarial?" I got the idea from my interview with the KI-2, as he mentioned that "*it can engage but it is not necessarily mean to take up everything that people want. Those are two different things. So, for some stakeholder, they perceive engagement as government doing what they have told. ……The challenges are that the way some partners interpret the engagement. If I told you what to do, you refuse to do what I told you. Then you have not engaged as a perceptive of some partner.*

> *So, they will come out and say they have very little engagement and you are asking why well, because can you see what they are doing is not correct. Why you are participating. No, because I know they will not accept what I am saying, so is that engagement or not?"* (KI-2, p6,7)

- Under **accountability**, I have added some questions to start with. "Please tell me about the understanding of roles and responsibilities among key stakeholders in the health system since devolution? What do you think are the consequences of the lack of role clarity?" I got the idea from my interview with KI-2, as he mentioned that *"…because there are a lot of stepping on each other toes. You are entering my area this and my area that. People look at it as an empire, not as a service."* (KI-2, p9)

- Under **accountability**, I replaced my question of "What have been the successes regarding accountability?" with this one "Do any complaint mechanisms exist? Do people feel empowered to use them? Why/why not?" Because I got unrelated or very superficial answers on the success of accountability. Besides, from my interview with KI-3, he mentioned that "*the accountability also involves the complaint redress. It also has that accountability to people complaint redress mechanism which is available and functional.*" (KI-3, p1)

- Under **accountability**, I replaced my question of "Do you have non-compliance in practising certain policies on MNH services? In such case, which kind of sanction is practising in your institution? How are those sanctions enforced and why?" with this one "What are the measures of performance and non-performance? Do you know what are the rewards for those performing well and repercussion for those performing poorly?" Because I got unrelated or very superficial answers on non-compliance and people cannot specify.

- Under **accountability**, I found that participant found difficult to answer some questions like "among the professions within your facility, on the provision of the MCH services, particularly CEmOC, what are the main accountability challenges you would see?" She asked me to give an example or explain what I want to know. The answers she gave for that accountability challenges are other health system issues such as lack of medicines, supplies & equipment, HRH, transportation.

- The questions "what are the main health priorities in MNH? How those priorities are identified in the devolved health system?" under **responsiveness** was moved to before strategic vision as this was part of input (i.e. participatory priority-setting as part of strategic vision). Initially I had that under responsiveness on how this is about measuring responsiveness. But this question has been modified as "needs" rather than "priorities". See below.

- It is sometimes difficult to ask the question regarding "**health priorities**". Before asking the question on responsiveness, I started my question with priorities in MNH. Then, I ask them whether those priorities have been responded or not. I had difficulty to make the KI-10 as he couldn't understand my question on "what are the

main priorities on MNH in this institution?" I even got not relevant answers as he replied that they were the leading causes of death when I asked him "why do you think they are priorities?" He replied, "*If you don't act, the mothers will die*". But later I thought, they should be replaced with "**health needs**", not "priorities". "Priorities" is not the right word. So, I have modified the question as "If we consider for a moment maternal and newborn health (MNH) services in Kenya, what are the main health needs in MNH? How those needs are identified in the devolved health system?"

- Regarding **participation**, it was difficult to ask sometimes at the facility, e.g. the nurse in-charge of maternity unit to ask who participates in the implementation of the policy. I have asked him using different questions, but I could not get useful information.

- When I find out that a particular facility is used by a certain population which kind of question should I ask for **equity**? e.g. Pwmani hospital. I felt that I didn't ask questions to probe equity issue. The matron said certain population groups are using that facility. Should I ask whether the county government aware of that? Does that facility receive any support from any government institutions?

- Similarly, is that enough to find out information on equity? "Please tell me about any policies in place to ensure fair access of MNH services."

- For facility level topic guide, I should ask something particular in relevance to governance and EmOC service provision. Especially when they mention about certain signal functions which they can perform and not, then probe further. Anything relevant to governance and how it can be improved?

Appendix 10. Field memo

Interviewee (institution/ designation)	**KI-5 (National level, MOH)**	**KI-8 (County level)**
Date	21/04/2015	24/04/2015
Time	13-13:45	8:15-9:40
Interview place	MOH Health system reform office (Afya house)	Nairobi Provincial Health Quarter-Nyoya House
Setting	The interview was conducted at the respondent's office but the door was not closed. There were some noises from outside the building from time to time. There were some interruptions during the interview. The respondent's phone rang for 3 times and one of the calls was answered.	The interview was conducted in the respondent's office. The door was close but there were some noises from the windows. The respondent paid attentively to the interview as he refused calls by saying that he was in an interview. There was one interruption as one of his assistant directors came into the room.
Significant feelings about the interview	I waited for the respondent for an hour. Very rich information on health policy & planning. The respondent is the focal person in policy development. Very conversant with the system and updates on health systems governance. The respondent mentioned about the Ministry of Devolution which was recently formed with the merger of more than 5 ministries. The respondent didn't have the contact details of the focal person but promised me to send afterwards. I received a copy of KHSSP (2014-2018) report.	I was supposed to meet the boss of the respondent but the boss delegated me to the respondent. This interview was arranged by the county RH coordinator who issued the authorization letter to collect data within the county. The interview went in an amicable way as the respondent started a conversation about topics outside the interview. We discussed my own country and the politics for about 10 minutes before the interview actually started. I felt I got very rich information on the particular county before and after devolution. I received open and frank information on county health system after devolution with measures that the respondent thought could address them.

Appendix 11. Example of a thematic framework

Theme: accountability
National level participants

Participant/ Sub-theme	Financial accountability	Community accountability	Challenges to improving accountability
KI-1	Good tracking system for funds is essential: *"…from the newspapers the counties are still not as good in terms of accountability. And…with the time and as the law takes its course arresting some who misappropriate and things like those people will now be serious, following the guidelines and rule of law."* (p-7)		
KI-1	Perceived vulnerability: *"Quite a lot of counties because they were not very much exposed to management of huge funds. Before they were districts, and these things they never got managed that huge funds so we expect a lot of misappropriations here and there especially through procurement things like those."* (p-7)		
KI-2			Lack of role clarity: *"there are lot of stepping on each other toes. You entering my area this and my area that. People look at it as an empire, not as a service."* (p-9)

Participant/ Sub-theme	Financial accountability	Community accountability	Challenges to improving accountability
KI-2			Making use of accountability mechanism: "we have empowered our people appropriately to demand accountability. The kind of demand that you see is a poisonous in some instances...if I make noise, I know that I will get certain benefits out of the system. So I am making noise not because I want to improve services but because I want to be shut up. Which is not the kind of accountability that we are looking for." (p-10)
KI-2			There are even brokers to make use of the accountability and the system: "*you have professional civil society people, they earn a good living because whenever I made money, I just go and make a bit of noise*." (p-10)
KI-4		Collusion between management & governing boards: *"If the management is not willing to have a board in place, it becomes very difficult to establish one because they can influence who is coming into the board. They can influence what decision they make... At that level, there are at the mercy of the hospital technical team. In some cases, you find that the board and management team being together."* (p-5)	

Appendix 12. Ethics approval from the LSTM

LSTM
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Thidar Pyone
Liverpool School of Tropical Medicine
Pembroke Place
Liverpool
L3 5QA

Tuesday, 31 March 2015

Dear Ms Pyone,

Research Protocol (14.052) Health Systems Governance for Facilities Designated to Provide Comprehensive Emergency Obstetric and Newborn Care in Kenya

Thank you for your letter of 30 March 2015 providing the necessary in-country approvals for this project. I can confirm that the protocol now has formal ethical approval from the LSTM Research Ethics Committee.

The approval is for a fixed period of three years and will therefore expire on 30 March 2018. The committee may suspend or withdraw ethical approval at any time if appropriate.

Approval is conditional upon:

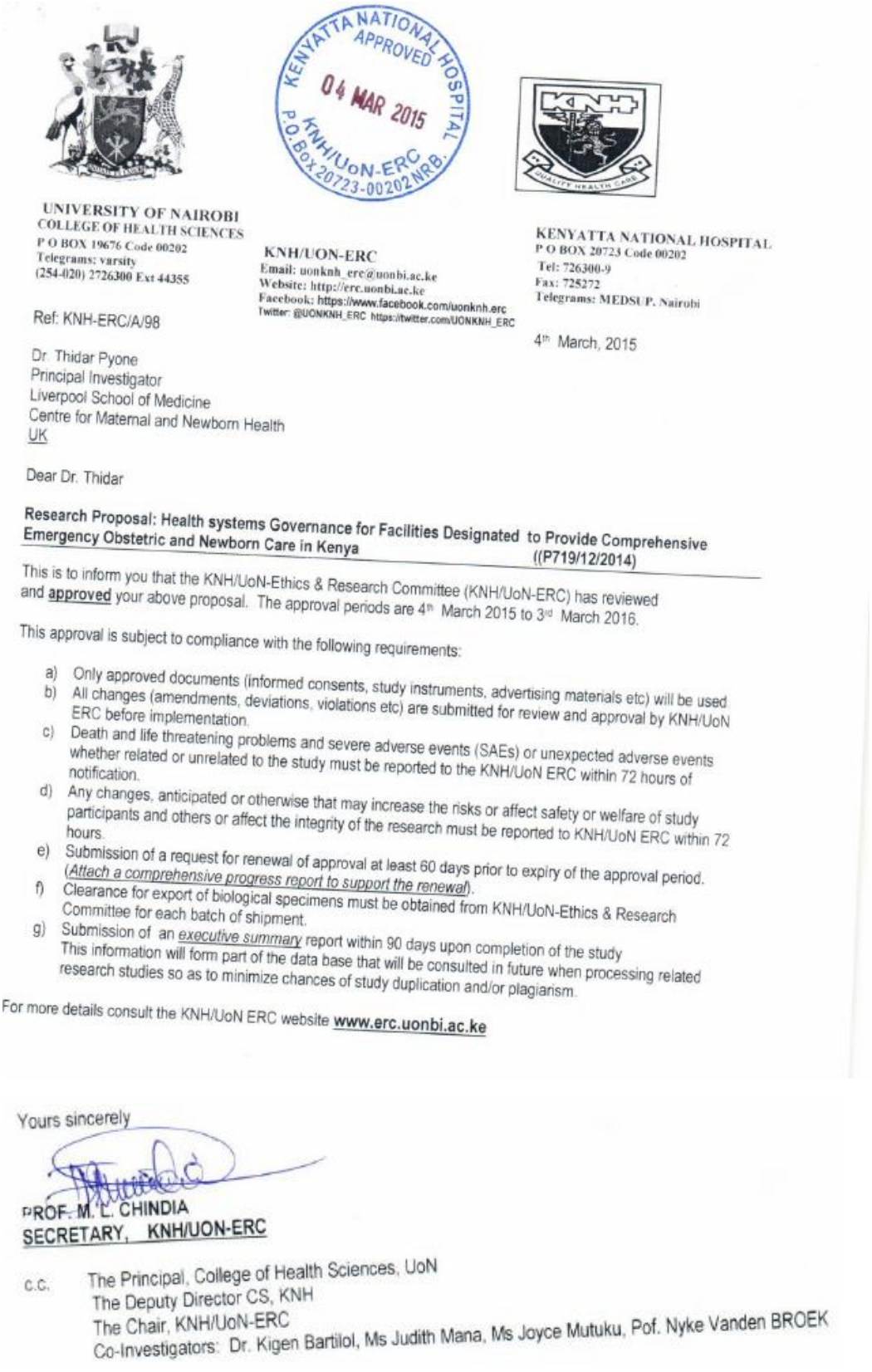
- Continued adherence to all in-country ethical requirements.
- Notification of all amendments to the protocol for approval before implementation.
- Notification of when the project actually starts.
- Provision of an annual update to the Committee.
  Failure to do so could result in suspension of the study without further notice.
- Reporting of new information relevant to patient safety to the Committee
- Provision of Data Monitoring Committee reports (if applicable) to the Committee

Failure to comply with these requirements is a breach of the LSTM Research Code of Conduct and will result in withdrawal of approval and may lead to disciplinary action. The Committee would also like to receive copies of the final report once the study is completed. Please quote your Ethics Reference number with all correspondence.

Yours sincerely

Dr Angela Obasi,
Chair,
LSTM Research Ethics Committee

Appendix 13. Ethics approval from the Kenyatta National Hospital-University of Nairobi Ethics Review Committee



KENYATTA NATIONAL HOSPITAL APPROVED 04 MAR 2015 P.O.BOX 20723-00202 NRB. KNH/UoN-ERC

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Ref: KNH-ERC/A/98

4th March, 2015

Dr. Thidar Pyone
Principal Investigator
Liverpool School of Medicine
Centre for Maternal and Newborn Health
UK

Dear Dr. Thidar

Research Proposal: Health systems Governance for Facilities Designated to Provide Comprehensive Emergency Obstetric and Newborn Care in Kenya ((P719/12/2014)

This is to inform you that the KNH/UoN-Ethics & Research Committee (KNH/UoN-ERC) has reviewed and **approved** your above proposal. The approval periods are 4th March 2015 to 3rd March 2016.

This approval is subject to compliance with the following requirements:

a) Only approved documents (informed consents, study instruments, advertising materials etc) will be used
b) All changes (amendments, deviations, violations etc) are submitted for review and approval by KNH/UoN ERC before implementation.
c) Death and life threatening problems and severe adverse events (SAEs) or unexpected adverse events whether related or unrelated to the study must be reported to the KNH/UoN ERC within 72 hours of notification.
d) Any changes, anticipated or otherwise that may increase the risks or affect safety or welfare of study participants and others or affect the integrity of the research must be reported to KNH/UoN ERC within 72 hours.
e) Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. (*Attach a comprehensive progress report to support the renewal*).
f) Clearance for export of biological specimens must be obtained from KNH/UoN-Ethics & Research Committee for each batch of shipment.
g) Submission of an *executive summary* report within 90 days upon completion of the study This information will form part of the data base that will be consulted in future when processing related research studies so as to minimize chances of study duplication and/or plagiarism.

For more details consult the KNH/UoN ERC website **www.erc.uonbi.ac.ke**

Yours sincerely

PROF. M. L. CHINDIA
SECRETARY, KNH/UON-ERC

c.c. The Principal, College of Health Sciences, UoN
The Deputy Director CS, KNH
The Chair, KNH/UoN-ERC
Co-Investigators: Dr. Kigen Bartilol, Ms Judith Mana, Ms Joyce Mutuku, Pof. Nyke Vanden BROEK

Appendix 14. List of documents reviewed

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