
# DECIPHERING GOVERNANCE:

## Analysing constructs of governance, and how they facilitate attainment of health goals in a low- or middle-income country. A Case Study from Kenya

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## Declaration

I, Humphrey Cyprian Karamagi, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.



**Section 3.3 is redacted from the publicly available version of the thesis for confidentiality purposes**

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# DEDICATIONS

MY PARENTS

Mr. Cyprian Rwakuliremu Karamagi and Mrs. Ann Mary Karamagi

I was encouraged to commence my Doctorate by my parents, who both placed an unwavering value on education and the pursuit of knowledge. Unfortunately, they both passed away before I completed the studies. I dedicate this thesis as a labour of love to them.

May they Rest in Peace

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I am most grateful to several people who, under no obligation on their part, put aside time to walk with me on this journey

My supervisor, *Dr. Neil Spicer PhD*, has been a most patient and understanding pillar of support. His expertise and guidance throughout my doctoral work is what made it possible for me to take on this topic of interest to me. His insights into the overall focus, design, conduct and presentation from the beginning to end of the doctoral assignment were most useful. I could not have had a better person to walk with me through this journey.

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Finally, I am most grateful to my family, Juanita Raphael and Vanessa. They patiently endured days and nights I was not available physically and emotionally because of the research. Without their understanding and support, I would have come out of this process worse off than when I started it. This sacrifice on their part is most valued.

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## ABSTRACT

Challenges with ensuring effective governance persist in low- and middle-income countries in part due to lack of a common approach to interpreting and applying it by those responsible for providing direction and oversight of the health agenda. My study explores how to overcome this challenge.

I document several theoretical, institutional or conceptual approaches to define the concept of governance. I postulate that through identifying a clear way to interpret and apply governance, health stewards and managers in low- or middle-income countries would be better able to plan, implement and monitor governance actions needed to facilitate attainment of their health results.

To explore this through case studies involving forty-nine Key Informants in Kenya representing health stewards and managers at macro, meso and micro levels of oversight, plus public, faith based and private sector providers plus civil society organizations. Amongst these, I explored the various ways governance is understood, and factors needed from the health sector and other sectors. To ensure a depth of exploration, I deconstructed governance into its constituent constructs.

I found that, these persons expected to implement governance actions understood these from the perspective of six primary characteristics. I also find that health sectors need to ensure a range of policy/legal, and structural (tangible) / process (intangible) based instruments and tools to facilitate the action of governance. Finally, other sectors need to focus on ensuring there are community transformation initiatives, processes to build social capital, participatory decision-making culture, systems to ensure equity and the right to health, governance improving processes and opportunities to expand devolved level decision space.

My results have some elements that have been identified before in literature, and some which are new or not part of the mainstream thinking. I therefore build a reconstruction of governance through structuring and outlining the actions health stewards and managers need to focus on for effective influence on their health results.

It would be worthwhile to explore how to make this construction of governance operational for health stewards and managers in low- or middle-income countries.

# ABBREVIATIONS

| | |
|---|---|
| ANC | Antenatal Care |
| CBO | Community Based Organization |
| CEC | County Executive Committee |
| CDH | County Director of Health |
| CHMT | County Health Management Team |
| CHSSIP | County Health Sector Strategic and Investment Plan |
| CHU | Community Health Unit |
| CHV | Community Health Volunteer |
| COH | Chief Officer of Health |
| DEA | Data Envelopment Analysis |
| DHIS | District Health Information System |
| DrPH | Doctorate of Public Health |
| EVD | Ebola Virus Disease |
| GAVI | Global Alliance for Vaccines and Immunization |
| GOK | Government of Kenya |
| HIC | High Income Country |
| HIV | Human Immunodeficiency Virus |
| HSS | Health System Strengthening |
| HW | Health Worker |
| ICF | Informed Consent Form |
| IMF | International Monetary Fund |
| KHSSIP | Kenya Health Sector Strategic and Investment Plan |
| KI | Key Informant |
| KNBS | Kenya National Bureau of Statistics |
| LMIC | Low- and Middle-Income Country |
| LSHTM | London School of Hygiene and Tropical Medicine |
| MDG | Millennium Development Goals |
| MIC | Middle Income Country |
| MOH | Ministry of Health |
| NCD | Non-Communicable Disease |
| OPA | Organization and Policy Analysis |
| PAHO | Pan American Health Organization |
| PHC | Primary Health Care |
| PhD | Doctor of Philosophy |
| ScHMT | sub County Health Management Team |
| SDG | Sustainable Development Goal |
| TB | Tuberculosis |
| UHC | Universal Health Coverage |
| UN | United Nations |
| UNDP | United Nations Development Program |
| UNOHCHR | United Nations Office of the High Commissioner on Human Rights |
| UoN | University of Nairobi |
| SC | Sub County |
| WB | World Bank |
| WGI | World Governance Indicators |
| WHO | World Health Organization |
| WHR | World Health Report |

## GLOSSARY OF COMMONLY USED TERMS IN THE THESIS

| Term | Definition used in thesis | Related terms |
|---|---|---|
| **Case study** | An empirical investigation of a contemporary phenomenon within a real-life context | |
| **Community health system** | The elements of the health system that are based at the household or community. These include human resources, infrastructure of medicines / supplies | Institutional health system |
| **De-concentration** | A form of decentralization where the central level transfers some of its responsibilities to lower-level administration units within its jurisdiction. The central level retains overall responsibility for the deconcentrated functions | Decentralization<br>Delegation<br>Devolution |
| **Decentralization** | The transfer of authority from a central to a lower level of administration | De-concentration<br>Delegation<br>Devolution |
| **Delegation** | A form of decentralization where the central level transfers some of their responsibilities to subordinate levels of administration. The subordinate level assumes responsibility for the delegated functions | Decentralization<br>De-concentration<br>Devolution |
| **Devolution** | A form of decentralization where the central level cedes some of its responsibilities to a lower level of administration outside of its jurisdiction. The central level loses overall responsibility to the unit it has devolved services to | Decentralization<br>Delegation<br>De-concentration |
| **Governance** | The economic, political and/or social institutions by which power and authority are exercised. Authority is not only that exercised by the state, but by all actors to ensure the collective authority of a community is used to achieve the health results it needs. | Stewardship<br>Management |
| **Institutional health system** | The elements of the health system that are based in facilities who's primary purpose is provision of health services. These include human resources, infrastructure of medicines / supplies | Community health system |
| **Key Informant** | A person who acts as a proxy for a targeted population with whom an interview is conducted. | |
| **Low-Income Country** | Countries with a gross national income per capita, calculated using the World Bank Atlas method, of $995 or less in 2017 | Low- Middle-Income country |
| **Low- Middle-Income country** | Countries with a gross national income per capita, calculated using the World Bank Atlas method, between $996 and $3,895 in 2017 | Low- Income country |
| **Management** | The process of achievement of agreed results | Governance<br>Stewardship |
| **Primary Health Care** | A whole-of-society approach to health and well-being centred on the needs and preferences of individuals, families and communities. | Universal Health Coverage |
| **Stewardship** | The form of direction and medium-term oversight given to facilitate movement towards desired results. | Governance<br>Management |

| Term | Definition used in thesis | Related terms |
|---|---|---|
| **Universal Health Coverage** | An approach to ensure that all people have access to needed health services (including prevention, promotion, treatment, rehabilitation and palliation) of enough quality to be effective while also ensuring that the use of these services does not expose the users the financial hardship. | Primary Health Care |

# INTEGRATING STATEMENT

Since I started working in public health policy, I have always been intrigued by the concept of governance and how it is applied in health. During my career, I have interacted with, asked advice from, and monitored actions of health managers at facility, sub national and national levels. Through this, I have noted that there is no coherent way to provide guidance on actions relating to governance that are important for improving attainment of health goals. I have experienced instances were a manager is perceived as ineffectual but is overseeing a system that is producing good health goals. The converse is also true – managers perceived to be very good, but attainment of health goals is not as would be expected. Even when comparing systems with similar levels of investments, the kinds of health goals attained are not linearly linked with the perceptions of governance.

I have noted that this situation is related to the fact that different people define and measure governance differently within the health sector. Health sector governance has remained quite a subjective concept in day to day practice. Priorities within governance are largely driven by perceptions of what people want – be they supervisors, development partners, or citizens. A system is therefore perceived to practice good governance if it focuses on the key stakeholders' perceptions of good governance. If the system has a key development partner that thinks corruption is a major issue, then it is perceived to be performing well in governance if it focuses on corruption prevention, irrespective of the effects it has on its health goals. This therefore makes it difficult to plan, implement and monitor governance in health in a coherent manner that coherently and predictably impacts on health goals.

This situation is made more challenging with the status of global health. More countries are facing increasingly complex health challenges, driven by increases in non-communicable conditions and emerging health threats that are negating the effects of progress made against communicable diseases. More actors are getting involved in health, and there is increasing potential for inefficiencies in the use of scarce health resources. Expectations of governments in health have as a result changed. In the past, governments focused on provision of publicly funded services to their people. However, they are currently being called on, while addressing the health agenda, to play a dual role of:

- Coordination of the increasing number of actors in health to ensure their actions are supporting movement towards a common set of outcomes, and
- Focus their service provision role to populations they are best suited to cover, and in a manner that makes best use of their limited budgets.

This shift from a focus on 'doing', towards a focus on 'guiding the doing' has led to a different set of skills and attributed expected of a health leader. Key has been a shift from a management, to a stewardship role

of government[1]. The quality of the stewardship has increasingly become a key determinant of the capacity to attain health goals in a country (Kirigia & Kirigia, 2011; Omaswa & Boufford, 2010).

When the World Health Organization (WHO) in 2006 concretized systems thinking around building blocks needed for attainment of health objectives, the need to better understand governance – one of the building blocks of a health system – took on more urgency. As a public health practitioner, I was constantly frustrated with the lack of succinct guidance relating to application of governance and stewardship, as compared to the other building blocks. Research into application, and outcomes of governance in health left me more confused about how it should be applied. I therefore decided to dedicate time on a research program to delve deeper into understanding stewardship and governance, to contribute to guidance being given to our health sector managers and stewards on how to approach this concept.

The DrPH program, being designed for public health leaders, was a natural fit for me as its design allowed me to explore this issue from a multitude of angles. The three components of the course – the taught component, the Organizational Policy Analysis (OPA), and the research component are all therefore linked together around this need for a better understanding of management and stewardship in the current health sector.

The taught course component gave me the theoretical understanding behind the concepts related to health leadership and governance. While I had applied many of these in practice previously, I was able to structure and organize the concepts, and eventually exhibit this improved understanding in the two outputs I attained:

(i) An analysis of how to generate required evidence for a policy maker on a key policy issue, using systematic analysis of existing knowledge. This is a common challenge for policy makers, as the ability to sift through and analyse existing evidence to inform their decisions is usually weak. Using an example of the use of evidence on community level marketing of alcohol on its use, I was able to illustrate how to generate evidence-based information for managers only based on systematic analysis of existing literature

(ii) Once evidence on a key issue exists, how to get the issue on the policy agenda using both a policy analysis approach to understand the context, actors and process and a strategic approach to understand the problem, policy and politic streams that would influence it ability to get onto the policy table. I was able to illustrate how to navigate the policy arena and get an important issue on the policy table.

[1] *In the context of this thesis, I distinguish a 'manager' from a 'steward' by the kinds of decisions they are responsible for. I refer to a manager where decisions have short term / operational implications, and a steward where decisions have short, medium (strategic) and/or long (policy) term implications. An individual may have management and / or stewardship roles depending on the delegation of authority*

The next component of the program – the organizational policy analysis (OPA) – allowed me to explore these concepts in a real-world setting. Given my overarching research interest in better understanding how governance and stewardship work, I chose a topic that would enable me to critically look at the decision-making process in government. Kenya had just passed a new constitution in 2010 that called for fundamental changes in the focus and make up of government. I therefore decided to use the process of translation of the constitution in health as an anchor around which I could apply research methods to explore how government stewards exercise decision making. I used an adaptation of the policy analysis framework (Walt & Gilson, 1994) to analyse the actors, processes and context influencing the adoption of the constitution imperatives in the Kenya health sector. The ever-changing nature of actors and motivations, together with the strong influence of contextual factors emerged as key influences on the steward's ability to make decisions with intended and unintended consequences arising from what initially appears to be a simple policy action. The OPA recommendations were three:

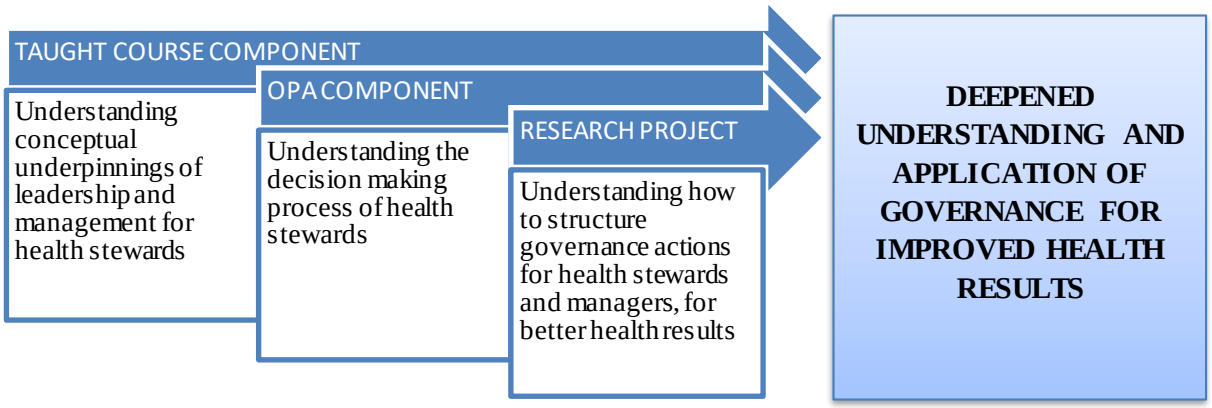
1. Need for development of stewardship capacity amongst governments – not just management capacity that many countries focus on,
2. Need for partners to provide real support to building this government stewardship capacity, and
3. Need for deeper research into understanding the governance, to provide succinct guidance to health stewards on how to focus their actions to improve the quality of health results.

These recommendations from the OPA provided the springboard to the research project, which focused on building a deeper understanding of how governance works to achieve its impacts on health objectives. My aim research aim – to interpret how to structure and apply health governance for stewards and managers in low- or middle-income countries for attainment of their health results – was based on the challenges faced in this due to lack of a common understanding of what governance entails. My research looked at understanding how governance is interpreted by health stewards and managers, plus identifying actions health sectors and other sectors need to focus on, to make governance results real.

The research should provide further clarity in planning, implementation and monitoring of governance actions, and so improve predictability and outcomes from governance investments in health.

All the study components are well intertwined around the need to improve the stewardship of the health agenda in countries, in the current understanding of health and its determinants. The taught course elements improved my conceptual understanding of leadership and management; the OPA my understanding of how the health sector decision making process; and the research project the interpretation of governance in health. These 3 components built on each other, leading to overall improvement in the understanding, and application of governance for the attainment of health results.

**Integrating components of the DrPH**




My ability to conduct most of the components of the doctorate in Kenya was facilitated by the fact that I worked within the health sector leading up to the research component. I had worked at the national level up to October 2015, as part of national health system strengthening support. This meant I had tacit knowledge about the issues and challenges relating to the health sector, which could have a positive influence on my work if appropriately managed. I was therefore constantly reflexive, exploring and questioning my design, application and analysis of the data to ensure my own assumptions and motivations are not being unduly influenced. I elaborate on the approaches I took to ensure this, within my methods of the research project.

# 1. CHAPTER 1: INTRODUCTION

## 1.1 Background to governance

The approach to, and description of health goals has evolved over the last 50 years as our understanding of health determinants and their interactions at the individual, household, community and national levels has improved. However, since 1948 when the World Health Organization (WHO) came into being, the perspective of good health as not just disease absence but as complete physical, mental and social wellbeing has been a constant thread (Evans, 1998; World Health Organization, 2006). This thread has run through the different paradigms guiding the focus of the health sector – primary health care and health for all (WHO, 1978); millennium declaration; universal health coverage and the sustainable development agenda (United Nations, 2015). The values guiding investments in health have remained closely linked to human rights and social values of the societies, with the quality of governance recognized as one of, and a key driver for attainment of these social values (Gross, 2013).

However, the study into governance and how it will support attainment of these values is still relatively young. This was initially driven by the private sector, who in the 1970s strove to better understand the interplay between shareholders, consumers, company executives and boards required to maximise their returns. Their study into governance focused on understanding relationships, goal-setting processes, and incentive structures needed to drive performance (Bradley & Wallenstein, 2006).

The public-sector entities began to look critically at good governance in the 1990s, when the need to make better use of available public resources became paramount. These public-sector entities are of varied and contesting goals and ideals but all aiming to influence public purpose. The perspective of governance amongst these actors went beyond the focus of the private sector, and placed more emphasis on the manner stakeholders interact to influence public policies (Bovaird & Loffler, 2003).

The need to better understand governance in health arose within this wider public-sector governance work. It has been recognized as a key element for countries to attain their health aspirations (Kirigia & Kirigia, 2011; Marks & Linda, 2014). The focus was initially placed on the appropriateness of the stewardship of the health agenda – defined as the careful and responsible management of the population's health (Hafner & Shiffman, 2013). This concept of health stewardship was formally used in the year 2000 by WHO in its annual World Health Report (WHR) (World Health Organisation, 2000). This was arguably the accelerant for the specific and targeted analytical work on health sector governance and its role to facilitate attainment of health goals, with a large volume of literature on health governance appearing since then.

However, the additional literature on governance in health has not been completely helpful in improving its understanding, as the literature is quite varied, with multiple perspectives and interpretations. The

concept of governance is understood differently, by different actors in health. This makes it difficult to provide coherent, but scientific guidance on how to address the challenges of governance.

My research interest arises from this – addressing the need for practical guidance for health stewards and managers on ways of interpreting and applying governance actions to attain health results.

Governance and its associated terms (specifically stewardship, and management), however, is not a concept understood consistently – it means different things, to different actors. It is important to clarify the interpretation I am using for these terms in my research as they have been used in different situations in literature. Based on the focus and purpose of my research, I use definitions of the common terms I will be using – governance, stewardship and management – informed from literature focusing on health in low- or middle-income countries. My working definitions are as follows:

- Governance: The economic, political and/or social institutions by which power and authority are exercised (Gross, 2013; Kaufmann, Kraay, & Mastruzzi, 2011; Lewis & Pettersson, 2009; Savedoff, 2011). Authority is not only that exercised by the state, but by all actors to ensure the collective authority of a community is used to achieve the health results its constituent citizens seek.
- Stewardship: The state's role in defining, leading and guiding the attainment of health results (Travis, Egger, Davies, & Mechbal, 2002). It is concerned with identifying the direction and medium-term oversight needed to facilitate movement towards desired health results.
- Management: I use the definition of management used my Travis *et al* (2008) as the process of achieving agreed results in my research. This is focused on *'how'* results are achieved as opposed to defining '*what'* those results ought to be (stewardship), with emphasis on process efficiency.

The three terms are used in my research based on these different understandings.

## 1.2 Overview of research location

My interest is in governance in Low- and Middle-Income Countries (LMICs). This is where guidance on governance is most critical as they build and design their systems needed to improve delivery of health results (Barbazza & Tello, 2014). I specifically chose to conduct my research in Kenya for several reasons:

- It is unique amongst the LMICs as it is currently in transition, from a low to middle income country (World Bank, 2016), a trend expected to be taken by more low income countries. The results therefore would therefore be of interest to both the low- and middle-income classifications.
- It has a defined vision and strategy both at the wider government through the Vision 2030 (Government of Kenya, 2007), and the health sector through its national health policy (Republic of Kenya, 2014a) and strategic plans (Republic of Kenya, 2014b).

- It had just instituted a major political decision – creation of a devolved system of governance as part of implementation of a new constitution (Republic of Kenya, 2010). The devolution created 47 autonomous units of administration (see figure 1-1 below). This provided a natural situation with new administrative structures which I could use to explore my research.

**Figure 1-1: Kenya counties and their geographical boundaries**


*Source: 2010 constitution of the Republic of Kenya* (Republic of Kenya, 2010)

Kenya has a population in 2013 of 38.6 million, and a GDP per capita of 648.84 US$, (Kenya National Bureau of Statistics, 2013). The Life Expectancy (LE) at birth is 60 years, with 106 deaths per 100,000 of the population (Republic of Kenya, 2014b).

## 1.3 Governance and devolution in Kenya

### 1.3.1 Rationale for changing of governance approach in Kenya

The need to improve governance to facilitate better public administration and attainment of desired outcomes has been increasingly recognized by stakeholders (Savedoff, 2011; UNDP, 1997). Decentralization – the redistribution of authority and responsibility across different levels of government (Rondinelli, 1980; A. Schneider, 2003) – has been championed as a means to facilitate better public administration. As a result, a number of low and middle income countries have incorporated different forms of decentralisation into their public administration systems, ranging from de-concentration, through delegation to devolution (Yuliani, 2004). Devolution is interpreted as a form of decentralization where there is extensive transfer of authority for decision making, finance and management to autonomous units of local government (Cascón-Pereira, Valverde, & Ryan, 2006; Yuliani, 2004).

In my research site (Kenya), the post-independence system of governance through local governments reporting to strong centralized structures had entrenched challenges of inefficiencies, lack of accountability, unequal distribution of national resources and minimal community participation in local development (Khaunya, Wawire, & Chepng, 2015). These challenges persisted, and were attributed by some as precipitating factors in the disputed 2008 Presidential Elections and the ensuing post-election violence (Mueller, 2011; Roberts, 2009). The coalition government that emerged prioritized enactment of a new constitution to begin to right these perceived injustices, leading to the 2010 constitution (Republic of Kenya, 2010).

### 1.3.2 Devolution in Kenya

Introduction of devolution was one of the major new initiatives in the 2010 constitution. Through this, the country was subdivided into 47 semi-autonomous counties as the devolved units of governance, which were at par with (not subservient to) the national government. Devolution recognized the right of citizens to make decisions about the kind of development they wanted. It was designed in a manner to ensure decisions about resource allocation, implementation and management were made as close to the citizens as possible. The large number of counties meant decision makers were close to their populations. It also had a strong equity component, to build the rights of marginalized communities and promote development amongst them by incorporating equity in the resource allocation formulae and providing specific equity focused grants for counties with large marginalized populations (Tsofa, Molyneux, Gilson, & Goodman, 2017).

In Kenya, all devolved functions, including health, were the responsibility of the new county governments, and financed using un-earmarked resources from the national government allocated based on a constitutional formula derived by an independent institution, the Commission of Revenue Allocation (CRA).

The devolved units were not homogeneous, and varied significantly in size, population, economic status and internal resources. Based on the projections from the 2010 national census (Kenya National Bureau of Statistics, 2010), the average 2013 population per county was 889,362 persons, with an average size of 12,978 (population density of 68.5 persons per sqkm). The counties however have 2013 populations estimates that ranged from a low of 101,639 persons (Lamu county) to a high of 3,138,639 persons (Nairobi county) persons. In terms of size, they ranged from a low of 212.5sqkm (Mombasa county) to a high of 71,597.8sqkm (Turkana county).

### 1.3.3 Application of devolved authority

The overall responsibility for the devolved government rests in a governor, an executive team for each sector and a legislature. The governor and the legislature are elected by universal adult suffrage, while the county executive committee (CEC) is appointed by the governor to represent specific sectors. The legislature is made up of representatives of each ward – each county being constituted from an average of 31 wards.

Each county has a CEC for health vested with the executive authority over the health sector. However, the legislature in the county also has a county health committee, composed from the elected county health assembly. These exercise the devolved executive and legislative authority over health respectively.

The health stewardship and management functions are spread across different actors within the county, covering political administrative and technical functions (Republic of Kenya, 2014b). The health stewards – those responsible for leading and guiding attainment of health results – are multiple and need to maintain relationships not only across different actors in the county but also with the national Ministry of Health. These include:

- The CEC Health and the county health committee – political institutions with the overall responsibility for devolved functions;
- A chief officer for health (CoH – equivalent of a permanent / principle secretary), providing overall administrative leadership;
- A county director of health (CDH – equivalent of a Director General), providing overall technical leadership; and
- A hospital superintendent providing leadership of the management team in a hospital.

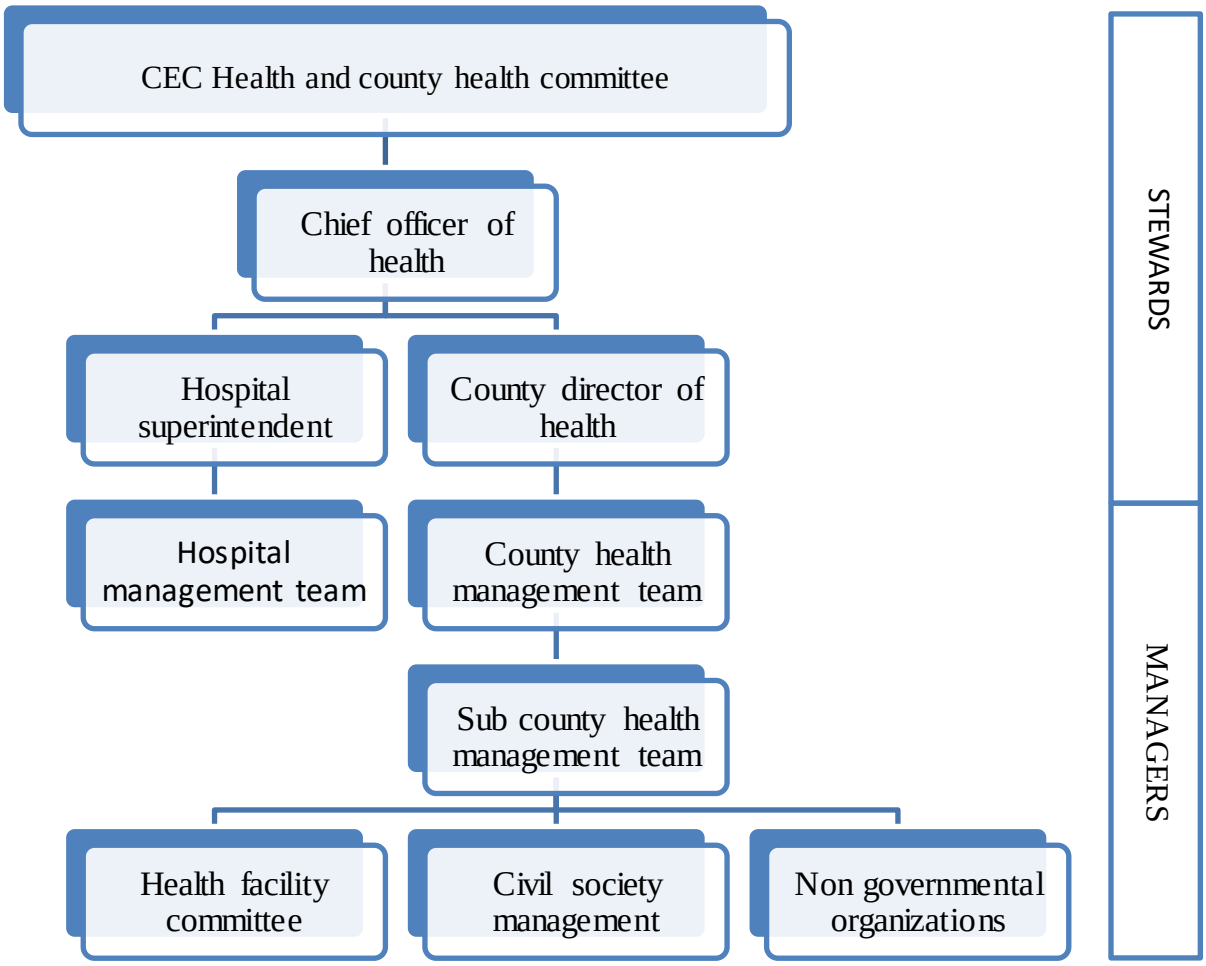
In contrast to the health stewards, the health managers – those that implement the agreed health actions – function at the various levels of the sector to execute technical functions. They are:

- A county health management team (CHMT) for each county constituted from health teams at the county level;

- A sub county health management team (ScHMT) for each of the sub counties that make up a county and constituted from the health teams at this level;
- Health facility management teams ranging in size depending on the type of facility – one-person teams for small facilities to complex management organs for hospitals.

These various stewardship and management structures are illustrated in figure 1-2 below.

**Figure 1-2: Health stewardship and management structure at the county level**



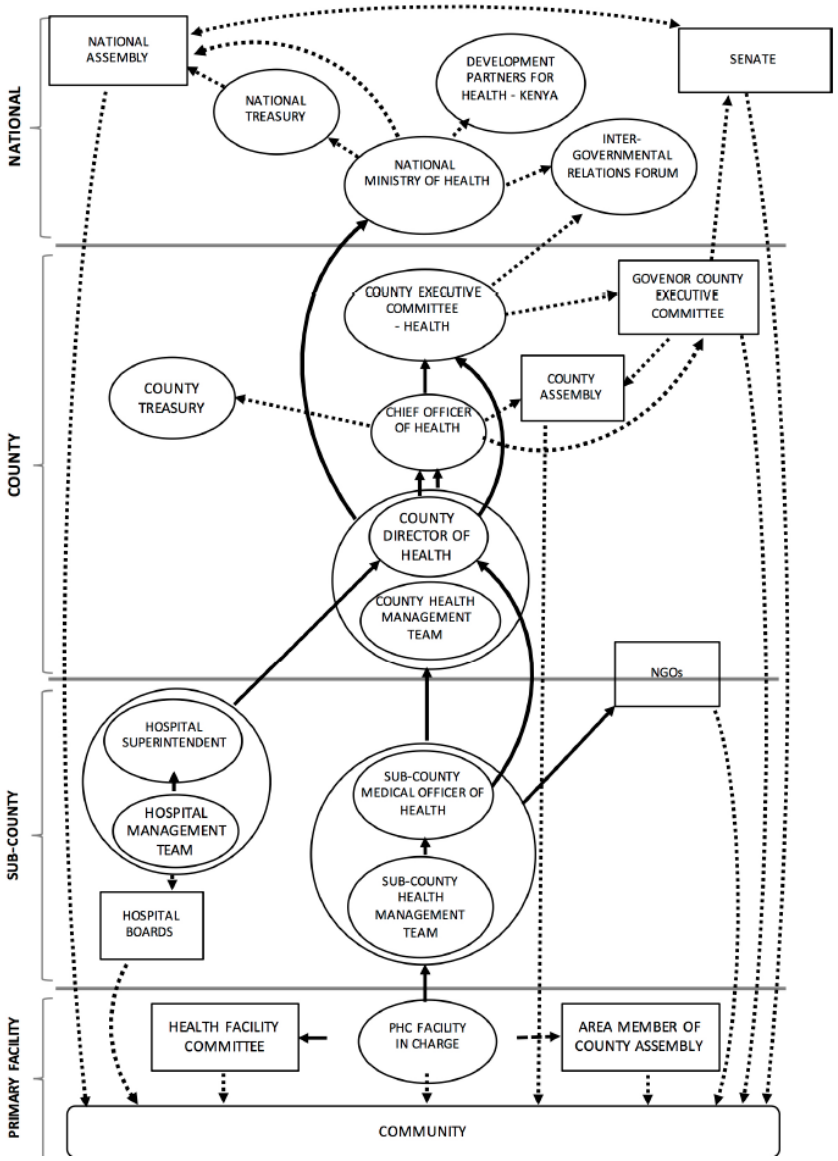

*Source: Authors own*

Both the public and non-public service providers function through this stewardship and management structure – it is not only representative of the public-sector. Thus, a private health centre would report to the sub county management team responsible for the area it is located. In addition, the civil society and non-governmental organizations also report through the same management structure.

However, the accountability and reporting channels in the sector are not as linear as this structure suggests. These are convoluted, because of multiple and overlapping responsibilities and sub divisions of authority

(Nxumalo et al., 2018). An example of the existing accountability channels is illustrated by these authors in figure 1-3 below.

**Figure 1-3: Accountability map for a county in Kenya**




*Source: Figure 3, in (Nxumalo et al., 2018)*

All this was important for my study, as it provided me with a relatively newly established pool of health stewards and managers with whom I could explore my study interests – defining practical guidance for health stewards and managers on ways of interpreting and applying governance actions to attain health results. As I conducted my study shortly after the health stewards and managers had been appointed, I was presented with a natural situation to follow up how governance is understood and applied in practice by stewards and managers that are still grappling with the same issue.

## 1.4 Research aim and objectives

My research aimed at providing a ***way to structure and apply health governance for stewards and managers in low- or middle-income countries,*** to facilitate attainment of their health results. This I did by exploring three specific objectives namely:

(i) **Understanding how governance is interpreted by health stewards and managers.** I explored the different ways the terminologies and definitions of governance are used by different health stewards and managers, to build identify common themes and ways they perceive these. This allowed me make suggestions of how these themes should be applied.

(ii) **Identifying the expected actions by the health sector to facilitate the effect of governance on health results.** This presumes the effects of governance on health results are strengthened when certain conditions determined by health sector stakeholders exist. This is useful in describing these conditions health stewards need to create, for the actions in governance impact highest on health results.

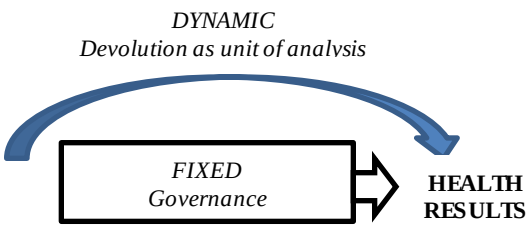
(iii) **Identifying the expected actions by other sectors to facilitate the effect of governance on health results.** This objective takes the presumption in objective 2 further to identify conditions that need to exist in the overall government (other sectors beyond health), for the results of actions in governance on health results to be maximized. This is useful in describing these conditions health stewards need to look out for in the overall government focus, which will lead investments in health sector governance to have the highest impact on health results.

Through exploring these objectives, I intended to suggest guidance to health stewards and managers in low- and middle-income countries on how to interpret and apply the different concepts of governance to facilitate attainment of their desired health results.

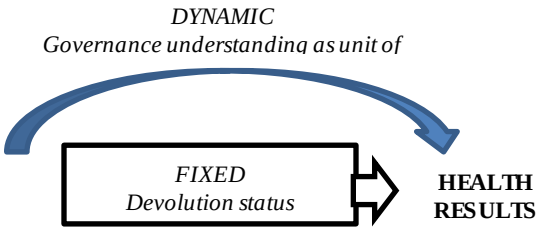
There are two approaches I could take to arrive at the way to structure governance for health stewards and managers. I could look at the evolving devolution context and analyse how governance quality was changing with this. In this instance, my fixed point of reference would be my understanding of governance, and my research would explore how this is changing as devolution evolved. However, as I conducted my literature review, it became clear that there is no fixed reference from which to understand governance. I therefore elected to approach the research from a different angle, where the fixed reference was devolution and the changing reference became the understanding and application of governance by different stewards and managers. I would be exploring how, in a newly devolved system of governance, the newly constituted health stewards and managers understandings of governance concepts influence the attainment of health results. These two approaches are illustrated in the figure 1-4 overleaf.

**Figure 1-4: Possible approaches to address the research question**

**Approach 1: Governance understanding fixed, changing devolution dynamic**




**Approach 2: devolution fixed, governance understanding dynamic**




*Source: Authors own*

The value of devolution in this second scenario was it provided me with a wide range of different stewards and managers, each with different ways of looking at the same governance concepts and who were all relatively new and were just starting to see the results of how they have applied these concepts. The understanding of how governance is best described for health stewards and managers was an area that I felt first needed to be explored (approach 2), after which such an understanding can be fixed and the effect of devolution on attainment of health results then analysed (approach 1). Given the scope of work needed would be beyond the range of my research, I opted on only focus on approach 2.

## 1.5 Study justification

Governance has been recognized as a complex concept, affected by multiple influencers each with multiple motivations and interactions (Hill, 2011). Governance has been perceived by some authors as not a single concept, but rather a construct of many distinct but mutually dependent variables (Qudrat-I Elahi, 2009; Savedoff, 2011; The World Bank Group, 2015). It is interpreted and applied in different ways depending on the stakeholder, and on the expectations. Governance would be structured and applied by a health steward or manager differently from the way a citizen, an international partner, or a civil society organization would do so. In addition, the purpose of governance actions would influence the way it is structured and applied – with some instances where the governance action is itself a desired result (such as controlling corruption), while other instances the governance action is intended to facilitate attainment of other results (such as better health outcomes). It is therefore important to frame my study focus clearly – the study is targeting health stewards and managers, to facilitate their efforts to improve their defined health results.

The kind of governance has been identified by both policy makers and researchers as a key variable that will assist countries in attaining their health results (Greer & Méndez, 2015; Makuta & O'Hare, 2015;

Rajkumar & Swaroop, 2008). Without appropriate governance, countries will find it difficult to attain their agreed development goals.

However, there are currently multiple approaches to define and apply governance, most of which are not applied in practice (Health Systems Governance Collaborative, 2018). Thus, the abundance of governance literature has still not effectively provided health stewards and managers with clear and actionable guidance on how to improve governance to attain their health goals.

A more succinct description of health governance for health stewards and managers is therefore imperative for guiding countries on what to focus on as they aim to attain their health results. My research is focused on improving this, through undertaking a deeper insight into how health stewards and managers perceived and expect governance to influence health goals. It is useful to governance stakeholders in low- and middle-income countries:

- For ministry of health, my study provides a practical interpretation of governance that can be used to plan, implement and monitor it as they do with other investment areas in health.
- For international partners, my study provides a clear picture of how they can incorporate and assess investments in governance strengthening in their support programs.
- For non-state partners including civil society and communities, my study provides information on what the health stewards need to be focusing on to improve the quality of governance, and how they can engage to improve governance holistically.

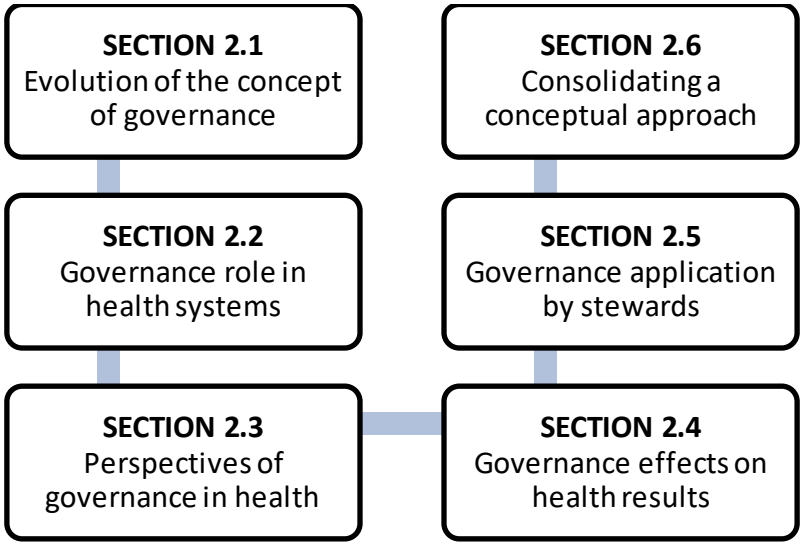
# 2. CHAPTER 2: LITERATURE REVIEW

## 2.0 Structure and process of the literature review

My literature review is aimed at building a succinct conceptual approach to address my study objectives by exploring the literature to better understand how governance understanding has evolved and is practiced. The literature review has four distinct sections that are all leading to this. First, I explore the evolution of the concept of governance to this point in time. Second, I highlight why governance is important for health and how it fits into current health sector paradigms. Third, I explore the different theoretical approaches applied to governance. Following this, I deconstruct the different frameworks of governance, highlighting its different components and their inter-relations. With this information, I then build my conceptual understanding of governance and health results, which will inform my study.

There exists a wide range of literature on governance in general, and on its application in health in particular. A systematic review would have facilitated an extensive exploration of this literature to better understand the depth of its application. However, I intended to build my understanding of governance for attainment of health stewards and managers through exploring multiple connected but independent but sequentially linked areas all linked around a common conceptual approach, as illustrated in figure 2-1 below.

**Figure 2-1: Sections of the literature review**




Each section represents an area I was exploring, to generate information to inform my research. However, this would require at least 5 different systematic reviews as I needed a different set of variables to explore each. I therefore chose to focus my literature review of systematic searches for each section I was reviewing, to identify literature needed to inform a narrative on each section.

To identify appropriate literature to guide my search, I explored the use of both search engine platforms and bibliographic databases. I considered options commonly used for health and social sciences research, including google scholar, PubMed, Web of Science (WoS), Ovid, Scopus, CINAHI, Cochrane library, Medline, Scopus and HINARI[2]. I opted to use, for my literature search, both google scholar and the citation database MEDLINE/PubMed as these are the most widely used by researchers and contain a broad range of citable material as compared to specialist platforms or databases (Gasparyan et al., 2016). I opted for one platform (google scholar) and one database (PubMed) to ensure I capture information the other may miss. These two options are considered user friendly in use, would include most social science journals in the other platforms / databases and provided me with direct access to full texts for the articles I need (Giustini & Barsky, 2011; Shultz, 2007). The ease of use was particularly important for me as various alternate terms are used in the governance literature, and I needed to search using multiple permeations of words to identify relevant literature.

For each section, I explored the literature using key words together with alternative search terms using Boolean operator (OR) to separate them. All literature since 1 January 2000 was included, and searched in abstracts, key words, subject headings, titles and text words. Inclusion criteria was limited to English results, and to disciplines related to health such as applied sciences, economics, government, international relations, medicine, political science, public health and social science.

I searched for literature with all identified key words, plus different permutations of some (at least 3) key words to increase the probability of identifying required literature. This meant I had to review many potential articles. I screened the results by titles for relevance, to identify those who's subject was relevant to the specific section of the review. For those titles related, I sought the article abstracts to gain more insights into them. I combined all the results from both google scholar and PubMed to eliminate duplicates. Therefore, abstracts reviewed were a combination of results from both databases. Those that were having information informative to the section, I then sought the full texts of the articles from the HINARI database. Where I found more than one abstract with similar information, I only maintained the original one, unless the later one provided a significantly different approach to interpreting or presenting the information. For example, where I found many abstracts referencing a given framework in section 2.4, I would only maintain the oldest reference to the framework.

For each section, I first reviewed the identified literature, before building an outline of its structure and content. With this outline in place, I would revisit my search terms to identify any alternative terms I may

[2] HINARI is a programme set up by WHO and major publishers to allow researchers and policy makers in low- and middle-income countries gain access to biomedical and health literature from up to 15,000 journals, 60,000 e-books and other health information resources. It contains literature from the major electronic databases: CINAHI, Cochrane library, Medline, Scopus and the global health database. Website: https://www.who.int/hinari.en/

have missed but may provide information useful for the section. This iterative process was repeated till the draft of the section was completed. As an illustration, I included search terms to do with stakeholder engagement, community participation and social capital in section 2.4 only after I had the section outline. Table 2-1 below illustrates the process and search terms I employed for each section of the literature review.

**Table 2-1: Key words used for the systematic search for each section of the literature review**

| Section | Key words | Alternate search terms | Articles reviewed |
|---|---|---|---|
| **2.1: Evolution of the concept of governance** | History | Evolution; development; progress; growth | Titles identified: 134<br>Abstracts reviewed: 21<br>Articles reviewed: 16 |
| | Health | Health system; health sector; health administration | |
| | Governance | Leadership; stewardship; accountability | |
| | Africa | Sub-Sahara; low income; middle income; developing | |
| **2.2: Governance role in health systems** | Governance | Leadership; stewardship; accountability | Titles identified: >300<br>Abstracts reviewed: 55<br>Articles reviewed: 10 |
| | Africa | Sub-Sahara; low income; middle income; developing | |
| | Health system | Health reform; health system development | |
| | Health | Health sector; public sector; well-being | |
| **2.3: Perspectives of governance in health** | Health | Health system; health sector; health reform | Titles identified: 121<br>Abstracts reviewed: 56<br>Articles reviewed: 20 |
| | Governance | Leadership; stewardship; accountability | |
| | Framework | Model; measure; definition; structure | |
| | Africa | Sub-Sahara; low income; middle income; developing | |
| | Construct | Attribute; indicator | |
| **2.4: Governance effects on health results** | Health | Health system; health sector; health reform. | Titles identified: > 500<br>Abstracts reviewed: 53<br>Articles reviewed: 22 |
| | Governance | Leadership; stewardship; accountability. | |
| | Framework | Model; measure; definition. | |
| | Africa | Sub-Sahara; low income; middle income; developing | |
| | Devolution | Decentralization; choice; delegation | |
| | Stakeholder | Partner; participant | |
| | Social capital | "Social support"; "vulnerable groups"; "self-help" | |
| | Participation | "Community involvement"; "citizen involvement" | |
| | Performance | Result; outcome; effect | |
| **2.5: Application of governance by health stewards** | Health | Health system; health sector; health reform. | Titles identified: 72<br>Abstracts reviewed: 27<br>Articles reviewed: 3 |
| | Governance | Leadership; stewardship; accountability. | |
| | Africa | Sub-Sahara; low income; middle income; developing | |
| | Performance | Result; outcome; effect | |
| | Application | Use; approach; mechanism | |

## 2.1 Evolution of the concept of governance

Literature on this section is primarily focused on governance as a generic concept, but with an increasing amount on literature on public sector governance since the year 2000. The concept of governance has long been a focus as an area to improve performance of institutions. However, this only took a scientific and analytical focus from the 1970s, primarily driven by private corporations need to better understand the interplay between shareholders, consumers, company executives and boards required to maximise their returns. Governance focused on understanding relationships, goal-setting processes, and incentive structures needed to drive performance (Bradley & Wallenstein, 2006). It was based on understanding of the relationships amongst directors, executives and shareholders of companies and how these relationships influenced eventual performance. This perspective of governance is more commonly termed corporate governance to distinguish it from other forms of governance that emerged later (Cheffins, 2011; Morck & Steier, 2005).

The drive for better understanding of governance eventually began to be prioritized in the public-sector institutions in the 1980's to 1990's, when the need to make better use of available public resources became paramount. However, one can trace this drive for governance in the public-sector back till the colonial period, where the need for local management and human rights were becoming important global ideals and contributed to the decolonization in the early to mid-20$^{th}$ century (Weiss, 2000). The understanding of governance that arose during this period varied however, with academics and international institutions on one hand looking at governance as a complex set of structures and processes, both public and private on one hand, while many public writers and civil society groups perceived governance as being synonymous with government.

The public-sector is characterised by presence of contesting actors, each with different goals and ideals but aiming to influence public purpose. The interpretation of governance by the international institutions and academia placed more emphasis on the manner stakeholders interact to influence public policies (Bovaird & Loffler, 2003). As many stakeholders perceived governance as important, this interpretation has contributed to a multitude of actors evolving to exert influence on public policy. The health arena is now composed of many different actors all attempting to influence public policy and the national and international levels.

The lack of progress in public-sectors led to a further rethink of health and its governance. The major global health actors were periodically coming together to agree ways of coming together to influence public policy particularly in the low and middle income countries, with a Rome, Paris, Accra and Busan declarations passed respectively in 2003, 2005, 2008, 2011 (Development Assistance Committee, 2008; OECD, 2003,

2006, 2011). These efforts were all based around the need to harmonize actions of the influencers of public policy to enable more coherent public decision making.

These efforts led to mandated partnerships in countries, with structures and processes imposed on countries and have been linked to external financing as a carrot – stick approach (Green, Ritman, & Chisholm, 2017; Popp, Brinton Milward, Mackean, Casebeer, & Lindstrom, 2015). At the global level, this has led to the international health partnership set up in 2007 and has evolved into the UHC2030 by 2016. At the national level, many low- and middle-income countries set up structures and processes as mandated. Sector coordination committees, inter-agency coordination committees, compacts, memoranda of understanding and other coordination instruments thus arose as examples of governance mechanisms.

However, these have not yet led to the kind of governance needed. Initially, there was limited involvement of users and allowing countries to self-learn as they built governance processes (Martini et al., 2012). However, the understanding of governance was reduced to presence of structures, many of which the low- and middle-income countries detested in practice but applauded in public.

The current work on governance is building on these lessons, and on shifting emphasis from mandated to emergent partnerships around governance (Popp et al., 2015). Focus has now shifted to concepts relating to collaborative governance, which places emphasis on the understanding of, and inter-relations amongst all persons affected by or influencing health and wellbeing – citizens, public and private providers, donors, non-health sectors, civil society, to mention but a few (Emerson, Nabatchi, & Balogh, 2012; World Health Organization, 2012). This represents a recognition of the complexity of governance in health, taking the debate beyond the presence/functionality of structures and processes and focus on understanding the different dimensions that encompass governance internally and externally. A good example of how this is being explored is in the health system governance collaborative, which is a network of practitioners, policy makers, academics, civil society representatives, agencies, decision-makers and other committed citizens that has evolved as a 'safe space' to explore how to evolve 'actionable governance' in health (Health System Governance, 2017). This current focus on collaborative governance is focusing the discussion of governance on its role in supporting attainment of health results – universal health coverage to be specific – away from the way governance had evolved into an end in itself, and is built around the need for inclusiveness, with all the actors who have a role to play are able to do so. The efforts are focusing on defining action countries need to focus on for governance to facilitate attainment of health results – away from trying to define what governance is.

## 2.2 Placing governance within health systems

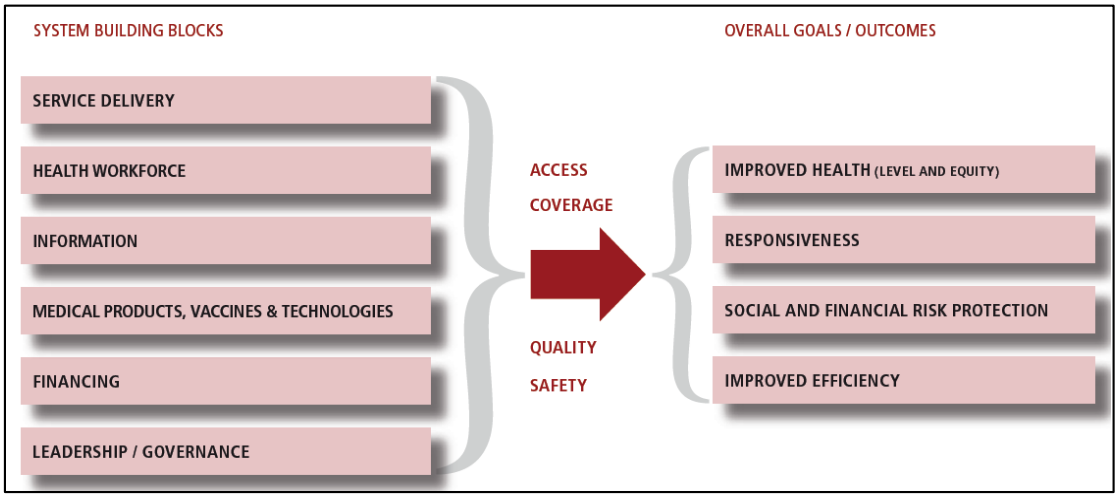
The literature in the section is primarily from international development institutions, and / or authors associated with these. The literature base is vast but is largely repetitive with the same concept found in

multiple literature sources. As such, must of the literature review was spent identifying source literature and eliminating duplications. Google scholar was particularly useful in identifying the literature from these international development agencies, as some of it is only found in reports and their internal publications.

Global health actors have placed a strong emphasis on the need to strengthen health systems as a focus for countries to achieve their health goals at least for the past 30 years (World Health Organisation, 2000). This focus was accelerated by two key events. First, was the experiences from the Ebola Virus Disease (EVD) outbreak of 2015 where weak systems were a recognized accelerant to the outbreak (Kieny, Evans, Schmets, & Kadandale, 2014; O'Hare, 2015). Second, the global agreement around the SDGs as the rallying call for sustainable development, which have Universal Health Coverage (UHC) as an overarching health target for countries to achieve (United Nations, 2015).

The attainment of expectations arising from these events calls for accelerating Health System Strengthening (HSS) efforts, whose aim it is to have resilient, robust and fit for purpose health systems in countries. WHO (2000) defined a health system is defined as the people, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve, while responding to people's legitimate expectations and protecting them against the cost of ill-health through a variety of activities whose primary intent is to improve health. The health system, and its related goals and outcomes have been structured in different ways, the most widely used being as six building blocks working to produce four distinct goals / outcomes (World Health Organization, 2007). This relationship is illustrated in figure 2-2 below.

**Figure 2-2: Health system strengthening framework**




*Source: World Health Organization, 2007*

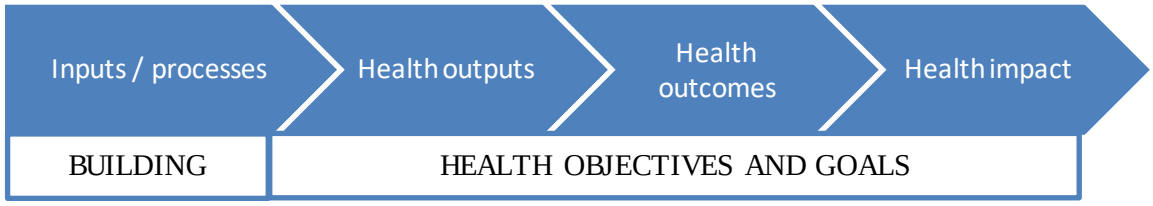
The building blocks represent the components of a system into which countries need to plan their investments, with the goals / outcomes the result of these investments. Governance is structured as one of these building blocks of the health system. There have been several critiques to this approach, largely focusing on its rigid nature in describing a very complex and fluid concept of systems and their effects on services (Lazarus & France, 2014; Manyazewal, 2017; Mounier-Jack, Griffiths, Closser, Burchett, & Marchal, 2014). They have however remained a useful way for designing, funding, implementing and monitoring actions in health. Many critiques therefore propose modifications to the framework based on different viewpoints, as opposed to replacing it completely.

In the context of this research, I apply a further modification as the health systems strengthening framework ignores the sequential nature of actions needed to achieve health results in a logical chain approach. This observation was noted also by Mounier-Jack *et al* (2014) in their critique. The objectives and goals as defined are a mixture of outputs, outcomes and impacts that a system desires to have. This makes alignment of a results chain, from investment to impact, difficult. To guide action, therefore, it is important to un-package these health goals and objectives in a manner that takes cognizance of their level in the health results chain guided by conditional causality (McLaughlin & Jordan, 1999):

- Output goals relate to the direct results of investments in the building blocks,
- Outcome goals relate to the improvements in health services arising from better outputs, and
- Impact goals relate to the improvements in health, resulting from better service outcomes.

This logical chain of the different health goals and the health system is shown in figure 2-3 below.

**Figure 2-3: Results chain logic, and relationship to governance**




*Source: Authors' summary*

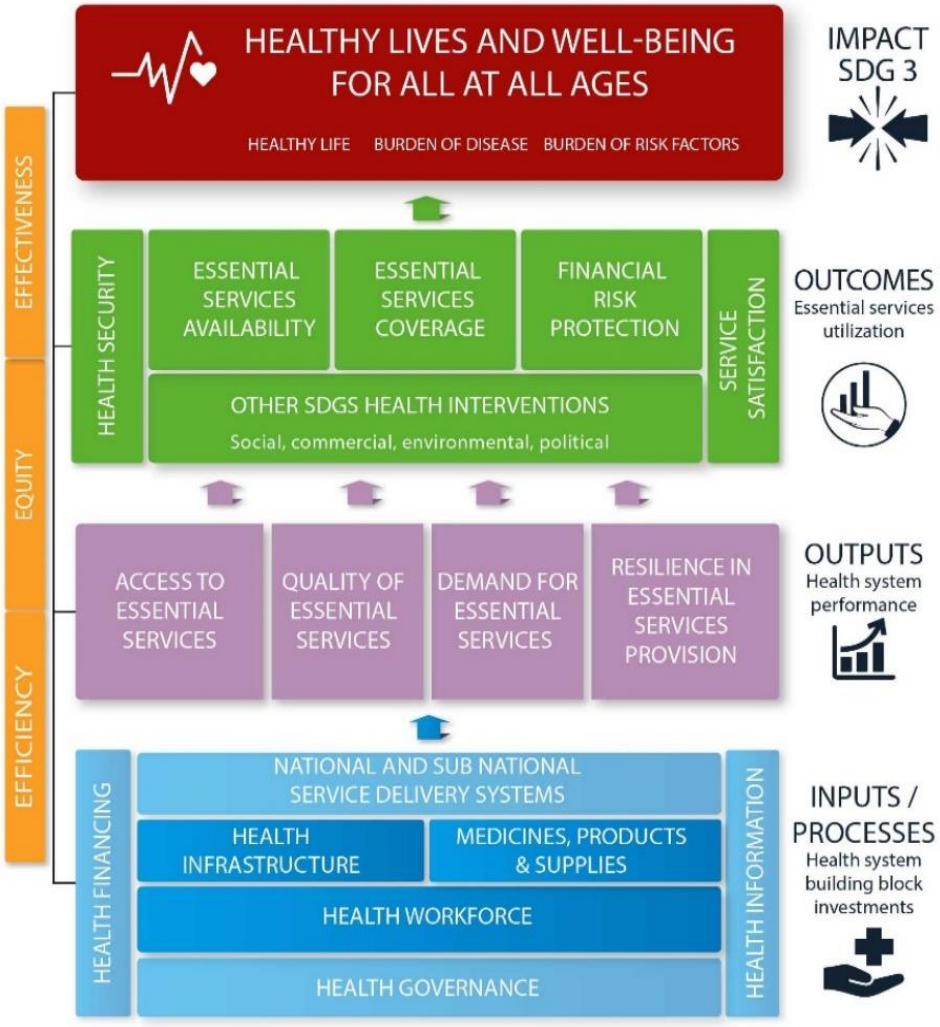
Health results can be perceived at the output, outcome or impact level depending on how these are to be used. From figure 2-2, dimensions of access, quality and safety could be perceived as output targets, with coverage an outcome dimension of health results.

This approach has been applied by WHO in the Africa Regional Office (AFRO), to define a logical approach to link the health system building blocks to services in the context of the SDGs, (World Health Organization, 2016). This approach, targeted at country health stewards, provides a comprehensive ad

integrated approach to guide achievement of health results. The health goals are unpackaged at the output, outcome and impact levels to provide guidance on the immediate, medium and longer term influences any investment in the building blocks will have on the health goals. The health goals immediately influenced by actions in the building blocks (including governance) include: strengthening the system resilience; improving efficiency and equity of access; improving the quality of care provided; and/or strengthening the demand for services by individuals, households or communities.

The other health goals at the outcome and impact level relating to better services, and eventually better health respectively are derivative goals from these health output goals. Achievement of the outputs will lead to improvements in outcomes and impact goals in line with the logical manner of results. The relationship of these different levels of health goals and the health system is shown in figure 2.4 below.

**Figure 2-4: Logical approach for Health Systems Strengthening for UHC and SDGs**




*Source: (World Health Organization, 2016)*

Analysing the implications of governance on health goals therefore is most feasibly done by focusing on its influence on the health outputs, as:

- The outputs represent the set of goals most directly influenced by actions at the governance, and other building blocks, and
- The outputs represent the set of goals that are immediately achieved because of actions in the building blocks, with improvements at the outcome and impact levels being reflected relatively later in time.

## 2.3 Perspectives of understanding governance in health

There is a wide range of literature on perspectives of governance. Many authors have attempted to frame the concept, to give it characteristics that can be compared and planned. The papers that have informed this section are shown in table 2-2 below.

**Table 2-2: Analysed publications on health governance perspectives (in author name alphabetical order)**

| Author (year) | Name of publication | Article source |
|---|---|---|
| **Abimbola S. *et al* (2017)** | Institutional analysis of health system governance | Journal article (Health Policy & Planning) |
| **Baez-Camargo C. and Eelco J. (2011)** | A Framework to Assess Governance of Health Systems in Low Income Countries | Report (Basel Governance Institute - https://www.baselgovernance.org/sites/collective.localhost/files/publications/biog_working_paper_11.pdf) |
| **Baez-Camargo C. and Eelco J. (2013)** | Social Accountability and its conceptual challenges: An analytical framework | Working paper series |
| **Barbazza, E., Tello, J.E. (2014)** | A review of health governance: Definitions, dimensions and tools to govern | Journal article (Health Policy) |
| **Bossert T (2011)** | Health sector decentralization and local decision-making: Decision space, institutional capacities and accountability in Pakistan | Journal article (Social Science and Medicine) |
| **Brinkerhoff T.W and Bossert T (2008)** | Health Governance: Concepts, Experience, and Programming Options | Journal article (Public Administration) |
| **Brinkerhoff T.W and Bossert T (2013)** | Health governance: Principal-agent linkages and health system strengthening | Journal article (Health Policy & Planning) |
| **Cleary S. *et al* (2013)** | Resources, attitudes and culture: An understanding of the factors that influence the functioning of accountability mechanisms in primary health care settings | Journal article (BMC Health Services Research) |
| **Iftimoaei C. (2015)** | Good Governance: Normative Vs. Descriptive Dimension | SEA - Practical Application of Science, *Fundația Română pentru Inteligența Afacerii*, Editorial Department |
| **Islam M. (2007)** | Health Systems Assessment Approach: A How-To Manual | Agency publication (USAID publication) |
| **Kaufmann D *et al* (2010)** | Response to: "The Worldwide Governance Indicators: Six, One, or None" | Online resource (http://siteresources.worldbank.org/DEC/Resources/ResponseToKnackLangbein.pdf) |
| **Kaufmann D *et al* (2011)** | The Worldwide Governance Indicators: Methodology and Analytical Issues | Journal article (Hague Journal on the Rule of Law) |

| Author (year) | Name of publication | Article source |
|---|---|---|
| **Lewis M, Petterson G. (2009)** | Governance in Health Care Delivery Raising Performance | Agency publication (World Bank policy research paper) |
| **Mikkelsen-Lopez I *et al* (2011)** | An approach to addressing governance from a health system framework perspective | Journal article (BMC International Health and Human Rights) |
| **Pyone T. *et al* (2017)** | Frameworks to assess health systems governance: A systematic review | Journal article (Health Policy & Planning) |
| **Rajkumar A.S., Swaroop, V. (2008)** | Public spending and outcomes: Does governance matter? | Journal article (Journal of development economics) |
| **Qudrat-I Elahi, Khandakar (2009)** | UNDP on good governance | Journal article (International Journal of Social Economics) |
| **Savedoff W. (2011)** | Governance in the Health Sector: A Strategy for Measuring Determinants and Performance | Journal article (Corporate Governance) |
| **Siddiqi et al (2009)** | Framework for assessing governance of the health system in developing countries: Gateway to good governance | Journal article (Health Policy) |
| **Travis P. *et al* (2002)** | Towards better stewardship: concepts and critical issues | Agency publication (World Health Organization) |

The interpretation of health governance is complex in the way it is defined, applied, measured and presented by different authors. This complexity in understanding governance is made worse by the complexity of the health sector, with multiple interconnected actors pursuing multiple interconnected results all working towards better health and wellbeing. Both the health sector in general, and the study of governance in particular can be classified as complex adaptive systems, characterized by multiple players who have different and constantly evolving inter-relationships and interactions, working to produce constantly changing results (Fairbanks et al., 2014; The health foundation, 2010). An effort to decipher governance in health therefore is a difficult undertaking, as one needs not only to focus on how it is structured, but also how its different components inter-relate with each other to produce a set of results that need to feed into another complex adaptive system for them to result in health benefits.

### 2.3.1 Framing the understanding of governance in health

This complexity has led to the varied and wide range of ways of classifying governance literature, which I classify in three broad approaches.

The first approach looks at health governance based on the conceptual underpinning being used. In this classification, health governance constructions are based on either descriptive, or normative concepts (Barbazza & Tello, 2014; Iftimoaei, 2015). Descriptive conceptual approach to governance is premised on the idea that governance is best understood and interpreted by understanding the inter-relations amongst actors in health. On the other hand, the normative conceptual approach is premised on defining a set of attributes to be adhered to for health governance. However, some authors feel this perspective does not bring out the realities of governance largely being a fluid concept based on who's perspective and which results one wants to achieve. Governance means different things to different stakeholders, and it is at times

difficult to reconcile these different expectations. It is in addition a concept that has evolved from outside the health sector, therefore the underlying theory needs to be understood to better appreciate how it is constructed.

As a result, a second approach to categorize how governance is proposed based not on the conceptual approach but on the institutional framing used (Abimbola, Negin, Martiniuk, & Jan, 2017). They perceive governance as the process of making, changing, monitoring and enforcing the demand and supply of health services. Governance is concerned with the analysis of institutions that enforce these structures and rules (both formal and informal) needed in a system. Governance approaches are defined in 3 categories, in decreasing focus on structures (hardware), and increasing focus on relations (software) as: government-centred approach – focusing on the role of governments; building-block approach – focusing on the workings of health care organizations; and institutional approach – focusing on how the rules governing interactions are made, changed, monitored and enforced.

A third, more recent approach categorizes governance based on the underlying theoretical underpinning driving the way it is applied (Pyone, Smith, & Van Den Broek, 2017). They recognize that governance is a concept difficult to assess, as it originates from multiple disciplines not only health. It is dependent on being operationalized by people different from the ones who define it. However, despite these challenges, they can propose three theoretical underpinnings of the approaches to health governance: new institutional economics; political science; and international development. The new institutional economics approaches look at understanding governance from the perspective of understanding the norms and rules that underpin economic activity. The political science approaches look a governance as a bureaucratic function, while the international development approaches perceive governance from the lens of the need to produce global public goods. Instead of proposing a specific way of deciphering governance, the authors recommend a process to validate and apply existing approaches to identify those that work well in specific settings, as assessment of governance is very critical for moving forward the health agenda.

These different approaches to categorize health governance are summarized in figure 2-5 below.

**Figure 2-5: Approaches to categorizing the understanding of governance in health**

| CONCEPTUAL VIEW | INSTITUTIONAL VIEW | THEORETICAL VIEW |
|---|---|---|
| •Descriptive approach<br>•Normative approach | •Government centred approach<br>•Building block approach<br>•Institutional approach | •New institutional economics approach<br>•Political science (and administration)<br>•International development |

These three approaches represent different ways of classifying the broad literature base, each of which approaches governance from a different angle. All three approaches are appropriate, from specific

perspectives and results. Given my focus on a health steward / manager aiming to influence health results, I opt to use the conceptual understanding as a base around which I further explore the literature and integrate elements of the institutional and theoretical views into this. I opt for this approach as, based on my tacit knowledge and experience, I believe it is the perspective most commonly understood by my target audience as they attempt to improve health results.

### 2.3.2 Governance as a descriptive concept

This perspective looks at health governance based on understanding the inter-relations of different actors in health, and how these lead to the desired health results. In the institutional approach to defining governance frameworks, this corresponds more to the institutional approach, and partly the building block approach which focus on understanding the rules and processes needed for functioning of systems. This also corresponds more closely with the new institutional economics theoretical underpinnings in the theoretical approach to categorizing governance.

In these approaches to defining governance, emphasis is placed on the software intricacies associated with the inter-relations, interests, and values amongst different stakeholders as drivers of performance. The stakeholders involved are vast, and include:

i) beneficiaries / communities for whom good health results are sought;

ii) the government other stakeholders with the legal authority to provide the services needed to produce good health, and

iii) the civil society and other stakeholders who operate in between these two actors

Governance in this context is perceived as a part of software in any health system – facilitating the better functioning of the rest of the system (Sheikh et al., 2011). Three groups of literature capture this perspective succinctly from my literature review: (Brinkerhoff & Bossert, 2008, 2013); (Baez-Camargo & Jacobs, 2011; Baez Camargo & Jacobs, 2013); and (Cleary, Molyneux, & Gilson, 2013).

These papers highlight the principal – agent theory as the one underpinning this perspective of governance. This is said to exist where one entity can make decisions that impact another entity. The different entities in its simplest form are: the beneficiaries of services / citizens (the principals), and the government/ health service provider (agents). The government (agent) is expected to work in the interests of the citizens (principals), who have contracted them. However, due to information asymmetry and poor accountability mechanisms, the principal does not always pursue interests of the agent, in many instances pursuing interests that may be detrimental to them. The governance theories here are concerned with putting in place the different mechanisms, incentives and sanctions needed for the principal to act in the interests of the agent.

Based on this perspective, David Brinkerhoff and Thomas Bossert laid out a definition for governance in 2008 as understanding the interplay amongst actors in the institutional arenas of civil society, politics, policy and public administration (Brinkerhoff & Bossert, 2008), and further refining this in 2013 (Brinkerhoff & Bossert, 2013). They focus on deepening understanding of the interactions among: beneficiaries/service users, Political and government decision-makers, and health providers (public, private, non-profit). While descriptive in concept, Brinkerhoff (2008) proposes four normative expectations for good governance:

i) There are mechanisms for accountability of all actors to the beneficiaries,
ii) There is interplay amongst competing interest groups on a level playing field,
iii) The State has appropriate capacity power and legitimacy, plus,
iv) Non-State Actors are effectively engaged in policy making.

Other descriptive approaches go further into succinctly including the mechanisms that allow accountability. Baez-Camargo (2011, 2013) propose accountability based on appropriate institutions to ensure voice; and propose both direct (citizen voice) and indirect (appropriate institutions to respond to citizen voice) mechanisms (Baez-Camargo & Jacobs, 2011; Baez Camargo & Jacobs, 2013). Another approach instead focuses on factors that need to be present for accountability; proposed as: attitudes, resources and values (Cleary et al., 2013).

### 2.3.3 Governance as a normative concept

The perspective relies on defining a set of attributes that construct governance. Governance is constructed from several sub components, each of which can be independently defined but are all dependent on each other to produce the effect of governance on health (Kaufmann, Kraay, & Mastruzzi, 2010; Qudrat-I Elahi, 2009; Savedoff, 2011). Together, they 'construct' the concept of governance. An understanding / analysis of governance needs to be based on an understanding / analysis of these independent but interdependent constructs that constitute it. These constructs can be planned for, their implementation measured, and their effects monitored.

This understanding of governance aligns more with the government centred approach of the institutional view of governance, and the international development approach for the theoretical perspectives.

Multiple approaches to defining governance were found in literature. They largely draw their norms from international development agency constructions of governance, specifically the World Banks worldwide governance indicators project (Kaufmann et al., 2011), World Health Organization (Pan American Health Organization, 2008; Travis et al., 2002), and the United Nations Development Program (UNDP, 1997). I have focused my review on four literature sources that, using different ways to mix and match these

governance norms, have presented distinctly different ways to construct governance. These are: (Islam, 2007; Lewis & Pettersson, 2009; Mikkelsen-Lopez, Wyss, & de Savigny, 2011; Siddiqi et al., 2009).

Islam (2007) defines governance around a number of constructs relating to general governance, and health sector specific areas (Islam, 2007). The general governance constructs are derived from the Worldwide Governance Indicators project (Kaufmann et al., 2011) while the health system specific constructs are largely derived from the WHO stewardship indicators (Travis et al., 2002), and include information / assessment capacity, policy formulation / planning, social participation / responsiveness, accountability and regulation.

Lewis and Petterson (2009) take a more system-oriented approach to deciphering governance. They propose a list of constructs of governance relating to five principles: resource management, provider incentives, facility performance, informal payments, and corruption perceptions (Lewis & Pettersson, 2009). Within each, a group of questions are proposed to explore its status.

Mikkelsen-Lopez et al (2011) adopted a problem driven approach and applied principles from the WHO building blocks to construct his governance framework from 5 principles of strategic vision / policy design, participation / consensus orientation, accountability, transparency and control of corruption (Mikkelsen-Lopez et al., 2011). They focus on identifying barriers to good governance across these principles.

Siddiqi et al (2009) on the other hand adopted principles from four existing frameworks: World Health Organization's (WHO) domains of stewardship (Travis et al., 2002); Pan American Health Organization's (PAHO) essential public health functions (Pan American Health Organization, 2008); World Bank's six basic aspects of governance (Kaufmann et al., 2011); and the United Nations Development Programme (UNDP) principles of good governance (UNDP, 1997). From these, he constructed a governance framework based on 10 principles: strategic vision, participation and consensus orientation, rule of law, transparency, responsiveness, equity and inclusiveness, effectiveness and efficiency, accountability, intelligence and information, and ethics (Siddiqi et al., 2009).

The similarities (and differences) across these different approaches to constructing governance are shown in the table 2-3 below.

**Table 2-3: Approaches for construction of governance from a normative lens**

| Islam (2007) | Lewis and Petterson (2009) | Mikkilsen-Lopez et al (2011) | Siddiqi et al (2007) |
|---|---|---|---|
| **voice and accountability** | corruption perceptions | control of corruption | rule of law |
| **political stability** | resource management | accountability, | Intelligence and information |
| **government effectiveness** | provider incentives | participation / consensus orientation, | participation and consensus formation |
| **regulatory quality** | facility performance | strategic vision / policy design, | strategic vision |

| Islam (2007) | Lewis and Petterson (2009) | Mikkilsen-Lopez et al (2011) | Siddiqi et al (2007) |
|---|---|---|---|
| rule of law | informal payments | transparency | responsiveness |
| control of corruption | | | effectiveness and efficiency |
| information / assessment capacity | | | accountability |
| policy formulation / planning | | | transparency |
| accountability | | | equity and inclusiveness |
| social participation / responsiveness | | | ethics |
| regulation | | | |

COLOUR KEY: World Bank World Health Organization United Nations Development Programme

They are each defined and applied differently, depending on the governance perspective. Thus, a given construct may be similar only in name, but are defined and applied differently based on the perspective. For example, accountability from the WHO perspective is focused on the mechanisms to monitor system performance, as opposed to how well the system reports to the citizens in the UNDP perspective.

The health governance collaborative has approached this difficulty in a different way, by proposing a focus on governance 'actions' as the basis to define norms – away from constructs. They propose five actions expected of governance, which incorporate all element of the above normative frameworks (World Health Organization, 2014):

1. Formulating policy and strategic plans;
2. Generating intelligence: information and analysis for decision-making;
3. Putting in place levers or tools for implementing policy;
4. Collaboration and coalition-building across sectors and with external partners; and
5. Ensuring accountability.

We have seen two different ways governance is constructed in literature: a descriptive (and rules / process based) approach, and a normative (structure) based approach.

The descriptive approach has been criticized for borrowing too strongly from western political philosophy – a perspective not shared amongst all societies. The western political philosophy is based on the premise of a population that cedes its right to self-determine to a state in exchange for the societal benefits derived from state sovereignty – governance by consent of the governed. Many countries still do not fully subscribe to this. Even where it is adopted legally, the practice is not applied as expected with hybrid systems more common particularly in low- and middle-income countries which are the focus of my research. As such, governance is practiced in a spectrum of governance systems ranging from an absolute state with citizens

as subjects, through to a representative state with citizens having effective participation mechanisms. In addition, it is difficult to plan, and hold stewards accountable to descriptive expectations, which are open to mis-interpretation. The approach on its own does not provide an adequate construction of governance needed to effect changes expected in low- and middle-income countries.

On the other hand, the normative approach to understanding governance has largely been championed in the international development literature and as a result is what is more commonly known by many health stewards and managers in low- and middle-income countries. However, it does not present an accurate picture of governance, as it largely ignores the software aspects of governance – the inter-relations, power plays, personal motivations, political considerations and other attributes which are an inherent part of a governance definition. It assumes governance can be structured and applied like any other development priority, which in practice has not always worked. Thus, Ministries perceive establishment of a hotline or a suggestion box (something tangible and normative) as adherence to a transparency construct, and not actually looking at how transparent the system is to allow stakeholders, including citizens, know what is being done. On its own, this perspective does not provide a comprehensive picture of governance needed to make the changes needed in our low- and middle-income countries.

A focus just of structures of governance needs to be strengthened with an understanding of the different actors and their inter-actions amongst each other for governance effects on health results to be understood (Hill, 2011). An effective and comprehensive understanding of governance for my targeted health stewards and managers is needed, which draws from both perspectives of governance.

However, to appreciate how deeply we need to investigate this understanding of governance, it is important to explore how important – if at all – governance is to the attainment of health results.

## 2.4 How governance influences attainment of health results

As the concept of governance has been described as complex and feeding into health system that is also inherently complex, some authors are of the view it is difficult to pursue the question of whether governance influences attainment of health results. Any results will be dependent on multiple assumptions, many of which cannot be tested in the real world. My literature search was therefore broad, covering multiple key words and their alternates to reflect the multiple expected ways governance could influence health results. From over 500 possible titles, I was able to identify 53 potential pieces of work to inform this section, which I narrowed down to 22 full text articles that were used. A few authors have however attempted to answer this question. From my review of the literature, I identified the publications that can inform this discussion.

### 2.4.1 Does governance influence health results?

I explored this question by first looking at if there is a documented relationship between governance and public outcomes. An early paper that explored this theme was by Rajkumar & Swoop (2008), who explored

the problem of why public spending does not always lead to the expected population benefits and the role governance quality may play in this (Rajkumar & Swaroop, 2008). They were able to demonstrate empirically that public outcomes are better in countries with good governance, and vice versa. They were able to demonstrate this for health, and education sectors. They were conversely able to demonstrate that improvements in public spending had no impact on desired outcomes in situations with demonstrably poor governance.

This relationship was further explored in more depth for the health sector by Makuta and O'Hare (2015). Using a panel data regression analysis of data from 43 countries in Africa, they found that an improvement in the quality of governance enhances the overall impact of public spending on health (Makuta & O'Hare, 2015). They found a clear relationship between the quality of governance and the impact of public spending on health outcomes. They argue that the quality of governance mediates the impact of public spending on health, with the same increase in public spending on health being twice as effective in countries with good quality of governance as compared to those with poor quality of governance.

The international development actors have usually championed the need for good governance as it improves efficiency of public-sector management. However, I was not able to find peer reviewed literature that shows governance improves efficiency of health system functioning. The evidence shows a relationship between governance quality and public-sector efficiency in some areas (administration, infrastructure, and stability), but no efficiency in social services (education specifically) as this is heavily influenced by contextual factors (Hwang & Akdede, 2011). This gap in literature is recognized, and is currently a focus of the USAIDs 'Marshalling the evidence for governance contributions to health system performance and health outcomes' initiative set up in 2016 (Health Finance and Governance team, Abt Associates, 2017). The initiative brings together over 50 health governance experts to increase awareness and understanding of the evidence of what works and why on how strengthened governance contributes to improved health system performance and outcomes.

Therefore, despite the complex nature of governance and health sector, there is evidence that good governance can contribute to better health outcomes – though evidence on its effect on health system performance is still mixed. There is therefore a case to be made, to invest time and effort in deciphering governance for a health steward or manager.

### 2.4.2 How does governance influence health results?

If governance can improve health results, it would be important to understand how it does this. As we have established in the previous section (2.3) that it is a constructed concept, it would be valuable to explore the different constructs of governance to identify which can contribute to better health outcomes to better

understand this. By identifying these constructs, a health steward or manager will be able to focus improvement efforts on these, for better health results.

A review of the literature found a synthesis of paper that reviewed the nature of the relationship between governance and health outcomes in Low- and Middle-Income Countries (LMICs) published in 2014 (Ciccone, Vian, Maurer, & Bradley, 2014). The authors reviewed 30 studies, from which they identified (1) the mechanisms by which governance influenced health outcomes, and (2) the characterization of the association between governance and health.

#### *2.4.2.1 Mechanisms by which governance influences health results*

Ciccone et al (2014) identified four mechanisms by which governance may influence health outcomes in these settings: health system decentralization that enables responsiveness to local needs and values; health policymaking that aligns and empowers diverse stakeholders; enhanced community engagement; and strengthened social capital.

##### Health system decentralization

Decentralization as a mechanism to improve health outcomes has been championed for the past 30 years. However, it exists in different forms, which are dependent on the level of decision space stewards and managers have. Bossert (1998) presents three characteristics of a decentralized system that allow for appropriate improvement in health results: (1) amount of choice transferred, (2) types of choices local officials make and (3) the effects these choices have on system performance (T. Bossert, 1998). This decision space can range from "narrow" (little local choice – de-concentration), "moderate" (a range of choice but limited by central rules - delegation) or "wide" (little constraint on local choice - devolution). The more the decision space, particularly at the lower levels of the system, the better the performance of a health system (Thomas J Bossert & Beauvais, 2002; Thomas John Bossert & Mitchell, 2011). Conditions needed for decentralization to improve health system performance relate to multi-stakeholder planning, capacities for local revenue raising and central pooling, central level capacity for augmenting resource needs at local levels, good relations between local stewards and elected officials, promoting innovation, and central level support for timely and accurate data management (Liwanag & Wyss, 2018). These are most effective when there is wider decision space to make these decisions, particularly at the lower levels of the health system.

However, the relationship between devolution and better health outcomes is not a clear and linear one. Increasing decision space makes it more difficult to cultivate a common and coherent focus and set of results, as decision space means local managers can choose different targets and goals. This leads to a complex sector made up of autonomous units each exhibiting non-deterministic actions and interactions that may be contrary to overall desired health outcomes. A lack of effective oversight of decentralized units

may therefore balance out the effects of the increased decision space. A decentralized health sector is therefore best perceived as a network of actors working independently and learning from each other to influence a tortuous movement towards jointly agreed health results (Holland, 1998). As decision space is increased, the overall implications on health result is more a function of how well the different autonomous units associate with the nationally desired results, and the nature of their interaction amongst each other (Waldrop, 2016). The role of governance in this situation is focused not just on attainment of a multiple set of (potentially conflicting but jointly agreed) results, but also managing the inter-relations amongst the different actors to ensure interdependence and harmony in their actions.

### Stakeholder engagement

The call for effective stakeholder engagement has been core to health since Alma Ata declaration of 1978, where this was highlighted as one of the pillars of primary health care (WHO, 1978). Collaborative decision making where the different partners involved jointly come up with actions reduces on inefficiencies and improves the quality of decisions made. While universally perceived as important, most literature on the subject is focused on corporate governance where it is important in building social capital for firms (Maak, 2007). Within the health sector, the arguments for stakeholder engagement are primarily in grey literature from governments and international institutions, which argue for this as a pre-requisite for good governance. However, stakeholder engagement is only valuable if there is appropriate communication – and not just structures of communication – amongst the different stakeholders, crossing professional, organizational and political boundaries (Huotari & Havrdová, 2016).

### Community participation

This varies from the stakeholder engagement as it emphasizes the role of communities / citizens in the care process, ensuring they are active contributors– not passive recipients of services (Baisch, 2009). One systematic review on how benefits from community engagement arise recognize a continuum of 3 community engagement strategies: transactional, transitional and transformational (Bowen, Newenham-Kahindi, & Herremans, 2010). The quality of community engagement and its sustained results improve along this continuum, till the community is fully transformed and own the factors of production of their health results. Community engagement is therefore able to influence governance constructs more when it is at a transformational stage, with the community's active contributors to, and producers of health.

### Strengthened social capital

This has been defined as the resources inherent to institutionalized relationships of mutual recognition (Bourdieu, 1980). Such resources – usually intangible – can be drawn upon to support achievement of health goals. By establishing such resources, a community has capital that it can use to enforce required

governance for attainment of their health results. Thus, a group of individuals that share a common characteristic – such as fishermen or widows/widowers – can come together and form a collective that can exert the required influence on a given governance arrangement to achieve a health result they want. This is perceived to act through enforcing mechanisms that ensure bonding within a vulnerable group; bridging across vulnerable groups and linking with support structures (Szreter & Woolcock, 2004). Social capital creates social safety nets, which facilitate the action of governance.

#### *2.4.2.2 Characterization of the association between governance and health*

While they were able to confirm the association between governance and health results, Ciccone et al (2014) showed that this association varied in practice, ranging from a direct and positive relationship (N = 9), or an indirect relationship reliant on context (N = 5), a moderating effect on other system structures or processes (N = 4), a mixed association (N = 6), or even no / inconclusive association (N = 6). This wide range of effects was found to be related to the way governance was constructed and interpreted, with the constructs associated with these different effects highlighted in table 2-4 below.

**Table 2-4: Constructs of governance and effects on health outcomes**

| Direct, positive effect | Indirect positive effect | Moderating effect | Inconsistent effect | No demonstrable effect |
|---|---|---|---|---|
| Voice and accountability | | Voice and accountability | | |
| Political stability | | Political stability | | Political stability |
| Government effectiveness | | Government effectiveness | | |
| Regulatory quality | | Regulatory quality | | |
| Rule of law | | Rule of law | | |
| Control of corruption | | Control of corruption | | Control of corruption |
| Participation | | Democracy and participation | | |
| Community engagement | | | Community participation | Community participation |
| Sustainable economic opportunities | Social capital | | | |
| Decentralization reform | Decentralization reform | | Decentralization reform | |
| | | | Right to health | Right to health |

*Source: Adapted from Ciccone and others, 2014 (Ciccone et al., 2014)*

This shows that the constructs of governance have individually very different effects on health outcomes – with the same construct seen to have direct, indirect, to no effect. There is no construct that has a single effect. This is most probably related to the summary from the literature on governance perspectives (section 2.3), where it emerged that an effective understanding of governance for health stewards and managers needs to draw from both a normative and descriptive view of governance. The need to define both structures and the rules / processes appears to be needed at the construct level.

Looking at the specific constructs influencing governance, 11 were distinctly identified as influencing health outcomes (community engagement / participation was merged, as was participation / democracy and sustainable economic opportunities / social capital as these were referring to the same functions when I reviewed the underlying papers). Of these 11, six are constructs are primarily under influence of the health sector, while 5 are primarily under influence of other sectors. This distinction is shown in the table 2-5 below

**Table 2-5: Authority responsible for governance constructs influencing health outcomes**

| CONSTRUCTS UNDER RESPONSIBILITY OF HEALTH SECTOR | CONSTRUCTS UNDER RESPONSIBILITY OF OTHER SECTORS |
|---|---|
| • Voice and accountability<br>• Political (steward) stability<br>• Government effectiveness<br>• Regulatory quality<br>• Rule of law<br>• Control of corruption | • Participation<br>• Community engagement<br>• Sustainable economic opportunities<br>• Decentralization reform<br>• Right to health |

The health stewards' actions drive the issues to do with voice and accountability, government effectiveness, regulatory quality, rule of law, control of corruption and their own stability. Outside influences on these constructs are possible, but with effective oversight and direction the health stewards can effectively control these. On the other hand, the remaining constructs are primarily driven by actions by others. Participation and democracy are primarily wider governance issues driven by the political agenda; community engagement and sustainable economic opportunities / social capital are driven by the form on community – government arrangements; decentralization is usually driven by the planning ministries and the right to health is primarily a constitutional or legal issue embedded in the rights-based approach of the country. Health stewards and managers more often are influenced by this second group of constructs.

It is interesting to note that four out of the five constructs that are classified as the responsibility of other sectors also are classified as the mechanisms by which governance achieves health results (section 2.4.2.1 above). The right to health is the only construct that is not also perceived as a mechanism through which governance achieves health results. We note though that it is shown to have at best an inconsistent, but

otherwise a negative effect on health results (table 2-4), which is a surprising finding. The right to health has been recognized as an integral part of health services, and is even enshrined in the universal declaration of human rights (United Nation General Assembly, 1948) and the WHO constitution (World Health Organization, 2006). Investment in health, and attainment of desired health results are not a privilege but a right for all citizens in a country which a government needs to ensure. The challenge has been with how to translate this right into action (The Lancet, 2008). Some have argued that the right to health is unattainable, and should be distinguished from the right to health care, which is a clearer goal to plan for and attain (Grossman, 1972). However, it is critical to maintain a focus on the right to health. A review across 194 countries of the world showed there is still need to particularly strengthen strategies and approaches that improve equity and the right to health in countries (Backman et al., 2008).

## 2.5 Application of health governance in practice

With this overall picture of the history, role, understanding and structuring of health governance, I reviewed the different ways the concept has been applied by health stewards and / or managers in low- and middle-income countries. To identify relevant literature, There is a paucity of literature on this subject, with many of the articles purporting to do so are independent assessments of governance (Kirigia & Kirigia, 2011; Mo Ibrahim Foundation, 2017; Olafsdottir, Reidpath, Pokhrel, & Allotey, 2011). These assessments are conducted by external actors – not the country stewards and managers and largely focused on assessing governance norms. I did not find any actual assessments that attempted to understand the inter-relations of actors in health, plus the rules and processes needed for understanding the descriptive perspective of governance.

I further searched the literature using the Africa Index Medicus, a database that contains a wide range of grey literature on African countries (http://indexmedicus.afro.who.int/about.html). Here, I found multiple program reports and plans from each country of the African region. I extensively reviewed 25 documents that I identified, of which 12 were plans and 13 reports. Of the plans, 5 were broad sector strategic plans and 7 program specific plans. On the other hand, 4 reports were sector strategic reviews and 9 program specific reviews. Within these documents, I found governance aspects were being planned for and reported in a non-orderly manner. Five (5) of the documents I reviewed did not mention governance at all, focusing instead of describing program-based results. However, all the sector wide strategic plans and reviews I reviewed mentioned governance in them.

I opted to further review country plans to see how well they are incorporating health governance elements in their planning processes. A comprehensive compendium of country health plans and reviews exists as a one stop location (http://www.nationalplanningcycles.org/) from which I found these documents. On review of the African countries, I found all plan and review the state of governance, but limit this in two

ways. Firstly, they all focus on a structural perspective, with none including governance processes, rules and inter-relations. Secondly, they focus on specific constructs of governance, with none reflecting all the constructs identified in section 2.4 as having an influence on health outcomes. All the plans / reviews incorporated elements of governance effectiveness and voice/accountability. The elements of government effectiveness most reflected were about presence of policy/planning, resource management, effectiveness/efficiency, and strategic vision. On the other hand, the elements on voice/accountability most commonly included relate to description of partnership and coordination mechanisms, putting in place community members in facility oversight organs and ensuring open budgeting. The other elements were mentioned but with less frequency. Control of corruption was mentioned in the context of having a hotline and ombudsman functions in the sectors. Regulatory quality was mentioned too, but there was no systematic approach to this – different plans were suggesting different legal instruments, ranging from program specific, to re-writing existing ones. I did not find any plan talking about the rule of law or political (steward) stability.

### Summary of literature review

The literature so far presents quite a rich range of information to better focus my research. Firstly, the concept of governance is not a concept that developed within the health field, but rather evolved from the private sector in the quest to improve efficiency in public administration. Its principles have been imported and stretched to encapsulate the current health sector that is constituted from multiple actors pursuing multiple results that are all at times independent, and other times inter-dependent. It is alien but adapted to fit the needs of health. Secondly, governance has now been well entrenched into health systems thinking and is now recognized as a core / central element in system development. Third, however, governance remains a concept constructed from multiple, but interdependent attributes whose description and application are not uniformly applied in practice, leading to a mixed perception of how to address it. There are multiple perspectives and interpretations of governance in health, but it is important in whichever perspective to reflect both its normative and descriptive aspects. Forth, governance does have a positive effect on health results, acting through health system decentralization; involved and empowered stakeholders; enhanced community engagement; and strengthened social capital. Fifth, over 11 distinct constructs of governance are identified that have an influence on health outcomes, of which 6 are inherent to actions by health stewards / managers and the remaining 5 by others beyond them. And finally, there is no consistent way governance is being applied by health stewards, in spite of the breadth of academic work being generated on the subject.

Health stewards and managers – both in public and private sectors in low- and middle-income countries – are more often working with a bureaucratic approach, where they want clearly defined, actionable and

measurable deliverables against which they can plan and be monitored. As seen from my literature review, the field of governance, while recognized as important for attainment of health results, is still difficult to understand and consistently apply for a bureaucrat. A more accessible understanding of health governance is needed, which builds on the current definitions to provide our quintessential health steward and/or manager with actions they can implement, which will lead to better governance.

My research is focused on this – taking the multiple understandings of governance and interpreting them in the context of a health steward or manager into something that they can implement to attain better health results.

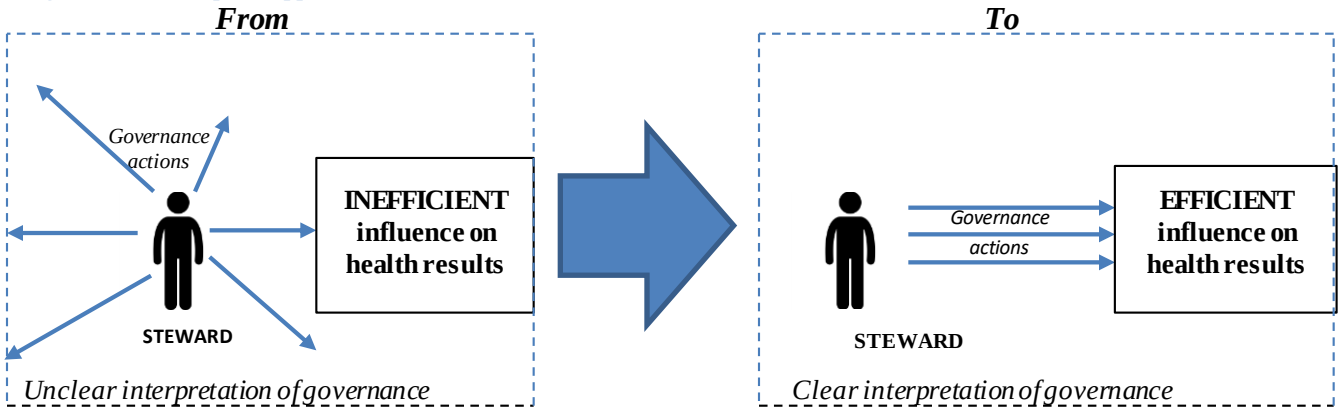
This will add to the literature on governance by distilling the very useful thinking and concepts that have so far emerged on health governance into a comprehensive picture that can be implemented by a health steward or manager in a low- or middle-income country.

## 2.6 Research conceptual approach

The appropriate identification and application of governance will influence health results in a given entity. It is therefore important that a common interpretation of governance exists for the health sector stewards and managers who are responsible for making operational the health agenda. In the absence of this, with multiple ways of interpreting the governance concepts, health sectors are at best partially benefitting from good governance. Having a comprehensive and coherent interpretation of governance allows health stewards and managers to target their actions in a predictable and measurable manner leading to more consistent effects on health results.

I hypothesize that by providing an interpretation of governance in the form better understood by health sectors in low- and middle-income countries, their health stewards and managers will be able to better target governance improvement actions and therefor maximize the effects of governance on health results. This I summarize in the figure 2-6 below.

**Figure 2-6: Conceptual approach for research**




*Source: Authors' construction*

By having a clear interpretation of governance actions, the health stewards and managers would be able to ensure the efficient attainment of the effects of governance on health results. This would be beneficial as these effects would be maximized, more predictable, easier to quantify, and achieved with less wastage of effort and resources.

## 2.7 How governance is described in my analysis

As I found in my literature that neither descriptive, nor normative based approaches are important on their own, I explore an approach to interpret governance for the health stewards and managers that draws from both perspectives. I structure the research based on clear constructs and explore each of these in terms of both their description (normative perspective) and their inter-relations and attributes (descriptive perspective).

I deconstruct the concept of governance using the 11 governance constructs in my literature review shown to have an influence on health outcomes (see table 2-4). I explore the interpretation of the 2 sets of constructs – those primarily under the responsibility of health stewards or managers and those primarily under the responsibility of other actors – differently. For the 6 constructs primarily under the responsibility of health stewards or managers, I explore how these are interpreted by the health stewards and managers to derive common understandings of them. On the other hand, those that are primarily the responsibility of other sectors, I explore how the stewards or managers expect these to be structured for them to influence governance actions.

For a common understanding and discussion during my research, I elected to have a common interpretation of each construct. This was to ensure I and the stewards providing information were having the same interpretation of what we were discussing at a given time. As these 6 constructs are close to the World Banks governance dimensions, I used as my starting point their definitions captured by Kaufmann *et al* (2011). These I customized for the health sector, based on (1) my knowledge and experience with working with health stewards and managers, (2) ensuring aspects of descriptive and normative perspectives of governance (sections 2.3.3 and 2.3.4) are reflected, and (3) discussions I held with 3 national level managers to build consensus on the new definitions to ensure these were clear enough for without diverting from the original definition. The final agreed definitions that emerged each of the 6 constructs under the responsibility of health stewards are shown in table 2-6 overleaf.

**Table 2-6: Definitions of governance constructs used in my study**

| Construct | Original WB definition | Agreed definition during the study | Comments |
|---|---|---|---|
| **Voice and accountability** | The extent to which a country's citizens are able to participate in selecting their government, as well as freedom of expression, freedom of association, and a free media. | The extent to which the population can participate in decisions relating to provision of health services. | *My study definition focuses the construct on the need for participation in health decision making – the aspect of voice and accountability needed in the health sector.* |
| **Political stability** | The likelihood that the government will be destabilized or overthrown by unconstitutional or violent means, including politically-motivated violence and terrorism | The extent to which health stewards and managers have both the mandate and support from the wider government to lead the health agenda and are able to make decisions based on this mandate | *My study definition focuses political stability definition on the level of permanency felt by health stewards and managers, to allow them focus on strategic issues. Without this, their priorities are more aligned to personal survival.* |
| **Government effectiveness** | The quality of public services, the quality of the civil service and the degree of its independence from political pressures, the quality of policy formulation and implementation, and the credibility of the government's commitment to such policies | The extent to which the structure, culture, and actions of the government health stewards are facilitative of the attainment of desired health results with a clear evidence-based decision-making culture being practiced | *My study definition is largely like the original definition, only differing by focusing on the health sector not generically the public-sector.* |
| **Regulatory quality** | The ability of the government to formulate and implement sound policies and regulations that permit and promote private sector development | The extent to which the legal and regulatory environment in health is appropriate to provide oversight and guidance to actions by decision makers | *My study definition is largely like the original definition, only changing in 2 areas: a focus on health sector as opposed to overall government, and a focus on all actors in health, not only the private sector. Regulations should influence all actors* |
| **Rule of law** | The extent to which agents have confidence in and abide by the rules of society, in particular the quality of contract enforcement, property rights, the police, and the courts, as well as the likelihood of crime and violence. | The extent to which the decision makers use the existing legal framework to base and guide their decisions and actions. | *My study definition is largely like the original definition, only making it more succinct for a health steward or manager* |
| **Control of corruption** | The extent to which public power is exercised for private gain, including both petty and grand forms of corruption, as well as "capture" of the state by elites and private interests | The extent to which stewards and managers actions are transparent and carried out in a clear framework that ensures all health stakeholders can monitor the implementation process and limit leakages of resources. | *The original definition emphasis on private gain elicits a defensive response, which I felt would hinder open discussion from my KIs. My definition therefore focused on using wording that would be less provocative to the respondents* |

*Source: Original WB definitions from (Kaufmann et al., 2011)*

These revised definitions were very useful during the fieldwork, to provide the KIs with a clear understanding of what we were discussing for each construct. Without them, given the wide variety of governance literature they have been exposed to, they could potentially have ended up discussing different issues from what I was exploring.

# 3. CHAPTER 3: RESEARCH METHODS

My research is exploratory, attempting to better structure and apply the concept of governance for a health steward and/or manager by deciphering how it is understood and applied by them. I focus on the health stewards and managers as I want to allow recommendations to emerge that are based on different real-world experiences of governance. As I am not aiming to quantify the existence of different experiences but rather understand them, the quantitative method would have been inappropriate. I highlight the different approaches I undertook to design my study in this frame.

## 3.1 Study design

The quantitative method focuses more on attempts to quantify an issue through generating data that can be transformed into statistics while the qualitative method focuses more on understanding why a given phenomenon is the way it is (C Pope, Mays, & Popay, 2007). Qualitative methods allow the issue being investigated to be explored in more depth, with feedback able to be followed up as part of the method. It is also useful for potentially sensitive subjects. My study is more interested with understanding and deciphering the phenomenon of governance for a health manager, so my focus on qualitative methods – specifically qualitative interviews with health stewards and managers. I had five options of qualitative approaches, differentiated by the study purpose– ethnography, narrative, phenomenological, grounded theory, and case study (Creswell, 2009):

- Ethnography focuses on the researcher experiencing the event being studied to understand it
- The narrative approach focuses on the researcher weaving together a story that explains the event
- The phenomenological approach aims to understand the meaning of the event being studied
- Grounded theory on the other hand aims to provide an explanation of the event
- Finally, a case study approach involves a deep study into the event to better understand it

I opted for the case study approach, as this is the one best able to investigating a contemporary phenomenon (governance in my study) within a real life context (Yin, 2009). It is a particularly useful methodology when examining events within a 'messy' real work setting with events that the researcher has no control over, and allows for the phenomenon being examined to be viewed from multiple lenses (Keen, 2006).
I elected to use a county as my case study. This is a devolved autonomous unit of governance described in section 1.2. Being autonomous, I would be able to fully explore the phenomenon of governance within a contained case study responsible for decisions relating to governance and their implications.

## 3.2 Selection of case studies

I explored the phenomenon in 2 case studies, to allow as wide a variety of responses as possible. I therefore selected these case studies purposively, to ensure they were as different as possible. I needed different case

studies, to ensure I get as wide a variety of respondents as possible. I also wanted to explore for any variations in governance perceptions across different types of case studies.

To ensure variation in the two different case studies, I selected these based on the kinds of health results they were achieving. I sought one case study that was having good, and the other relatively poor health results. My assumption is that I would most probably have some differences in perspectives of governance in health stewards and managers in good and poor performing case studies.

Identification of these 2 case studies needed to be carefully done, to ensure I selected ones that would exhibit variations in governance perspectives where these existed.

Firstly, I was aware that attainment of health results could not only be attributed to perspectives on governance. The levels of investment being put into health is a more important confounder. As such, I needed to determine good and poor performing case studies after correcting for level of investment. I therefore opted to use a method that classifies health results after correcting for level of investment. At the time of my assessment, the ministry of health was producing annual league tables for counties, based on performance. The performance measure they used was based on efficiency of counties – looking at the results produced adjusted for level of investments made.

Secondly, I appreciated the complexity of determining what health results were accepted. The health sector is associated with multiple types of results, across different programs. Thus, the measure of results needed to take into be a composite of many specific result areas, for it to be more representative.

Third, I knew health results are not felt immediately but would usually manifest sometime after the investments are made. Thus, health results being reflected are usually a function of actions taken in the past. This effect is more pronounced as one moves from outputs, to outcomes and impact type of health results. Given how close my research was to the policy change (devolution) that provided me with the stewards and managers I needed, I decided to focus on the output level of results as this is where I would most probably have the effects of the steward's actions already felt.

Given these confounders, I needed to identify counties based on a method that measures results after correcting for level of investment, uses multiple indicators to determine the result status and can provide output level information. I found the health sector annual reports being produced at the time had these characteristics. They produced county league tables based on efficiency comparisons that determined health results based on multiple inputs/output indicators. I chose the 2014 annual report to identify my case studies, as this was 3 years since counties came into existence and they had their required stewards and managers in post and I expected their actions were already having effects on health (Government of Kenya, 2014). While this uses different results to determine comparative performance, it is limited in focusing on normative measures of performance, with some descriptive and more person-centred results such as how

responsive services are to people's needs are not included. I use the method with an understanding of the presence of this limitation, as it was the only way I could compare different counties independently.

The annual health sector performance report analysis used the Data Envelopment Analysis (DEA) approach to compare county performance – a method suited for comparison of multiple input/output production units (Banker, Charnes, & Cooper, 1984). Using multiple input and output variables, it classifies the production units (Counties) into efficient and inefficient ones. Efficient ones are producing health results using different permeations of the best use of resources. These form an efficiency frontier against which levels of inefficiency of the inefficient production units can be compared.

From the report, 20 out of the country's 47 counties were deemed efficient and the remaining had various levels of inefficiency. The large number of efficient counties reflects the large number of efficient ways of using available resources to produce health results. The 5 most inefficient counties (making poorest use of their available investments) were the counties of Kakamega, Meru, Bungoma, Kitui and Machakos. For the case study, I purposively selected one county from amongst those perceived to be efficient to represent the 'good performing case study' county, and one from amongst those perceived to be inefficient to represent the 'poor performing case study' county. Given the sensitive nature of the subject I was investigating, I anonymize the actual case study counties, with County A representing the efficient county case study and County B the inefficient one.

## 3.3 Overview of case study sites

Thus, I only refer to the specific county names in this section 3.3, which will be redacted from the publicly available version of the thesis for confidentiality purposes.

I purposively selected the two case studies with an aim to have as many non-governance related characteristics that are similar. The selected counties were Baringo (efficient county, referred to as County A in subsequent sections of my thesis) and Bungoma (inefficient county, referred to as County B in subsequent sections of my thesis), which had the following similarities:

- They are both high population counties, improving the sensitivity of the study findings.
- Both counties have high levels of poverty, and dynamic populations – due to pastoral nature in Baringo county, and peri urban nature in Bungoma county.
- They are primarily populated by single socio-cultural groups – Kalenjin in Baringo county and Luhya in Bungoma county.
- In both counties, the full complement of health management teams was in place.
- It is possible to access a large part of both counties, making data collection more feasible.

I however ensured they do not neighbour each other, limiting overlap of perceptions due to geographical similarities.

### 3.3.1 Bungoma county (County B)

Information on the county overview is derived from its integrated development plan, 2013 – 2017 (County Government of Bungoma, 2013). The county is in western Kenya, covering an area of 3,032.4 $Km^2$ and bordered by the republic of Uganda to the north west, Trans-Nzoia county to the north-east, Kakamega county to the east and south east, and Busia county to the west and south west. The County's location in Kenya is shown in figure 3-1 below.

**Figure 3-1: Bungoma county location**


*Source: Kenya council of governors*

Demographic information, compared against overall Kenya information, projected from the most recent national census (Kenya National Bureau of Statistics, 2010) is highlighted in table 3-1 below.

**Table 3-1: Key demographic information for Bungoma County, Kenya**

| | Bungoma County | Total for Kenya | Average per county |
|---|---|---|---|
| Total population | 1,557,236 | 41,800,000 | 889,362 |
| Total area (sq km) | 3,033 | 610,000 | 12,978 |
| Population density | 513.4 | 68.5 | 68.5 |
| Percent population under 1 | 2.7% | 3.2 | 3.2 |
| Percent population in labour force | 40.2 | 55.1 | 55.1 |
| Percent of population living in urban areas | 10.3 | 24 | 24 |

*Source: (County Government of Bungoma, 2013)*

The county is small geographically, but with a relatively large population giving it a population density over 9 times the average for Kenya. The population is rural, with a relatively low proportion within the labour force. Ethnically, the population is primarily Luhya, a Bantu ethnic grouping though there are

populations of other tribal groupings in the urban areas. Most persons in the county are peasant farmers, with the major agricultural activity relating to outgrowing sugarcane.

Administrative sub divisions are by sub county / constituency and wards. The county is divided into 9 sub-counties and 45 wards all with varying population distribution as shown in table 3-2 below.

**Table 3-2: Sub counties, wards and population in Bungoma county**

| Sub county / constituency | Number of wards | Total population | Population density |
|---|---|---|---|
| **Mount Elgon** | 6 | 194,766 | 204 |
| **Sirisia** | 3 | 115,725 | 542 |
| **Kabuchai** | 4 | 159,442 | 686 |
| **Bumula** | 7 | 202,133 | 581 |
| **Kanduyi** | 8 | 259,536 | 815 |
| **Webuye East** | 3 | 114,141 | 706 |
| **Webuye West** | 4 | 146,009 | 602 |
| **Kimilili** | 4 | 150,074 | 828 |
| **Tongaren** | 6 | 211,829 | 560 |

Information on the county health services is derived from the CHSSIP (County Government of Bungoma, 2015) developed in 2013 but launched in 2015, and the subsequent Kenya health sector annual performance reports for 2014 and 2015. The county status in 2013 when created with regard to the three health sector input investment areas defined in the KHSSP(Republic of Kenya, 2014b), together with trends in selected health sector monitoring output indicators between 2013 – 2015 from the annual sector performance reports and the District Health Information System (DHIS 2) are shown in table 3-3 below.

**Table 3-3: Comparison of health inputs (2013) & health goals (2013 – 2016) between Bungoma County & Kenya**

| ***SELECTED INPUTS IN 2013*** | | | | | ***TRENDS IN SELECTED HEALTH GOALS, 2013/14 – 15/16*** | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| *Variable* | | *Total* | *Numbers per 10,000 population* | | *Variable* | *2013/14* | | *2014/15* | | *2015/16* | |
| | | | *Bungoma* | ***Kenya*** | | *Bungoma* | ***Kenya*** | *Bungoma* | ***Kenya*** | *Bungoma* | ***Kenya*** |
| Health workers | Total | 1464 | 9.40 | ***16.05*** | % ANC coverage 4 visits | 29.8 | ***34.7*** | 34 | ***39.7*** | 28.7 | ***35.7*** |
| | Doctors | 54 | 0.35 | ***0.54*** | % births attended by skilled HWs | 47.7 | ***50.9*** | 52.3 | ***55.5*** | 46.6 | ***53.1*** |
| | Nurses | 598 | 3.84 | ***5.79*** | Per capita OPD utilization | 0.81 | ***1.3*** | 0.93 | ***1.4*** | 0.67 | ***1.1*** |
| Health facilities | Level Vs | 0 | 0 | ***0.002*** | % children fully immunized | 70 | ***67.9*** | 70.9 | ***71.6*** | 55.4 | ***62.6*** |
| | Level IVs | 11 | 0.07 | ***0.14*** | Facility deaths per 10,000 population | 11.30 | ***24.45*** | 15.64 | ***27.13*** | 20.32 | ***26.84*** |
| | Level IIIs | 20 | 0.13 | ***0.25*** | Tuberculosis cure rate | 84 | ***82*** | 83 | ***82*** | 85 | ***81*** |
| | Level IIs | 79 | 0.51 | ***0.88*** | ANC coverage 1 visit | 75.3 | ***74.8*** | 77.2 | ***75.7*** | 61 | ***68.6*** |

*Source: Inputs – 2013 Kenya Service Availability and Readiness Assessment Mapping;*
*Outputs – Kenya District Health Information System (DHIS-2)*

All the key tangibles required to provide health services were below the national values at the formation of the county. Looking at the output trends on the other hand, all apart from Tuberculosis cure rate, are worse off in 2015 as compared to 2013, and the drops are more marked for Bungoma County as opposed to the Kenyan average. This is summarized in table 3-4 below.

**Table 3-4: Variance in output variables in Bungoma County, between 2013 and 2015**

| *Variable* | *Change in county performance, 2013 – 2015* | *Change in national performance, 2013 – 2015* |
|---|---|---|
| ANC coverage 4 visits | -4% | 3% |
| % births attended by skilled HWs | -2% | 4% |
| Per capital OPD utilization | -17% | -15% |
| % children fully immunized | -21% | -8% |
| Facility deaths per 10,000 population | 80% | 10% |
| Tuberculosis cure rate | 1% | -1% |
| ANC coverage 1 visit | -19% | -8% |

*Source: Authors summary, from above*

Since 2013, the county has had an appointed CEC/health, chief officer and director of health together with a county health management team. In addition, each sub county has a health management team.

### 3.3.2 Baringo county (County A)

Information on the county overview is derived from its integrated development plan, 2013 – 2017 (County Government of Baringo, 2013). The county is in the rift valley region of north-central Kenya, covering an area of 11,015.3 $Km^2$ and bordered by Turkana and Samburu counties to the north, Laikipia to the east, Nakuru and Kericho counties in the south, Uasin Gishu to the south west and Elgeyo-Marakwet and West Pokot to the west. The county location within Kenya is highlighted in figure 3-2 below.

**Figure 3-2: Baringo county location**

*Source: Kenya Council of Governors*

The county is of average size compared to others, but with a lower average population and therefore an under average population density. The population is rural, with a relatively average proportion within the labour force. Only 9.7% of the people live in urban areas. Ethnically, the population is primarily Kalenjin, a Nilotic grouping. Most persons in the county are nomadic, with the major activity relating to animal rearing. The county population demographics are highlighted in table 3-5 below.

**Table 3-5: Key demographic information for Baringo County, Kenya**

| | Baringo county | Total for Kenya | Average per county |
|---|---|---|---|
| Total population | 633,617 | 41,800,000 | 889,362 |
| Total area (sq km) | 11,015.3 | 610,000 | 12,978 |
| Population density | 57.5 | 68.5 | 68.5 |
| Percent population under 1 | 3.5 | 3.2 | 3.2 |
| Percent population in labour force | 48.8 | 55.1 | 55.1 |
| Percent of population living in urban areas | 9.7 | 24 | 24 |

*Source: (County Government of Baringo, 2013)*

Administrative sub divisions are by sub county / constituency and wards. The county is divided into 7 sub-counties and 30 wards all with varying population. The highest population is in east pokot sub county, while the highest population density is in Baringo central sub county. Mogotio sub county has the lowest population, while east pokot has the lowest population density, as shown in table 3-6 below.

**Table 3-6: Sub counties and wards and population (2012) in Baringo County**

| Sub county / constituency | Number of wards | Total population | Population density |
|---|---|---|---|
| **Mogotio** | 3 | 67,303 | 51 |
| **Koibatek** | 6 | 116,228 | 116 |
| **Marigat** | 4 | 80,792 | 49 |
| **Baringo central** | 5 | 98,454 | 123 |
| **Baringo north** | 5 | 103,549 | 61 |
| **East pokot** | 7 | 147,049 | 32 |

*Source: Baringo county integrated development plan, 2013 - 2017*

Information on the county health services is derived from the CHSSIP (County Government of Bungoma, 2015) developed in 2013 but launched in 2015, and the subsequent Kenya health sector annual performance reports for 2014 and 2015. The county status in 2013 when created with regard to the three health sector input investment areas defined in the KHSSP(Republic of Kenya, 2014b), together with trends in selected health sector monitoring output indicators between 2013 – 2015 from the annual sector performance reports and the District Health Information System (DHIS 2) are shown in table 3-7 overleaf.

**Table 3-7: Comparison of health inputs (2013) and health goals (2013 – 2016) between Baringo County and Kenya**

| *SELECTED INPUTS IN 2013* | | | | | *TRENDS IN SELECTED HEALTH GOALS, 2013/14 – 15/16* | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| *Variable* | | *Total* | *Numbers per 10,000 population* | | *Variable* | *2013/14* | | *2014/15* | | *2015/16* | |
| | | | *Baringo* | ***Kenya*** | | *Baringo* | ***Kenya*** | *Baringo* | ***Kenya*** | *Baringo* | ***Kenya*** |
| Health workers | Total | 1102 | 17.39 | ***16.05*** | ANC coverage 4 visits | 26.2 | ***34.7*** | 30.1 | ***39.7*** | 28.5 | ***35.7*** |
| | Doctors | 21 | 0.33 | ***0.54*** | % births attended by skilled HWs | 38.4 | ***50.9*** | 42 | ***55.5*** | 41.2 | ***53.1*** |
| | Nurses | 443 | 6.99 | ***5.79*** | Per capital OPD utilization | 1.1 | ***1.3*** | 1.3 | ***1.4*** | 1.4 | ***1.1*** |
| Health facilities | Level Vs | 0 | - | ***0.002*** | % children fully immunized | 55.4 | ***67.9*** | 57.3 | ***71.6*** | 49.5 | ***62.6*** |
| | Level IVs | 7 | 0.11 | ***0.14*** | Facility deaths per 10,000 population | 12.39 | ***24.45*** | 15.66 | ***27.13*** | 14.39 | ***26.84*** |
| | Level IIIs | 22 | 0.35 | ***0.25*** | Tuberculosis cure rate | 78 | ***82*** | 79 | ***82*** | 78 | ***81*** |
| | Level IIs | 126 | 1.99 | ***0.88*** | ANC coverage 1 visit | 62.2 | ***74.8*** | 63 | ***75.7*** | 61.1 | ***68.6*** |

*Source: Inputs – 2013 Kenya Service Availability and Readiness Assessment Mapping;*
*Outputs – Kenya District Health Information System (DHIS-2)*

However, its performance is much better than the average Kenya performance during this period, with 5 out of the 7 output variables showing better performance as compared to Kenya as a whole. The health performance of the county over time, against the national average is summarized in table 3-8 below.

**Table 3-8: Variance in output variables in Baringo County, between 2013 and 2015**

| *Variable* | *Change in county performance, 2013 – 2015* | *Change in national performance, 2013 – 2015* |
|---|---|---|
| ANC coverage 4 visits | 9% | 3% |
| % births attended by skilled HWs | 7% | 4% |
| Per capital OPD utilization | 27% | -15% |
| % children fully immunized | -11% | -8% |
| Facility deaths per 10,000 population | 16% | 10% |
| Tuberculosis cure rate | 0% | -1% |
| ANC coverage 1 visit | -2% | -8% |

*Source: Authors summary*

Since 2013, the county has had an appointed CEC/health, chief officer and director of health together with a county health management team. In addition, each sub county has a health management team.

## 3.4 Study populations and participants

I used interviews – specifically Key Informant Interviews (KIIs) as my primary source of data. This was because I needed to explore in detail the different concepts associated with the governance constructs and elicit as many different perceptions in each case study as was feasible. In addition, some of the questions

were potentially sensitive, making group methods of collecting data unsuitable. Observation and document reviews would not provide me with the depth of data in needed.

Potential interviewees were national public stewards, county public stewards, county public managers, county partners, county civil society organizations, or county public beneficiaries. I took a pragmatic approach, to select a specific set of interviewees from whom I felt I could still get some perceptions from all these stakeholders. I therefore focused on stewards and managers at the county level. These those from public, non-public (partners, and civil society organizations) stakeholders. I did not include:

- National level stewards or managers, as I wanted to frame my study from the perspective of the county level and felt any issues of import would arise from the county level stewards
- The public as inclusion of micro level managers, plus civil society organizations are interviewees would be a more pragmatic approach to eliciting public views as compared to including public members as interviewees as this would need a wide selection of different public groups (mothers, adolescents, persons with specific conditions, etc) I would have had to consider for the views of the public to be representative. However, it would be worthwhile having a standalone detailed study on public perceptions of governance and how it needs to be structured.

The stewards and managers to be interviewed were identified based on

- The **level** at which they function: The options being macro (county), meso (sub county) or micro (facility) level in the county. This is a recognition of the fact that managers perceptions of the same construct may differ depending on their specific management roles. While recognizing stewardship and management to be closely inter-twined concepts I considered for pragmatic reasons to consider those working at the macro level to be more of health stewards, while those at the micro level health managers. Those at the meso level I considered as having both as stewards and managers combined.
- **Institution** they work through: The options being public, or non-public. Each of these had further sub categorizations: public were both service delivery and oversight functions, while non-public included non-governmental organizations, service providers and civil society organizations working in the county. This allowed me to probe into any variations in perceptions amongst managers that are 'outside' of the government system.
- The **nature** of their work: The options being political, technical or administrative. This recognizes the different managers may be driven by a wider set of considerations beyond technical and so probes for variations in these amongst non-technical health managers.

A total of 48 KIs were targeted, with 24 from each case study. In each, I targeted 8 KIs at each of the macro, meso and micro levels of health governance. Of these, 9 in each case study were from non-public stakeholders. These non-public stakeholders included development partners (multilateral and/or bilateral

international partners), and Non-Governmental Organizations (NGOs) / Civil Society Organizations (CSOs) active in the study sites. The detailed description of the KIs targeted are shown in table 3-9 below.

**Table 3-9: Key informants targeted in each case study**

| Health governance level | Public stewards | | | Non-public stewards |
|---|---|---|---|---|
| | Political | Technical | Administrative | |
| **Macro level of health governance (stewards)** (8 KIIs per case study, 16 in total) | **1** Chair of the county health committee | **1** County Director of Health (CDH) | 1 Chief Officer for health (CoH) | **2** The heads of the major development partners identified together with the CEC-health |
| | **1** County Executive Committee member for health (CEC-health) | **2** County Health Management Team (CHMT) members – 1 from a service program (e.g. HIV, Malaria) and other from a system program (e.g planning, monitoring) area | | |
| **Meso level of health governance (stewards / managers)** (8 KIIs per case study; 16 in total) | | **4** Sub County Health Management Teams – All from one sub county, with 2 from service programs (e.g HIV, or Malaria), & two from systems programs (e.g. planning M&E) | | **2** The two major CSOs in one sub county, to be identified together with the CEC-health |
| | | **1** The major public hospital in the sub county, to be identified together with the CDH | | **1** The major private hospital in the sub county, to be identified together with the CEC-health |
| **Micro level of health governance (managers)** (8 KIIs per case study, 16 in total) | | **4** Four public health facilities, to be identified together with the CDH | | **4** Four non-public health facilities, to be identified together with the CEC-health |

## 3.5 Inclusion and exclusion criteria for KIs

The inclusion criteria used to qualify persons as KIs are as follows:

1. Formally employed health staff in the case study sites, who have been in the position of interest for at least 6 months;
2. Had no known professional or other relationship with I as the researcher, to limit possible impact this may have on the responses;
3. Were able to dedicate adequate interview time to effectively complete the full research tool;
4. Accepted and signed the Interview Consent Form (ICF); and
5. Had a good command of the English language, as this is what will be used for the interview process.

On the other hand, a participant was excluded from the research if they:

1. Willingly declined to participate before, during or after the formal interview process for any reasons;

2. Had not been formally employed in the case study sites, for at least 6 months prior to the interview date;
3. Had any professional or other relationship with I as the researcher;
4. Had not been able to dedicate adequate interview time to effectively complete the full research tool, even if they are willing to participate;
5. Declined to endorse the Interview Consent Form (ICF); and
6. Did not have a good command of the English language.

The 24 KIIs in each case study were aimed to be knowledgeable stakeholders, allowing analysis into the breadth and depth of views relating to the different governance constructs.

### 3.6 Recruitment strategy and procedure

The recruitment procedure for the KIs was as follows:

i) All study sites were blind as to the reason for their selection. This was to avoid the perception of performance influencing the responses in the interviews. I explained to interviewees the reason for the choice of the county as being I anticipated it would present unique perspectives of health governance that I may not get in other counties.

ii) For achieving comprehensive views and saturation, the CEC-health in each case study was the focal point to facilitate KI identification. They represent the topmost health authority in the case studies and so were judged most appropriate to identify appropriate KIs for all the categories of persons targeted.

iii) On arriving in each case study, an appointment was attained with the CEC health, during which an in-depth introduction of the research, its goals and expected outputs was presented together with the approved research protocol, ethical approval and tools. This is to ensure they had a comprehensive grasp of the research aims, process and expectations and therefore can facilitate identification of the most appropriate KIs.

iv) Guided by the targeted profile of KIs and the inclusion/exclusion criteria, the CEC-health then proposed KIs to be included. For each KI proposed, the CEC-health provided justification for why they are appropriate, and if in any doubt, another KI was proposed.

v) This process was carried out for all the targeted KIs till all the KI profiles had an interviewee identified. The CEC-health then provided contacts for the identified KIs, plus formal introductory letters to facilitate their engagement.

vi) Following this, each identified KI was given a reference number that enables identification of their county, and profile within the county. Moving forward, the KIs were identified by this reference number to ensure anonymity.

vii) KIs were then contacted directly and dates for the interview set. Where KIs were unable or declined to participate, the CEC-health was asked to provide an alternate. No KIs were coerced to participate in any way.

## 3.7 Tools, and the data collection process

### 3.7.1 Tool design process

The interviews with the KIs were based on a pre-designed tool that sought establish views and perceptions relating to health governance in general, and the specific identified constructs based on the elaborated research questions (see Annex 2: Interview guide and tool). The interview questions were selected to allow me collect information relating to the research objectives in a manner that allowed the KIs to express themselves freely, and in different possible ways. The research questions associated with the different objectives are highlighted in table 3-10 below.

**Table 3-10: Relation between research objectives and interview questions**

| Area of analysis | | Related interview questions |
|---|---|---|
| **General perceptions relating to governance and health** | | i) What goals you are working to attain in health<br>ii) How would you describe governance in health?<br>iii) How do you think this influences your ability to achieve your goals?<br>iv) What is it about governance in health that makes it important for you in achieving your desired health goals, and why is this so? |
| **Specific perceptions for each construct** | Research objective 1: Understanding of the construct | v) What is the understanding of the construct in the specific context in which you are working? (how do you define it?)<br>vi) Do they feel the construct is important in attaining your desired health outputs, and why? |
| | Research objective 2: Supportive health sector mechanisms that accentuate action of the construct | vii) How does this construct influence your ability to attain your desired health outputs?<br>viii) What needs to be present for the construct to positively influence achievement of your health outputs? |
| | Research objective 3: Supportive contextual mechanisms that accentuate action of the construct | ix) What other factors in your environment need to exist, for this construct to positively influence attainment of your health goals? |

The tool was designed in two parts:

- Part 1 focused on *'breaking the ice'* with the KI, and was targeted at gauging the overall perceptions and understanding of health governance, while
- Part 2 focused on exploring perceptions and understanding in relation to each of the governance constructs in the study.

The same set of questions was asked of each KI in each case study, to see if there would be similarities and/or variations in perceptions.

To better appreciate the practicability of the tool, I first pre-tested it with 3 national level managers. This assisted me ensure the questions were clear, and better time the interview. This pre-test assisted the process as follows:

(i) The sequencing of questions for each governance construct were standardized, as it was seen the interview flowed better when the KIs knew what questions to anticipate. In addition, the order in which the constructs of governance would be explored in the interview was set, starting with community engagement, followed by transparency and government effectiveness as these were the constructs where opinions were most strong. The same order was to be applied in all interviews.

(ii) The interview time was determined at approximately 45 minutes. It could therefore be conducted in one sitting.

(iii) The information on governance in general tended to be provided throughout the interview, not necessarily during the discussion on the given construct. I however decided to maintain the approach of addressing construct by construct to ensure information on all the assessed constructs was collected.

Following revision of the tools based on the pre-test, the final tool was submitted as part of the documents for ethical approval in Kenya and endorsed.

### 3.7.2 Data collection process

During the actual field work, the KI was introduced to the research, its purpose and how it affects the county, and their consent sought. The Informed Consent Form (ICF) was formally signed before the interview proceeded (Annex 1). The interview then commenced guided by the interview guide and tool (Annex 2). The first part of the interview focused on collection of data on the KIs perceptions on overall health governance. This looked at their overall perceptions of governance in health, and its influences on their health goals. The interview then progressed into a second part, where the identified governance constructs were introduced to the KI. For each, the working definition was given to the KI, followed by an open discussion exploring their perceptions based on research questions relating to the four study objectives.

The same questions were applied for each of the researched constructs of governance to complete the interview. The interviews lasted an average of 40 minutes, but ranged from 20 minutes (one micro level interviewee – who had many patients waiting for the day but opted to complete the interview, as *'every day is like this, there is no good day'*), to a 3 hr 15 minute interview with one macro-level interviewee – who was well read and quite happy to discuss governance at length. I didn't discern any variation in interview time by the type of interviewee, or whether they were public or non-public. Some authors have argued for a KI to last under 30 minutes (Allen, 2017; UCLA Center for Health Policy Research, 2017). However, I

found my KIs very engaged in the discussion, with all the interviewees happy to discuss the topic as the common perception was this was a critical area to be addressed. I therefore felt the time I spent was appropriate to elicit the information and views I needed.

I conducted all the interviews personally, though I was joined by a research assistant for the interviews with the micro level managers – 16 out of the 48 targeted interviews. I identified a research assistant experienced in qualitative research methods to join me for these selected interviews for two reasons:

- These were the first interviews I conducted in each county, and I wanted to ensure I was conducting them accurately, and
- These KIs were known to be more open about their views, irrespective of who they were talking to. I anticipated that openness would decrease the higher up the stewardship and management chain one is given the potential political effects of their perceptions. I therefore conducted the interviews for the meso and macro level KIs alone.

As the research assistant was an experienced qualitative researcher, I first reviewed the research tools with them to ensure a common understanding of each question and the expected responses. We then jointly conducted the interviews in each county at the micro level to ensure I was getting the expected responses. The KIs were first completed in a given case study, before any management and analysis of data were initiated. The interviews were conducted in Bungoma County during the period 15 – 28 February 2016, followed by Baringo county during the period 10 – 30 March 2016. Follow up interviews were conducted during April for 2 and 1 KIs in Bungoma and Baringo respectively who were not able to dedicate time in the scheduled periods above. By end of April 2016, all interviews were completed.

A total of 49 KIs were eventually interviewed across the two case studies – one more than targeted. In the good performing county (County A), an extra KI – the outgoing county executive for health – was interviewed as he was in the process of being transferred after staying in the position since the county was formed. The new county executive for health was also interviewed, as while he was in the post for under 6 months (and so would have been excluded based on the exclusion criteria), it was politically expedient to interview him, plus he was a transfer from another post within the county health team and so had valid views. The distribution of interviewees compared to those targeted are shown in table 3-11 overleaf.

**Table 3-11: Targeted and actual KIs interviewed**

| Health governance level | Sector | Categorization | Targeted | *Actual KIs, Efficient county case study (County A)* | *Actual KIs, Inefficient county case study (County B)* |
|---|---|---|---|---|---|
| **Macro level (primarily stewardship functions)** | **Public** | **Political** | **1**<br>**Member of the County Assembly for health** | *1*<br>▪ *Member of the County Assembly for health* | *1*<br>▪ *Member of the County Assembly for health* |
| | | | **1**<br>**County Executive Committee member for health (CEC-health)** | *1*<br>▪ *County Executive Committee member for health (CEC-health)* | *2*<br>▪ *Current County Executive Committee member for health (CEC-health)*<br>▪ *Former County Executive Committee member for health (CEC-health)* |
| | | **Technical** | **1**<br>**County Director of Health (CDH)** | *1*<br>▪ *County Director of Health (CDH)* | *1*<br>▪ *County Director of Health (CDH)* |
| | | | **2**<br>**County Health Management Team (CHMT) members** | *2:*<br>▪ *In charge, Planning and M&E*<br>▪ *County Administrator* | *2*<br>▪ *Deputy County Director of Health and in charge preventive services*<br>▪ *In charge reproductive health* |
| | | **Administrative** | **1**<br>**Chief Officer for health (CoH)** | *1*<br>▪ *Chief Officer for health (CoH)* | *1*<br>▪ *Chief Officer for health (CoH)* |
| | **Non public** | | **2**<br>**The heads of the major development partners** | *2*<br>▪ *Head, MANI Project*<br>▪ *Head, APHIA plus* | *2*<br>▪ *County in charge, UNICEF*<br>▪ *County in charge, World Vision* |
| **Meso level (mixed stewardship / management functions)** | **Public** | | **4**<br>**Sub County Health Management Teams** | *4*<br>▪ *In charge, sub county team*<br>▪ *Sub county AIDS coordinator*<br>▪ *Sub county public health nurse*<br>▪ *Sub county partner liaison officer* | *4*<br>▪ *Sub county reproductive health coordinator*<br>▪ *Sub county monitoring and evaluation office*<br>▪ *Sub county AIDS coordinator*<br>▪ *Sub county public health nurse* |
| | | | **1**<br>**The major public hospital in the sub county** | *1*<br>▪ *Medical superintendent, county referral hospital* | *1*<br>*Medical superintendent, county referral hospital* |
| | **Non public** | | **2**<br>**The two major CSOs in one sub county, to be identified together with the CDH** | *2*<br>▪ *Head, children civil society*<br>▪ *Head, centre for human right/ constitution education & implementation* | *2*<br>▪ *Head, centre of financing and good governance*<br>▪ *Head, selected institute of development* |
| | | | **1**<br>**The major private hospital in the sub county** | *1*<br>▪ *Chief executive officer, selected private hospital* | *1*<br>▪ *Chief executive officer, selected mission hospital* |
| **Micro level (primarily management functions)** | **Public** | | **4**<br>**Four public health facilities, to be identified together with the CDH** | *4*<br>▪ *In charge, selected health centre 1*<br>▪ *In charge, selected dispensary 1*<br>▪ *In charge, selected health centre 2*<br>▪ *In charge, selected dispensary 2* | *4*<br>▪ *In charge, selected dispensary 1*<br>▪ *In charge, selected dispensary 2*<br>▪ *Public health nurse at selected health centre 1*<br>▪ *In charge of selected health centre 2* |
| | **Non public** | | **4**<br>**Four non-public health facilities, to be identified together with the CDH** | *4*<br>▪ *In charge, selected private clinic*<br>▪ *In charge, selected mission clinic*<br>▪ *In charge, selected clinic*<br>▪ *Medical officer at selected family hospital* | *4*<br>▪ *In charge at selected private clinic*<br>▪ *Nurse on duty at selected mission private clinic*<br>▪ *In charge, selected nursing home*<br>▪ *Doctor on duty at selected specialist eye clinic* |

## 3.8 Management and analysis of the data

The interviews were recorded, and then transcribed verbatim. A written transcript of the interviews based on the interview guide questions was produced.

Analysis of the data was done in NVivo. A framework analysis approach as described by Pope and others (Catherine Pope, Mays, & Popay, 2006) was used for analysis. This approach for analysis is useful in situations such as this, where there are very clear themes around objectives for which data are needed. It is structured, but still allows for ideas and themes to emerge during the analysis, and so have the results influenced by the findings in a systematic manner. The analysis followed the following steps

a) Data re-familiarisation was first done through listening to the audio recordings and reviewing the transcripts.

b) Based on this, and guided by the research questions, a thematic framework was developed from the research questions, and used to code the entire data set[3]. Analytic nodes were developed for coding the data into NVivo (see example below, for one construct of governance).

**Table 3-12: Example of analytic nodes used for community engagement and participation**

| ANALYTIC NODES |
|---|
| **a. Perception of community engagement and participation** |
| Community engagement and participation perception macro level county A |
| Community engagement and participation perception macro level county B |
| Community engagement and participation perception meso level county A |
| Community engagement and participation perception meso level county B |
| Community engagement and participation perception micro level county A |
| Community engagement and participation perception micro level county B |
| **b. Mechanisms of community engagement and participation** |
| Community strategy |
| Health education |
| Outreach services |
| **c. Resources needed for community engagement and participation** |
| Clear governance structures |
| Financing and incentives for meetings |
| stakeholder support |
| **d. Interaction of community engagement and participation with other constructs of governance** |

[3] This approach has been found to be timesaving, flexible, transparent and easily auditable approach for analysing large data sets with many different variables in analysis. It has however criticized for being deterministic, can lead to a reduced focus on depth and meaning and involves extensive learning time prior to its accurate use(Gale, Heath, Cameron, Rashid, & Redwood, 2013). As I was using it for the first time, I had to constantly revise my codes during analysis, which meant I was re-analysing data constantly which was quite frustrating. However, after getting used to it, I found it very useful particularly in discerning patterns and unique emerging perceptions which I could have missed if I had manually attempted to analyse the 49 transcripts.

c) The coded sections were then organized into thematic charts related to the different governance constructs for each study area, by governance level, type of KI ownership for each case study.

d) Analysis was based on identifying / seeking areas of similarity or differences across and within each case study. The aim was to highlight similarities, and/or variations in perceptions of different actors in each case study for the topics analysed, based on their roles/functions within the county. There were therefore three levels of analysis done:

   a. By case study, looking at
      i. Perceptions of each stakeholder group for the different variables being researched;
      ii. Similarities and differences in perceptions for the macro, meso and micro levels of governance for the responses to each interview question; and
      iii. Similarities and differences between the public and non-public KIs perceptions for the responses to each interview question.
   b. Comparisons between the case studies, looking at
      i. Similarities and differences in perceptions for the macro, meso and micro levels of governance for the responses to each interview question; and
      ii. Similarities and differences between the public and non-public KIs perceptions for the responses to each interview question.

Each topic was analysed separately, with specific nodes derived to guide the analysis based on the responses from the interviews. Based on the analysis, overall emergent views were summarized in relation to each of the research questions.

## 3.9 Data validity and reliability

Pope et al (2006) suggest categorize approaches synthesis evidence into four broad groups: narrative, qualitative, quantitative, and Bayesian to enhance validity and reliability (Catherine Pope et al., 2006). Validity is focused on ensuring "appropriateness" of the tools, processes, and data, while reliability is focused on the replicability of the processes and results (Leung, 2015).

To improve on data validity, I applied the following during the research

- I underwent further formal training in qualitative data methods to improve my understanding and application of the study approach. This I conducted at the Kenya Medical Research Institute (KEMRI) Kilifi campus in Kenya.
- By having the experiences research assistant, I was able to have my methods and research process validated in real time.
- The pre-testing of the tool and methods with the 3 national level managers (described in section 3.7.1) allowed me to ensure the methods were able to be applied in the field.

- I ensured the KIs would provide as accurate information as possible by being transparent and open to them about the study and its use and conducting the potentially sensitive interviews (macro and meso level) myself.
- I ensured data triangulation in two ways. First, I ensured the KIs interviewed represented a broad range of health stewards and managers – both public and private – to capture as many different perspectives as possible. This was important not only for validity, but also to improve the generalisability of the results. Second for each KI grouping, I interviewed more than one KI, to ensure my results were not overly influenced by an individual viewpoint.
- Following transcription of the interviews, I shared the transcripts with a few KIs who had issues that were unique, to validate their perspectives. This I was able to do with 3 and 7 KIs in Bungoma and Baringo respectively and received confirmation of the perspectives as had been transcribed.
- Throughout the design, fieldwork and analysis of data, I was constantly consulting formally and informally with experts in qualitative research on my methods, to ensure these were scientifically robust. My supervisor, being well versed in qualitative methods, was particularly helpful in this.

On the other hand, I ensured reliability of the results in several ways:

- I ensured thorough keeping of records and data as it was being collected, to ensure I could revert to a written record whenever in doubt over an issue.
- I sound recorded the interviews real-time, to ensure an accurate recording of the interview process existed
- Transcription of the interviews was done verbatim, not attempting to interpret these in 'my own words'.
- I was constantly consulting formally and informally with experts in health governance as perspectives were emerging, to understand their perspectives of the emerging views – and ensure I am not misinterpreting my data.

## 3.10 Reflexivity

Prior to the commencement of the research, I had worked at the national level in the Kenya health system – a position I left in October 2015 prior to commencing the fieldwork. I was a part of the national level technical support in developing the guidance to the health sector on how to apply devolution in practice. While I did not interact or support either of the case study counties, I recognize that my tacit knowledge about the health sector in Kenya, plus role could influence my opinions, and/or opinions and perceptions of KIs about me and so influence my research. As a result, I constantly had to adopt a reflexive approach,

constantly exploring and questioning my design, application and analysis of the data to ensure my own assumptions and motivations are not influencing these.

During the preparatory and design phase of the study, I had different approaches to address this. First, I formally re-oriented orient myself with qualitative research methods formally to ensure my knowledge and skills were up to date. Second, I worked very closely with my supervisor during the study design, who constantly reviewed my design to assist me identify and correct for potential biases. Finally, presented and discussed my research method with an informal group of Kenya based researchers who knew about my position, and so were reviewing it from the perspective of identifying potential areas of bias. This helped me for example in the selection of the case studies, as it ensured I had no previous work experience with the selected ones. It was also through this process that the idea of working with an experienced research assistant arose and I was also able to modify the way I was asking my questions – making them more open ended than I had earlier intended.

During the fieldwork, I had the research assistant with me for my initial interviews, with the micro level managers. This again was to assist me to ensure I maintained an unbiased approach in data collection. I only conducted the interviews on my own at the macro and meso levels, where I felt the need for privacy outweighed any personal biases I may have had, and I was more confident in the approach to the responses. By recording, and transcribing the interviews verbatim, I was aiming to avoid my personal opinions influencing the way I recalled the interviews.

In data management and analysis, I also chose to analyse the data using the framework approach of NVivo, as this presented me with a fixed analytical method to allow for emergence of themes from the data – not my own views driving these themes. I did not commence any analysis till I had completed all the data again to avoid the possibility of my opinions being analysed, as opposed to the emerging views from the KIs. I discussed the emerging themes from the framework analysis with a different qualitative research expert to first get their interpretation of the data and compare this with mine. Only after this did I commence consolidation of the emerging views against each objective.

I therefore believe the research design, analysis and findings are an appropriate reflection of the views of the KIs, with limited influence from my own positionality, and beliefs. Indeed, the direction of the study findings I elaborate in the discussion is not in line with my original beliefs about governance. Prior to the study, I had a strong perception of governance influenced by the WHO description of stewardship (Travis et al., 2002).

## 3.11 Ethical considerations

The research is useful in informing the health sector on how it needs to structure its interventions in governance to achieve health results. The understanding, and application of governance is not only technically challenging, but also a politically sensitive topic for stewards and managers. Perceptions about governance quality have real life consequences on managers and stewards, making them quite defensive in any analysis. A health steward or manager may, for example through highlighting governance failings of their superior, find their career or influence curtailed. They are potentially grappling with professional (to talk honestly) versus personal (to talk without jeopardising their position) conflicts. My study, and others focusing on this area therefore must walk a tight rope of trying to scientifically discern patterns and issues that we believe will improve health and wellbeing of people, in a manner that is forthcoming to the same people that will act on the potentially critical results. This creates an ethical dilemma – full scientific independence and producing whatever results emerge, versus adjusting the scientific approach in a manner that takes away any possibility of criticism from the stewards and managers, so they can be free to express their views.

I took a middle ground in my research, ensuring the research methods were scientific, but choosing and applying them in a manner that maintained the interest and focus of the stewards and managers as respondents.

First, the use of KIIs as an interview method was sound, as it allowed me have private discussions with the interviewees. I did not feel other methods such as focus group discussions would be ethically appropriate and so I did not employ them.

Second, I emphasized and showed interviewees how our discussions would be fully anonymized, with minimal potential for them to be identified. I carried out most of the interviews (33 out of 49) alone and shared the transcription and analytical approaches to coding of the interviewee identifiers[4], and password protection of all my data with them. It was interesting that many of the interviewees who I thought would want full anonymity were not worried about their views being public. I assumed this was because they had already been expressing some of these views amongst their peers at the county level.

Third, I engaged the KIs who had strong views after transcription of the interviews. I shared with them the transcribed interviews, to ensure they agreed with what I was going to analyse. This further built confidence between me and the KIs.

[4] The coding of KIs was done in a manner that ensures someone is not able to directly attribute a response to a given individual, even though they know they were interviewed. The coding only allows identification of a given case study (Baringo or Bungoma), management level (macro, meso or micro) or institution (public, or non-public) but not the individual KI.

Forth, I had the study design reviewed by two independent Ethical approval bodies – from the LSHTM and from Kenya. There were 3 iterations of the proposal before ethical approval was fully granted, with changes requested focusing on strengthening the anonymity aspect of the study.

Fifth, I committed to, and on approval of this research will proceed to share it with the two case studies particularly focusing on recommendations for action. I also intend to share the recommendations with the Kenya Ministry of Health, after having anonymized the counties to maintain their confidentiality for guiding their actions in improving health governance application. Through this, the KIs were sure there was a clear benefit derived for them from participating in the research. I also will have to do this in a manner that does not betray the KIs confidentiality.

Sixth, by not focusing on one aspect of governance but rather looking at it holistically, the KIs felt more confident and willing to participate and share their views. I was informed by numerous KIs (both public and non-public) that they are tired of people thinking governance is just about corruption. This broad focus helped significantly in building confidence and openness with the interviewees and allowing them to overcome potential misgivings.

By the time I commenced the research, I was confident that the methods I had chosen would allow me to explore this very difficult topic in a manner that would limit possible ethical challenges. The study was designed to keep the KIs in a manner that allowed them share views openly, while maintaining ethical principles of autonomy for the research, prevention of harm to participants, and promotion of clear benefit for participants

# 4. CHAPTER 4: RESEARCH FINDINGS

The range of issues explored in the study need to be presented in a systematic manner. While the data was collected by case study, I present the results by each governance construct analysed. This is for ease of follow up, as presenting the results by construct from each case study together allows an immediate illustration of commonalities / differences between them. For each governance construct, I present the findings against each study objective. For each presentation, I highlight the common themes emerging, then specify any differences in findings from the different case studies, and/or the different stewards / managers. For the first study objective 1 – how the KIs interpret the different constructs of governance, I present the interpretations as reported by the KIs, and highlight any differences in interpretation.

For the second study objective 2 – identification of actions the health sector stewards need to prioritize, to strengthen the effect of improving governance on health results – the KIs reported a multitude of methods. I captured each method mentioned, as I was not aiming to apportion weights to methods based on reporting frequency. I classified the different methods mentions into those promoting instruments needed, and those proposing actions to be taken. The instruments proposed were either legislative of policy based on who is producing them – legislative produced by the political stewards (e.g. parliamentary committee), and policy produced by technical / administrative stewards. On the other hand, actions to be taken were either establishment of structures (tangible products such as such as a guideline, committee, or forum), or processes (intangible products to improve ongoing activities, such as building capacity).

Finally, for study objective 3 – identification of actions the overall government needs to prioritize to strengthen the effect of improving governance on health results – I compared the findings against the 5 constructs that were found to be facilitative to governance actions (see table 2.4), to identify which governance constructs were associated with the different facilitatory constructs. These constructs are community engagement, sustainable economic opportunities (social capital), decentralization reform and the right to health. The overall structure of the results is shown in the table 4-1 below.

**Table 4-1: Structure of presentation of results from the study**

| | **Section 4.1** Voice and accountability | **Section 4.2** Political stability | **Section 4.3** Government effectiveness | **Section 4.4** Regulatory quality | **Section 4.5** Rule of law | **Section 4.6** Control of corruption |
|---|---|---|---|---|---|---|
| Understanding of the construct | | | | | | |
| Actions by the health sector to improve effect of the construct | | | | | | |
| Actions by other sectors to improve effect of the construct | | | | | | |

I first present the overall perceptions of health governance from the two case studies.

## Overall perceptions of health governance

Prior to exploring the different governance constructs, I first sought to understand how the KIs perceived governance overall. The general perception of what governance entails focused on the presence of structures institutions, together with the processes lines of responsibilities and tools to provide direction in the health sector. This perception differed as one moved from the macro level stewards to micro level managers, with emphasis moving from a normative understanding at the macro level, towards a descriptive understanding at the micro level. This is illustrated in figure 4-1 below.

**Figure 4-1: Perceptions of governance from the study**

| **PRESENCE OF STRUCTURES, INSTITUTIONS, DIRECTION AND PURPOSE IN HEALTH** | | |
|---|---|---|
| *Macro level stewards*<br>PRESENCE AND FUNCTIONALITY OF STRUCTURES | *Meso level stewards / managers*<br>CLEAR HIERARCHY / ROLES & RESPONSIBILITIES | *Micro level managers*<br>APPROPRIATE GUIDANCE AND ACTIONS |

There were variations in perceptions across the case studies.

### Perceptions from County B (inefficient) case study

The unique perspective that emerged was on characterising the structures, institutions and direction provided as highlighted by one meso level public-sector KI *"when you talk of governance in health that means the structure, the leadership, how activities are organized, planned and executed. Do they meet the standard or they don't meet the standards"* (**KI-1**). At the macro level, this characterization was highlighting the need for the system to put in place the *technical mechanisms* needed to ensure *functionality* of the institutions and systems to guide the delivery of services, as quoted by one macro level non-public KI "*the partner coordination mechanism, the CHMTs, health facility management committees and boards. So are they functional, are they playing their roles, are they in existence?"* **(KI-1).** The focus at the meso level was on organization not functionality of these institutions and structures, while at the micro level this was on the policies and guidance to ensure things are done the way they should be done.

### Perceptions from County A (efficient) case study

In contrast with County B, the focus of the KIs in this case study was more on the presence of the institutions – from the decision-making level to the community. One non-public micro level KI puts this perspective quite succinctly as "*it is the whole system of admin, & leadership & management; it is to do with management of the institutions, for productivity and efficiency* **(KI-1**). Similarly, as with County B case study, the focus at the stewardship level was more on the presence of these institutions, while at the micro level on their functioning.

## 4.1 Findings for voice and accountability

This is focused on the extent to which the population can participate in decisions relating to provision of health services. I present the understandings of the KIs, actions by the health sector to improve effect of the construct and actions by other sectors to improve effect of the construct. These I present for each case study, and then a combination of the findings from both to consolidate the perceptions arising from both the case studies.

### 4.1.1 Understandings of voice and accountability

The findings from the two case studies slightly varied in terms of the understanding of this construct.

#### *Perceptions from County B (inefficient) case study*

In this, it was perceived to relate to how *responsive* the health sector and its interventions are, to the needs of the people. This perspective was permeating from all the KI stakeholder groups.

At the primarily stewardship level (macro), the responsiveness of the health sector was perceived from the perspective of how to ensure the system is ***designed*** to take care of the population needs. This focus was on the design of institutions guiding service provision, ensuring these can allow responsive service provision to the population. This perspective is reflected in this quote from one of the non-public KIs, who defined accountability as '*How people do their things – the financial; infrastructure; human resources, and supervision systems to help give people services they are asking for – they need* **(KI-2)'.**

The perspective at the other management levels however looked at the responsiveness, not from the system design but from the implementation actions that are carried out during implementation, to ensure the services are responding to the needs. Again, this perspective is reflected in this quote by a meso level non-public KI who defined accountability as '*Executing service delivery according to plan; to expectations; a systematic way of documenting the need, the process of selecting suppliers and purchasing.* **(KI-1)'.**

#### *Perceptions from County A (efficient) case study*

In the 'good performing' case study, this was perceived to focus on the obligation that the stewards have, to those that require the services. As one macro level public KI out it, '*It is an obligation to serve* **(KI-1).** The recipient of this obligation however varied across the KI groups. At the macro level, the perception was stronger that this obligation was to the government and the appointing authorities who bear eventual political responsibility for the results of the sector actions. This perspective was well reflected by one macro level public KI, who defined accountability as '*How accountable to the governor we are. the governor appointed us, the assembly approve our work through progress reports. a part of performance, part of the job* **(KI-2**). Accountability to the population is thus an indirect responsibility of the health stewards, as they should prioritise accountability to their appointing authorities, who are the ones directly accountable to the citizens.

At the lower levels of management however, the obligation was perceived more direct towards the recipients, and was an opportunity for them to monitor and hold the health sector accountable to provision of their expected needs. These recipients were not only limited to the citizens, but also to peers to ensure they are adhering to set standards in service provision.

#### *Combined interpretation from both case studies*

Results from both case studies bring the two aspects of 'answerability' and enforcement as necessary for voice and accountability. The answerability perspective was emerging from both case studies, while the enforcement perspective was primarily from stewards in the 'good performing' case study.

My findings suggest ***a gap in the understanding of voice and accountability*** seen in the poor performing case study and in the management levels in the good performing case study. In these, they limit their understanding to the 'answerability lens' of voice and accountability, with little evidence on the need for the 'enforceability capacity of the system'.

It is important to emphasize voice and accountability should also focus on the enforcement capacity needed to ensure the interventions lead to actual responsiveness to the population. This is seen in practice, where there are usually good mechanisms on paper, but lack of enforcement capacity means there is limited responsiveness to the population needs. Additionally, gaps in accountability are accentuated by the 'lack of interest' by some population members in holding stewards / managers to account. As seen in the literature review, the relationship between health stewards / managers and the citizens is best described in a principal / agent relationship, with stewards are assumed to work in the interests of the population who are reluctant to take up their accountability responsibilities (see section 2.3.1). At times, stewards (and their institutions) have their own interests that may not always be aligned with the interests of the population, and therefore are not effective agents for them. Gaps in accountability therefore exist as appropriate accountability is not practiced – even in the presence of answerability systems.

### 4.1.2 Expected actions by the health sector to facilitate voice and accountability

A range of different actions the health sector can take were highlighted from the KIs.

#### *Perceptions from County B (inefficient) case study*

This need for health sector driven mechanisms that assure voice and accountability was universally acclaimed by the KIs, with a meso level non-public KI mentioning '*Everything should be done in the open and good participation. It allows a systematic and participatory way of documenting the need, the process of selecting suppliers and purchasers.* **(KI-4)'.**

A total of 7 different supportive mechanisms were highlighted in this case study, all aimed at ensuring there are formal process and systems in the community and health sector to hold stewards to account. These

included the presence of (i) effective supportive supervision mechanisms; (ii) regular financial reports; (iii) establishment of formal MOH community health units; (iv) functional community-based organizations; (v) functional stakeholders' forums; (vi) community health forums and dialogue processes; and (vii) functioning facility oversight committees.

There was no discerned pattern in the mechanisms mentioned amongst different KI groups.

### *Perceptions from County A (efficient) case study*

The KIs from the good performing case study also highlighted several mechanisms that would accentuate the actions relating to improving accountability to the population. These included: (i) having stakeholders forums to bring together all actors to review performance; (ii) use of community health forums/dialogue mechanisms for targeted engagement with specific communities and groups; (iii) having in place Adequate capacity for laws enforcement; (iv) using appropriate planning and monitoring tools for health; (v) establishing and supporting effective supportive supervision processes; (vi) establishing systems for performance appraisals; (vii) taking advantage of chief's baraza's (gatherings) to listen to communities; (viii) ensuring there is adherence to financial management procedures; and (ix) ensuring functional facility oversight committees.

The KIs with both stewardship and management functions however highlighted more of health sector management mechanisms in contrast to the other levels of where emphasis was on the wider management mechanisms relating to engagement, legal processes and others outside the control of the health sector.

### *Combined interpretation from both case studies*

Various, distinctly different mechanisms were highlighted from the KIs across the two case studies, with no distinct difference in the kinds of mechanisms across the two case studies. These represent the full range of the policy/legislative instruments, and the tangible/intangible nature of mechanisms. I summarize them in table 4-2 below.

**Table 4-2: Classification of health sector actions needed to improve voice and accountability**

| | **Policy instruments** | **Legislative instruments** |
|---|---|---|
| **Structures / tangible products** | ▪ Formal MOH community health units<br>▪ Facility oversight committees<br>▪ Community based organizations<br>▪ Stakeholders forums | ▪ Regular financial reports |
| **Processes / intangible products** | ▪ Appropriate planning, implementation and monitoring processes<br>▪ Dialogue processes<br>▪ Effective supportive supervision<br>▪ Performance appraisals | ▪ Adherence to financial management procedures |

### 4.1.3 Expected actions by other sectors to facilitate voice and accountability

#### *Perceptions from County B (inefficient) case study*

Building the community's capacity to act was highlighted by KIs. In many instances, the community representatives are not interested or knowledgeable enough to engage and ask the right questions. This improvement in community's knowledge and capacities is a government wide function that needs to be scaled up; a position well captured by this quote from a meso level non-public KI '*Communities don't know their roles. They just sign participation lists to fulfil the requirement, but none of them understands that budget or that process, so they cannot interrogate it or suggest more effective ways of achieving better health outcomes* **(KI-3)'.** Building the community's capacity means they are able to 'ask the right questions'.

The additional perspective relating to governments capacity to be accountable was raised from the perspective that the health sector needs to be aware of and participate in wider government accountability mechanisms as communities judge government, not by sectors. As such, voice and accountability stand a better chance of succeeding if it is aligned with wider government accountability mechanisms, as communities will judge the health sector even for challenges in other sectors. This perspective from a meso level public KI captures this quite succinctly '*The population is not receiving the service, so they start querying – is our money being eaten? For County B, you heard the issue of the wheelbarrow. We don't have drugs and you are buying a wheelbarrow at 109,000! We reach a place where even sometimes patients don't have food. You know when the community look at it they feel like we are betraying them.* **(KI-1)'.**

#### *Perceptions from County A (efficient) case study*

The perspective here was different, focusing on the need to establish, and use mechanisms that put in place channels for three-way communication across communities, health actors and political actors. Without these communication mechanisms, there will always be misperceptions, as currently these actors are engaging separately. The effect of lack of this is well captured by one macro level public KI, who said '*Because of lack of communication between us and them… so the leaders come in here and they want to push what they think the population wants* **(KI – 3).** Such three-way forums for communication and engagement could be formal, and/or informal channels that allow information flow amongst these three groups.

#### *Consolidation of findings from both case studies*

Three general themes arose from the responses of the KIs, which would improve the effect of voice and accountability on health results: actions that improve the community's capacity to express their voice and demand accountability; actions that strengthen the overall governments capacity to be accountable; and actions that improve communication across communities, health stewards / managers and political actors.

The first theme seems closer to the construct of community engagement, as the responses were focused on how to build the community's voice and capacity to interact in the health sector.

On the other hand, the second theme resonates well with how well the overall government is accountable and responds to the local needs of the people. The example of the wheelbarrow scandal exemplifies this quite well – the entire government accountability has a strong effect on households and communities' perceptions of their government and by extension the health sector. Transparency enables creation of a democratic dividend that enhances the effects of voice and accountability.

The final theme also elaborates on the democratic gain by emphasizing the role of participation in the decision-making process.

Thus, the perceptions of the KIs focus on the wider government actions relating to constructs of community engagement, and democracy / participation.

## 4.2 Findings for political stability

This is focused on the extent to which health stewards and managers have both the mandate and support from the wider government to lead the health agenda and can make decisions based on this. I present the understandings of the KIs, actions by the health sector to improve effect of the construct and actions by other sectors to improve effect of the construct. These I present for each case study, and then a combination of the findings from both to consolidate the perceptions arising from both the case studies.

### 4.2.1 Understandings of political stability

The KIs from the two case-studies all perceived steward stability as an important construct based on it allowing for continuity of actions planned. However, the data pointed to some differences in interpretation of the continuity.

#### *Perceptions from County B (inefficient) case study*

The KIs highlighted the need for stability of staff and to reduce turnover of both stewards and service provision staff. It is important as it allows staff adequate time to implement their goals and plans, as each time there is change there are differences in focus and goals making it difficult to attain any results. The reportedly high staff turnover at the stewardship level in the county since its formation was reported as one of the hindrances to motivation and performance in the county, a perception well reflected in this quote from one of the macro level non-public KIs '*From 2013 we are having the third director of health services. This has caused anxiety with most people looking for greener pastures elsewhere* **(KI-2)'**. This perception relating to the definition and importance of steward stability was noted across all the KI groups.

The level of political interference in the stewardship, with people being changed for political, not technical reasons, was a hindrance to effective health governance. The public political level KIs at the stewardship level were of a different view, blaming the frequent changes of staff to poor management skills by stewards '*The county management needs to also be open when its handling employees of health sector. You see, it also raises – creates bad working environment'* **(KI-3).**

#### *Perceptions from County A (efficient) case study*

In contrast to the previous case study, the perception about steward stability was more focused on the stability of the system, and its capacity to allow continuity of expected functions irrespective of any changes or shocks it is subjected to. The focus was on the ability of the system to allow continuity of functions, independent of the individuals and/or how often they are changed as captured by one macro level public KI '*It is leadership and directions, with system continuity rather than person continuity. Because you don't want changes all the time there is a new person'* **(KI-2).** This perception was further elaborated on in different ways at the 3 levels of management.

At the macro (stewardship) level, continuity of the functions was perceived to function where there are clear roles and responsibilities for different actors – together with contingency mechanisms in case one link in the chain is broken. By people knowing their roles clearly, with limited overlaps, continuity and stability can be attained even when there is movement of staff. On the other hand, the meso and micro levels perceived this process continuity from the perspective of how much autonomy given to managers to make appropriate decisions on the go. Higher levels of autonomy allow them act when there is a threat to system stability. This perspective was well reflected in the definition by one of the meso level public KIs, who looked at steward stability as '*leadership allowing freedom of lower levels to make decisions… so providing a stable working environment'* **(KI-3).**

***Consolidation of findings from both case studies***

The understanding of steward stability from the need to sustain continuity irrespective of the challenges the system is facing is a common theme from the different KIs. This is irrespective of the fact that there were variations in the perception of what this concept of continuity meant - continuity of individuals (poor performing case study) and the system (good performing case study). I reflect these as two different perspectives of the understanding of steward stability. This continuity was characterized in a number of ways, such as less political interference, establishment of strong independent structures, and allowing adequate decision space without interference in decision making. The stewards need to ensure this wide perspective of continuity are assured for steward stability to contribute to good governance.

### 4.2.2 Expected actions by the health sector to facilitate steward stability

The mechanisms for health stewards to strengthen steward stability were quite numerous from both case studies, though there were several overlaps.

***Perceptions from County B (inefficient) case study***

The KIs referred to 6 supportive mechanisms to accentuate the actions of steward stability. These included: (i) mechanisms to ensure good quality and effective managers are in place; (ii) systems to enhance teamwork; (iii) presence of dialogue processes to address conflict; (iv) functional staff motivation processes; (v) functional facility oversight committees; and (vi) presence of effective supportive supervision systems. Most of these mechanisms relate to good management practices being followed, from the recruitment through to management and supportive systems.

The different KIs placed emphasis on different mechanisms. At the macro (stewardship) level, the mechanisms that focused on ensuring there are good quality managers who can effectively communicate with, and motivate their staff were perceived most important to create steward stability. On the other hand, at the management level the perceptions are more related to teams working closer together and with

communities as creating the steward stability needed to impact on governance, as captured by one meso level public KI who said '*We don't do the boss kind of relationship. We are all at the same level. That keeps the team stable and happy* **(KI-5).**

### *Perceptions from County A (efficient) case study*

On the other hand, 8 different health sector specific mechanisms were highlighted by the KIs in the good performing case study. These included: (i) presence of adequate capacity for law enforcement; (ii) staff motivation measures; (iii) systems to enhance teamwork; (iv) effective supportive supervision; (v) functional mechanisms for facility/community communication; (vi) presence of good quality and effective managers; (vii) functional facility oversight committees; and (viii) presence of effective dialogue processes. The different KIs placed emphasis on different mechanisms. The non-public KIs were the ones that highlighted the informal mechanisms such as teamwork and dialogue, while the public KIs highlighted the more of the formal mechanisms.

### *Consolidation of findings from both case studies*

A total of 14 different mechanisms were highlighted from the KIs across the two case studies for improving steward stability. These were focused more on policy as opposed to legislative instruments, with the legislative instruments only mentioned once. I summarize the combined responses in table 4-3 below.

**Table 4-3: Classification of health sector actions needed to improve steward stability**

| | **Policy instruments** | **Legislative instruments** |
|---|---|---|
| **Structures / tangible products** | ▪ Facility oversight committees | ▪ |
| **Processes / intangible products** | ▪ Mechanisms for facility/community communication<br>▪ Effective supportive supervision<br>▪ Enhancing teamwork<br>▪ Good quality and effective managers<br>▪ Staff Motivation processes | ▪ Adequate capacity for laws enforcement |

### 4.2.3 Expected actions by other government sectors to facilitate steward stability

### *Perceptions from County B (inefficient) case study*

From the KIs, the key contextual mechanism influencing steward stability related to the form and quality of political influence. This was affecting performance and ability to achieve health goals, as captured by one macro level public KI who said '*Everything here is about politics. For example, the health workers strike was driven by politicians. Fahali wawili wakipigama myasi ndio huumia (when two bulls fight, it is the grass that feels pain)* **(KI-4).** The politicians made decisions about recruitment – at least for macro level stewards – and

allocation of resources. As such, the political influences are twofold; one about how decisions about health workers performances, and the other about support to stewards functioning.

Current methods for assessing and managing stewards by politicians are driven by political exigencies and not technical performance, with a result that stewards are frequently changed even when they are performing, and those not changed are not productive as they also do not know when they may also be changed limiting stability of stewards. One of the non-public KIs captured this sentiment when they mentioned '*Promotions are not done because of merit. People with good performance are still circulated to other departments, while those with political affiliations are promoted* **(KI-2)'.**

Secondly, politicians are making resource allocation decisions based on political, not technical needs. Funds are allocated where there is political gain to be made, not technical gain. It is important that allocation decisions are driven by ensuring availability of tools and support to steward service delivery. Steward stability is enhanced when they have political support and budgets needed to perform. Stewards are motivated to perform when they have staff, drugs and supplies they need.

### *Perceptions from County A (efficient) case study*

The KIs emphasized the need for processes that ensure the right technically competent and appropriately skilled stewards are identified and selected in the first place would enhance the action of steward capacity. A lot of the instability in the stewards and institutions is directly related to selection of stewards lacking the political, technical and/or managerial skills required for the position. This perception is captured in this quote from one of the macro level public KIs '*Some take advantage of the fact that the CEC does not have a background in health for example to alter procurement orders. it is better now when they changed with the chief officer who is a public health officer having a master's degree* **(KI-1)'.** If their selection and performance is competently managed, then there will be appropriate stability in the system. Approaches to achieve this that were mentioned include:

i) Having clear requirements for health stewards, with processes that are independent of political considerations used for identification and performance appraisal;

ii) Ensuring stewards selected have the correct technical capacity for the work expected. Technical incompetence affects their confidence, and introduces malicious behaviours that reduces productivity of other staff, such as unnecessarily penalising staffs; and

iii) Giving stewards and managers authority to make decisions and take responsibility for them.

### *Consolidation of findings from both case studies*

There are two ways of looking at the findings from the KIs.

First, is that the quality of democracy is an important factor. This is seen in both case studies, where they highlight the fact that the lack / absence of appropriate incentives to force stewards to make the correct

decisions hinders steward stability. Having decisions primarily driven by political exigencies and the politics of survival is a function of a poorly executed democracy. If a democracy is supposed to work effectively, the decisions arising from its agents need to be made for the benefit of the people, and not for the decision makers.

The second perspective from which to view the findings is from the need to allow the managers space they need to manage services. The elected leaders should reduce the level of interference in the sector, giving the health stewards / managers appropriate decision space to act. This relates to the quality of decentralization, focusing on the decision space actors at a given decentralized level have amongst each other to carry out their functions. When services are devolved, as in the Kenya context, there are multiple actors within a given level of devolution and the sharing of the devolved power and responsibilities needs to be done in a manner that allows the actors the needed space to carry out their devolved functions. To a health manager, decentralization may not give them the level of stability they need if they end up with less decision space because authority has just shifted from a central authority to the county administration.

Steward stability therefore appears linked to two of the constructs influencing governance – decentralization, and democracy / participation.

## 4.3 Findings for government effectiveness

This is focused on the extent to which the structure, culture, and actions of the government health stewards are facilitative of the attainment of desired health results with a clear evidence-based decision-making culture being practiced. I present the understandings of the KIs, actions by the health sector to improve effect of the construct and actions by other sectors to improve effect of the construct. These I present for each case study, and then a combination of the findings from both to consolidate the perceptions arising from both the case studies.

### 4.3.1 Understanding of government effectiveness

#### *Perceptions from County B (inefficient) case study*

At the various levels of management, the perceptions varied about what government effectiveness was about. However, the common thread running through the different perceptions related to the performance of government against expectations. At the macro level, this interpretation was perceived to mean how well the bureaucracy can achieve set health targets. At the meso level, the perception about government effectiveness was more about how well the bureaucracy is able to facilitate the delivery of required health services through supporting establishment of the required structures and facilitation, as captured by one of the public level KIs '*Structures have been properly set up – facilitation for supportive supervision, drugs and non-pharmaceutical supplies.* **(KI-4)**'. At the micro level, the emerging perception related more towards how well the bureaucracy can mobilise required resources to facilitate public and private service provision, as aptly stated by a public KI '*Be effective, with no cause for shortage of resources.* **(KI-2**

It was however interesting that the KIs at the lower management levels tended not to perceive themselves as part of the government that needed to be effective. They referred to the higher levels of management – the macro and meso levels – as the government that needed to be more effective.

#### *Perceptions from County A (efficient) case study*

There was an interesting perspective that arose in relation to government effectiveness in the county. KIs defined this from the perspective of the timeliness of government action. Government was perceived to be effective when it was doing what was expected, and at time it was expected to do, as captured by this macro level public KI, who defined government effectiveness as '*Basically doing the right thing, at the right time, in the right measure, and the right proportion* **(KI-1).** This perspective was not only seen in the public KIs – one of the private meso level KIs defined it similarly as '*The government does the work it is expected, and ensures the work is done in time and is monitored* **(KI-1)'.** Many times, government will do something that is needed very late, when the effect or need is no longer urgent. This cements the perception of it being ineffective, even though the right thing was eventually done. Drugs, equipment, staffs and other needs demanded for

service provision are known to come very late and in an uncoordinated manner, perpetuating the perception of ineffectiveness even when the government is responding to the expressed needs. This timeliness definition of government effectiveness was expressed in relation to both availing of inputs and supplies, and in provision of required services to the population.

#### *Consolidation of findings from both case studies*

The understandings of this construct were related to the ability of government to do the right thing (poor performing case study), and to do it right (good performing case study). The actions of government should be measured in this perspective. It is a perspective that takes the discussion of government literature from a process discussion to a results discussion. It adds to the existing interpretation of government effectiveness, which has been largely described from a process perspective – the presence of both institutional capacity, and processes needed to ensure government is doing what people expect, in a systematic and participatory manner (Yang & Holzer, 2006). This understanding of government effectiveness takes it beyond the process perspective to a focus on why this capacity is needed (to do the right thing and do it right). The way government is organized, and its institutions structured need to ensure it can do the right thing rightly.

### 4.3.2 Expected actions by the health sector to facilitate government effectiveness

#### *Perceptions from County B (inefficient) case study*

The KIs mentioned a total of 6 different health sector mechanisms that would accentuate the actions of any interventions to improve government effectiveness. These included the presence of (i) adequate resources and allocations; (ii) good quality and effective managers; (iii) clear management structures and processes; (iv) financial devolution; (v) capacity building initiatives; and (vi) effective supportive supervision processes.

It should however be noted that adequacy of resources as a key mechanism to ensure government effectiveness was only highlighted by public-sector KIs. Gaps in resources were noted by the public KIs as a key impediment to assuring government effectiveness, with the stewards being unfairly judged as ineffective, when resources were inadequate; a perspective well captured by this quote from one meso level public KI '*The community feels like you do not want to visit them, when you actually would like to visit them but you don't want to tell them that I do not have transport. So you just tell them you will come, and when you don't go they say you are not effective.* **(KI-3)'.**

At the other end, clarity of management structures and processes was a supportive mechanism only mentioned by non-public KIs. There was a perception that there was a lot of overlaps of job descriptions and functioning as a result of the absence of clarity of roles and responsibilities of different managers made it difficult for the government to be effective, as captured by this meso level non-public KI '*If you have*

*people there, and you say these are managers and those managers have no specific job descriptions. You will not hold them accountable* **(KI-2)**'.

Apart from these two, the other health sector supportive mechanisms were mentioned with no emphasis by a given stakeholder.

### *Perceptions from County A (efficient) case study*

The KIs mentioned 6 distinct health sector supportive mechanisms that would accentuate the action of government effectiveness. These included: (i) presence of adequate resources and allocations; (ii) functional management oversight committees; (iii) having appropriate planning and monitoring tools; (iv) clear management structures & processes; (v) capacity building for stewards, and (vi) effective and functional supportive supervision systems.

Capacity building was a common mechanism mentioned by all the categories of KIs. It ranged from improved training, construction of additional facilities, mentorship and motivation schemes as important mechanisms that would improve the effectiveness of government. Additionally, the need for management oversight committees was highlighted in the public-sector KIs as key. Of note was the need for these to be constituted from both public and non-public actors for effectiveness. The management oversight committees were mentioned as different from the facility oversight committees in being focused on coordinating the implementation of priorities that are agreed at the facility oversight committees.

### *Consolidation of findings from both case studies*

I see several mechanisms highlighted would improve government effectiveness, primarily policy instruments These are all summarized in table 4-4 below.

**Table 4-4: Classification of health stewards' actions to improve government effectiveness**

| | **Policy instruments** | **Legislative instruments** |
|---|---|---|
| **Structures / tangible products** | ▪ Clear management structures & processes<br>▪ Management oversight committees | ▪ Financial devolution |
| **Processes / intangible products** | ▪ Appropriate planning, implementation & monitoring processes<br>▪ Adequate resources and allocations<br>▪ Capacity building<br>▪ Effective supportive supervision<br>▪ Good quality and effective managers | ▪ |

Again, most of the proposed mechanisms are processes as opposed to establishment of structures. Both case studies highlighted issues of resources, support to management structures and processes, skills building, and support to supervision and mentoring processes. Without adequate funds, the stewards cannot implement the required actions needed. Management structures and processes at all levels of stewardship are appropriate for guiding focus, actions and responsibilities of the different stewards to ensure their

actions are complementary. These would relate to the appropriate institutional systems and mechanisms – organograms, staff management, political support – needed to make the government effective. Skills building particularly in leadership and management are quite important, as stewardship expectations are constantly changing. And supportive supervision is critical in ensuring constant engagement with the implementation level, for guidance and improving morale.

### 4.3.3. Expected actions by other sectors to facilitate government effectiveness

#### *Perceptions from County B (inefficient) case study*

From the feedback from the KIs, it was clear there is need for close oversight of the health stewards by the wider government entities, to ensure effectiveness of functioning is achieved. This oversight needs to be provided in a manner that can ensure support to, not spying on the health stewards that ensures they are focused and effective in their actions. A number of options were mentioned, including making sure financial management and allocation systems are transparent; putting in place mechanisms for continuous sensitization of health stakeholders to changes and challenges, and their relationship to wider government priorities – ensuring the health stewards are being recognized / blamed for the right actions; reviewing constantly, and providing guidance on the stewardship structures and teams expected to be in place; and actively putting in place mechanisms to strengthen trust and collegiate working between political and technical teams. There were no discernible differences in factors reported between public and non-public KIs amongst the responses.

#### *Perceptions from County A (efficient) case study*

To ensure effectiveness of government, the KIs highlighted a need for different processes and mechanisms that will ensure institutional government oversight and support is provided to the health stewards. Four different approaches were proposed for government effectiveness. First, was by ensuring political oversight is supportive, not antagonistic to actions of the health stewards. Second, the need for supporting operationalization of a functional organogram that allows people to be held accountable for clear results. Many times, the stewards define the appropriate structures to facilitate service provision, but these are stifled at the wider government levels, due to bureaucratic, or political patronage challenges. Third, the option for putting in place transparent performance appraisal mechanisms across the public service, which would recognize and reward performing stewards – and mitigate against laziness and corruption. Finally, the need for acting on requests to address identified challenges and gaps in service provision, such as shortages of staff, infrastructure, drugs or supplies.

### *Consolidation of findings from both case studies*

The feedback from the two case studies was common in focusing on the quality of governance in the wider government. The need for the wider government to be supportive – not punitive – and have in place processes needed to support the health steward effectiveness was clear. This perspective is not directly linked to any of the 5 constructs identified as influencing governance.

However, a link to decentralization is also present, particularly in relation to the responses calling for regular guidance to stewardship systems and building trust and collegiate working relations amongst colleagues. Decentralization aims not only to shift authority and responsibility to levels closer to the population, but also to make administration clearer and easier to manage. As I had highlighted in the literature review, Liwanag and Wyss (2018) highlighted the need for certain conditions for decentralization to improve health sector performance, and gave examples of open decision making and resource allocation, good relations, promotion of innovation and central level support as some of the factors that make decentralization work (Liwanag & Wyss, 2018). From my findings, I identify these mechanisms further, including continuous communication amongst health actors, building trust across citizens, political and technical teams, having clear organizational structures that are respected at the different levels (avoiding micro management of health stewards) and having clear and transparent means for performance appraisal and reward / sanction tools for all actors including how well follow up of actions highlighted is practices.

## 4.4 Findings for regulatory quality

This is focused on the extent to which the legal and regulatory environment in health is appropriate to provide oversight and guidance to actions by decision makers. I present the understandings of the KIs, actions by the health sector to improve effect of the construct and actions by other sectors to improve effect of the construct. These I present for each case study, and then a combination of the findings from both to consolidate the perceptions arising from both the case studies.

### 4.4.1 Understanding of regulatory quality

#### *Perceptions from County B (inefficient) case study*

The KIs had different perceptions relating to regulatory quality. The general interpretation, however, related to the presence of different health sector instruments needed to guide the provision of services. The instruments highlighted included policies, strategies, laws, regulations, guidelines, and professional codes of conduct. These different instruments all need to be in existence, in a manner that is easy to understand, and capacities to implement them exist.

The focus of instruments however varied at the different management levels. At the macro level, the interpretation was more about the presence and enforcement of official government instruments, specifically the policies, strategies and health laws and regulations. On the other hand, the other levels of management focused more on the presence and functionality of management instruments such as codes of conduct, values, and guidelines needed to ensure services are professionally provided in a manner that is clear and easy to translate to practice.

#### *Perceptions from County A (efficient) case study*

Perceptions from the different KI groups were interestingly uniform about what regulatory quality entailed– the legal and professional frameworks and guidelines that are there and working to guide adherence to professionalism in service provision. They understood this to capture all the different instruments that are needed, to guide the staff in provision of services, as captured by one meso level public KI, who defined regulatory quality as '*the things to guide us, and even the staff in facilities to do the right things and uniformity in work* **(KI-2).** The actual instruments mentioned were varied, and included policies, laws, guidelines, strategies, licences and professional codes of conduct. While these were all mentioned, it was felt there are still many gaps for this to be effective, as reflected by a public KI at the macro level, who said '*We only managed to do one law on alcohol and drug abuse. We want to build all our procedures; our systems into some regulative framework so that we work in a more regulated way* **(KI-1).**

### *Consolidation of findings from both case studies*

The construct was perceived form the results as the mechanisms to put in place the 'rules of the game' that guide service delivery – the presence and comprehensiveness of the policy, legal, and professional instruments that guide the process of service provision. The major new elements introduced by the KIs include expanding the scope of regulatory quality to include professional codes and values, inclusion of all actors in health within regulatory quality and emphasis on factors interior to the management of health, as opposed to a usual emphasis on the exterior factors. I perceive regulatory quality as a construct to define and enforce the rules of the game, crafted by, and applied to all stakeholders.

The quality element of regulation was is difficult to standardize, as there is no standard of 'quality regulation'. The OECD however provides a good way to conceptually perceive quality – by focusing on how regulations are conceived and made (Malyshev, 2006; OECD, 2008). Regulatory quality could therefore be perceived in a wider sense as the conception and application by health stewards of the rules to guide delivery of services for both public and non-public stakeholders. It encompasses the policy, legal, regulatory and professional dimensions to enable comprehensive guidance is available.

## 4.4.2 Expected actions by the health sector to facilitate regulatory quality

### *Perceptions from County B (inefficient) case study*

The KIs were able to highlight at least 6 different mechanisms to accentuate the action of regulatory quality. These included: (i) adequate capacity for enforcement; (ii) presence and use of appropriate planning and monitoring tools and processes; (iii) clear management structures & processes; (iv) effective supportive supervision; (v) functional systems for professional regulation; and (vi) mechanisms for facility/community communication. Presence of comprehensive and adequate policies, plans and guidelines were the most reported mechanism for ensuring regulatory quality. Use of legal tools was only suggested at the macro level, while the meso and micro level focused more on the professional self-regulatory mechanisms.

### *Perceptions from County A (efficient) case study*

Only four health sector mechanisms were mentioned by the KIs, as things that would accentuate the action of regulatory quality. These included: (i) presence of adequate capacity for enforcement of laws; (ii) clear management structures & processes; (iii) appropriate planning and monitoring tools; and (iv) presence of functional professional regulation. As seen, these are mechanisms for regulation, with the emphasis made on the need for the sector to facilitate their functioning.

The presence of comprehensive and adequate policies, plans and guidelines were the most reported mechanism for ensuring regulatory quality, being highlighted by almost all KI groups. In addition, the management structures and processes were proposed at the county and sub county levels as critical in

ensuring regulatory quality is achieved. Many times, the regulatory systems exist but because of poor management processes, these systems are unable to have the desired effect on governance, a position captured in this example from one meso level public KI '*Sometimes it is difficult to coordinate the objectives of the MOH and some partners and staffs. Coping with misconduct, disciplinary cases, absconding duties, people coming to work when they are drunk, talking, counselling, warning, disciplinary measures in full DHMT meetings could work to address these, if well utilised (***KI-3).**

### *Consolidation of findings from both case studies*

The health sector actions to facilitate regulatory quality were largely process related, with both policy and legal instruments suggested as summarized in table 4-5 below.

**Table 4-5: Classification of health stewards' actions to improve regulatory quality**

| | **Policy instruments** | **Legislative instruments** |
|---|---|---|
| **Structures / tangible products** | ▪ Clear management structures & processes | |
| **Processes / intangible products** | ▪ Mechanisms for facility/community communication<br>▪ Appropriate planning, implementation & monitoring processes<br>▪ Effective supportive supervision | ▪ Adequate capacity for laws enforcement<br>▪ Functional professional regulation |

This focus more on processes as opposed to tangible structures is interesting for an area such as regulatory quality, where one would have expected stewards prioritizing of products that can be felt and measured. It comes back to the need for a stronger focus on the descriptive perspective of governance – as we see mechanisms for better communication, supportive supervision, planning/implementation processes that would assist in improving the inter-relationships and interactions within stewards for effective governance.

## 4.4.3 Expected actions by other sectors to facilitate regulatory quality

### *Perceptions from County B (inefficient) case study*

From the responses of the KIs, it was clear that the wider government and stakeholders had a clear role, in facilitating regulatory quality through supporting improvement in capacity for adherence to the different instruments. While the health sector can bring the instruments together, other sectors are needed to support adherence to the expectations of these instruments, for them to be effective. For example, laws on importation and selling of substandard pharmaceuticals can be made by the health sector but can only be enforced by the judiciary and police supporting the health inspectors to arrest and try those breaking this law. This position is well captured by one of the non-public macro level KIs, who said '*You look at the documents they are very clear. If you look at the budget making process that are very clear. If you look at how peoples are supposed to be appointed, I think it is quite clear. But whether they are being adhered to I think is the question.*

*So I would not think laws is actually the solutions here, I think it's more of enforcing the adherence so all the laid down procedures are actually adhered to the letter* **(KI-1)**'.

The other aspect of improving the capacity for adherence of the regulatory instruments relates to improving the knowledge, and skills of health workers in regulatory instruments. At present, these instruments are not effectively understood by health workers. Having a process to better understand what they mean and how they impact on service provision would improve the effectiveness of regulatory quality.

### *Perceptions from County A (efficient) case study*

The requirement to have adequately oriented and knowledgeable staff was highlighted across the study cases as a critical facilitating factor. Most of the skills and competencies can only be provided by actors outside the traditional health sector – such as lawyers. The sectors need to work with these, to build the internal regulatory capacities.

The need to define and ensure application of a comprehensive regulatory framework was also highlighted in the 'good performing' study case – a focus only on select few elements will not lead to the desired influence on governance. This is seen in practice, where partial elements of the regulatory framework exist limit the overall impact. For example: good policies but poor legal framework; presence of laws but no enforcement or regulations; weak professional regulatory frameworks; amongst others which hinder the influence of a regulatory framework on governance and health outcomes.

### *Consolidation of findings from both case studies*

The findings point to two mechanisms. First, is the working arrangements with other government institutions that will support adherence to the rules of the game. Where there are poor working arrangements with these, then the regulatory quality will not have the desired effect as the health legal instruments are not functional. Second, the support provided by the wider government to build / improve the capacity of the health stewards and managers is also coming out from the findings. In some countries, public administration colleges exist to train and build capacity of all the civil service, not just health.

These two perspectives cannot be directly linked to any of the five identified constructs supportive of governance.

## 4.5 Findings for the rule of law

This is focused on the extent to which the decision makers use the existing legal framework to base and guide their decisions and actions. I present the understandings of the KIs, actions by the health sector to improve effect of the construct and actions by other sectors to improve effect of the construct. These I present for each case study, and then a combination of the findings from both to consolidate the perceptions arising from both the case studies.

### 4.5.1 Understanding of the rule of law

#### *Perceptions from County B (inefficient) case study*

The perceptions relating to the rule of law were around the written and unwritten laws governing the rights, dignity and culture of the people, and the capacity to enforce their provisions. These laws, it was felt, were important in providing an overall guiding framework within which any health sector actions need to be carried out.

At the macro and meso levels of management, the perception was focused only on the written laws particularly the provisions of the constitution, and how they guide the delivery of services. The bill of rights was particularly singled out as very important as it constitutionally defines the rights each person is entitled to, including the right to health. The rule of law was perceived to be important, as it was stable and above health sector influence, reflecting the overall aspirations of the people, as captured by one of the meso level public KIs, who said '*It is what makes the system stable. Without law, anybody would do what she or he feels like. We are working based on the constitution of this country* **(KI-2).**

At the micro level, KIs in addition emphasized the importance of the unwritten laws relating to basic human dignity and culture which also assist to shape the health sector actions. The need to empathize, and act in a manner that promotes dignity and not just because it is a responsibility were deemed important unwritten laws that adherence to is important in overall governance, as captured by one non-public KI who said '*It's about saving life, not just saying "according to the nursing council responsibilities, I am not allowed to do this"* **(KI-1).**

Effective governance in health therefore is about how well the stewards can ensure these written and unwritten laws are observed and guide the provision of services.

#### *Perceptions from County A (efficient) case study*

The perceptions about the rule of law were around the adequacy and applicability of the written laws of the land. The perception was largely around how to ensure the legal instruments governing service delivery can guide it appropriately and ensure people are following these. The examples highlighted were the wider government legal instruments needed to guide service provision, with examples given being the

constitution, the bill of rights, public service code of regulations amongst others. Their usefulness was well captured by one micro level public KI, who stated '*Law brings order. Decisions should be made as per the constitution, and the county health bill. It helps you knowing where to reach and where not to reach and which way to make things* **(KI-4).** The non-public KIs also highlighted moral laws particularly guiding mission-based service provision.

The perception was that, while these laws are already defined nationally, it is critical for counties to translate these in practice in line with their specific needs and policies, as captured by one macro level public KI that said '*Laws are there, and good. What is urgent are amendments to fit into the county context. It is a struggle for the national government to allow this.* **(KI-1)'.**

The need for good linkages between the laws, and the regulatory instruments was also highlighted, as these should be well linked. While the laws are designed and enforced by the wider government and the regulations are made and enforced by the health sector, they are all important as they facilitate standardization of the provision of services and so should be well linked. One macro level public KI noted this, saying '*Policies are stronger when they are made into laws, they should be geared towards improved government effectiveness and reduce wastage of resources* **(KI-3).**

### *Consolidation of findings from both case studies*

The perception of this construct was indeed quite interesting, vis-à-vis the previous one on regulation. While the view on regulation was largely around the 'rules' governing service provision, this construct was perceived to focus more on the wider set of laws that are not specific to service delivery, but rather define overall governance focus and principles in the land. The constitution, bill of rights, public service codes of regulation were the kinds of legal instruments being looked at as critical in this context.

It was interesting to note that the perception was not limited to the written legal instruments, but also the unwritten laws relating to basic human dignity morals and culture. This emphasis on the unwritten laws was highlighted in both case studies – by some non-public KIs in the 'good performing' case study and some micro-management level KIs in the 'poor performing' case study. The focus therefore was on how well the health sector managers are adhering to these wider written and unwritten laws relating to human dignity and rights. This focus is on the application, not definition of these laws.

This perspective makes a linkage with the rights perspective of governance (United Nations Office of the High Commissioner for Human Rights, 2000) as highlighted in section 2.2, and acts as a linkage with the management perspective (Saltman & Ferroussier-Davis, 2000). By having an appropriate application of the (written and unwritten) instruments relating to dignity, culture and rights, the health managers are expected to ensure a wider interpretation of governance is applied during provision of health services. Services are provided in a manner that is expected by the recipients – not only in a manner expected by the bureaucracy (as the regulation construct focuses on). This perspective provides more clarity to the definition I had used

for the rule of law, by placing more emphasis on the written and unwritten laws relating to human dignity and rights as the focus of the rule of law.

### 4.5.2 Expected actions by the health sector to facilitate the rule of law

#### *Perceptions from County B (inefficient) case study*

The KIs highlighted a total of 6 mechanisms the health sector needs to accentuate the action of the rule of law. These included: (i) adequate capacity for enforcement; (ii) effective supportive supervision; (iii) clear management structures and processes; (iv) capacity building of staff on laws; (v) presence of functional professional regulation; and (vi) mechanisms for facility/community communication.

The different KIs placed emphasis on different mechanisms. Adequate capacity for enforcement was the most reported means for ensuring the rule of law is contributing to governance in health. Having the laws without the health sector putting in place means to enforce them will fail efforts to improve governance, as captured by one micro level non-public KI, who said *Government is not very strict or harsh. That's why this is not working. Private is not like the GoK (Government of Kenya), here they are strict! if you mismanage a patient or you mishandle a patient they come and report to this office, or they can go to our directors. Action is taken!* **(KI-1).**

#### *Perceptions from County A (efficient) case study*

Four mechanisms were highlighted by KIs as things the sector needed to focus on, to accentuate the action of the rule of law. These included: (i) building capacity for enforcement of the law; (ii) having clear and functional management structures and processes; (iii) putting in place functional professional regulation; and (iv) having mechanisms for facility/community communication.

The presence of capacity for enforcement of laws was the most reported means for ensuring the rule of law is contributing to governance in health. However, the issues to do with instruments assuring community/facility engagement, particularly in relation to assuring patient rights, confidentiality, care for patients, right to information and moral laws were also highlighted as important in ensuring the rule of law.

#### *Combined case study findings*

The health sector mechanisms facilitating the rule of law were largely similar across the case studies. In addition, they were also like the mechanisms mentioned for the construct of regulatory quality., focusing more on the processes as opposed to structures needed to facilitate this construct. I summarize these all in table 4-6 overleaf. This focus on processes as compared to tangible products for enhancing the rule of law speaks once again to the need for the 'soft' aspects of governance to be enhanced.

Table 4-6: Classification of stewards' action to improve the rule of law

| | Policy instruments | Legislative instruments |
|---|---|---|
| **Structures / tangible products** | ▪ Clear management structures & processes | |
| **Processes / intangible products** | ▪ Mechanisms for facility/community communication<br>▪ Appropriate planning, implementation & monitoring processes<br>▪ Capacity building<br>▪ Effective supportive supervision | ▪ Adequate capacity for laws enforcement<br>▪ Functional professional regulation |

### 4.5.3 Expected actions by other sectors to facilitate the rule of law

*Perceptions from County B (inefficient) case study*

The perceptions relating to the factors positively influencing the rule of law related to two key action areas: community empowerment, and the overall government capacity / interest to adhere to the law.

Regarding the community empowerment mechanisms, it was felt important for communities to be appropriately supported and educated on the written and unwritten laws, and how they need to ensure they are adhered to. A community that is led – formally or informally – by informed persons would facilitate their ability to assure adherence to the rule of law.

On the other hand, the government's level of interest to adhere to the rule of law is important in ensuring the health sector does so. The willingness and capacity to set up clear systems for follow up of misconduct or non-adherence to the written and unwritten laws influences the ability of this construct to influence health goals. Where such systems are strict and deviation from the law is fairly punished by relevant institutions, then the rule of law will contribute to health goals attainment.

*Perceptions from County A (efficient) case study*

The mentioned perceptions relating to contextual factors positively influencing the rule of law relate to the level of engagement and participation of the different health stakeholders in the implementation process. The health stakeholders are not only the public-sector workers, but also the private sector, civil society actors who can facilitate implementation of the rule of law. Systems to ensure engagement and participation of all these actors in the processes of enforcement of the legal instruments would facilitate their influence on governance, as captured by one meso level non-public KI who said '*when it comes to implementation, you find that there is a lot of interference and lack of transparency because government; they are trying to shrink the space for the CSOs, who are instrumental in ensuring transparency* **(KI-1).**

### *Combined case study findings*

I see three emerging constructs guiding the wider government influences

The first is about democracy and participation. As highlighted in the County A case study, the level of involvement of different stakeholders facilitates adherence to the rule of law. Where people are engaged, there is a higher chance that non-adherence to the rule of law will be identified and sanctioned. The role of civil society in ensuring appropriate engagement of all actors is highlighted as critical.

The second is relating to community engagement. As highlighted in the County B case study, it is important for communities' capacities and understanding of the written and unwritten laws to allow them to have the oversight role over the actions of the sector. Civil society and community-based organizations also have a very important role here, in empowering the communities

Finally, I also see some perspectives that can be categorized under the need for wider government institutional support to health sector actions, just as with the construct of regulatory quality. As highlighted in the County B case study, the presence of mechanisms to follow up misconduct or non-adherence are an important mechanism in the wider government to facilitate functioning of this construct.

The findings therefore point to three constructs, democracy / participation, community engagement and wider government institutional support.

## 4.6 Findings for control of corruption

This is focused on the extent to which stewards and managers actions are transparent and carried out in a clear framework that ensures all health stakeholders can monitor the implementation process and limit leakages of resources. I present the understandings of the KIs, actions by the health sector to improve effect of the construct and actions by other sectors to improve effect of the construct. These I present for each case study, and then a combination of the findings from both to consolidate the perceptions arising from both the case studies.

### 4.6.1 Understanding of control of corruption

***Perceptions from County B (inefficient) case study***

The general perception about what this entails related to openness in the different processes that take place in stewardship of service provision. This interpretation was reflected at all the levels and ownership. At the macro level, the focus of openness was in the budgeting and use of resources, as illustrated by one of the public KIs who defined the construct as *Openness and putting everything on the table – open availability and use of resources. (***KI-2).** At the meso level, however, this openness focus was more towards openness in the planning and implementation of services, while at the micro level its focus was on reporting and sharing with the public to build trust with the communities. Similarly, the openness related more towards allocation and control of finances amongst the public KIs, while it was more about activities with the non-public KIs. These different perspectives are summarized in figure 4-2 below.

**Figure 4-2: Perspectives of importance of control of corruption amongst KIs in County B county**

| | **WHY IT IS IMPORTANT AND CRITICAL** | | |
|---|---|---|---|
| | **Macro level KIs** *Availability and use of resources* | **Meso level KIs** *Implementation of activities* | **Micro level KIs** *Sharing information* |
| ***Public KIs*** *Better allocation and control of finances* | Open decision making | Facilitates planning and control of implementation of activities | Scrutiny of finances |
| ***Non-public KIs*** *Better implementation of activities* | Better planning for our activities | Promotes integrity of leaders | Builds community confidence |

***Perceptions from County A (efficient) case study***

The general perception about what this entails related to openness and involvement of stakeholders in planning and budgeting processes. The planning and budgeting processes for both public and non-public-sectors is perceived as very critical in terms of health service provision, but also prone to significant abuse.

As such, these processes need to be carried out in a manner that involves all the different actors that are relevant. This perspective was well captured in the way one of the meso level public KIs defined transparency and control of corruption: '*It is being open about available resources, and how to use them responsibly. Use resources in a prudent and open way, used for the intended purposes* **(KI-2).** I discerned this perspective at all the levels of management, and from the public and non-public KIs.

#### *Consolidation of findings from both case studies*

It was positive to note that all the classifications of KIs perceived transparency from the broader perspective of how 'open and involving' the system is in all its decision making, not only in managing funds. That this perspective is held at all levels of government and by all classifications of stakeholders is very useful. The openness was highlighted in relation to three processes during service implementation: first is open planning processes, where openness is needed during the decision making on what priorities to implement; second is open resource allocation processes, where openness is needed during decision making on what funds to put in which priorities; and third is open implementation and reporting processes, where openness is needed during the implementation of activities, ensuring interested stakeholders are aware of how the implementation is proceeding.

### 4.6.2 Expected actions by the health sector to facilitate control of corruption

#### *Perceptions from County B (inefficient) case study*

The KIs mentioned 7 distinct mechanisms that would accentuate the actions of interventions to improve control of corruption. These included (i) conducting of regular audits; (ii) presence of effective supportive supervision; (iii) presence of mechanisms for facility/community communication; (iv) presence of adequate capacity for laws enforcement; (v) presence of facility oversight committees; (vi) presence of management oversight committees; and (vii) adherence to financial management procedures. Different KIs placed emphasis on different mechanisms. For example, the need for regular audits was highlighted only by KIs in the public-sector, suggesting it is more valued as a means to enhance transparency and control of corruption within the public-sector.

In addition, the need for management oversight committees was highlighted from KIs at the macro level of management – both public and non-public. Such management oversight committees were mentioned as different from the governance committees in that they need to bring together all service provider actors under one umbrella to jointly coordinate the technical process of service provision. This need was specifically highlighted for the non-public-sector, which is perceived to lack any form of transparency in their planning, budgeting and reporting processes and yet most of the blame for lack of transparency is targeted at the public-sector. This is well illustrated by this quote from one of the macro level non-public

KIs '*No one at the county has been proactive enough to demand that partners reveal the resource envelopes and give quarterly reports to the county management to see how they are utilising the finances* **(KI-1)'.** Such management oversight committees therefore are important to complement the work of the governance-focused facility oversight committees who's need was also highlighted and aimed at ensuring community groups have oversight over activities and financing. The two committees are needed for effective transparency and control of corruption in facilities.

### *Perceptions from County A (efficient) case study*

The KIs highlighted 6 different mechanisms that need to be focused on to accentuate the effect of transparency and control of corruption as a governance construct. These included: (i) systems to ensure adherence to financial management procedures; (ii) use of chief's baraza's (gatherings) to engage communities; (iii) putting in place mechanisms for facility/community communication; (iv) establishment of functional facility oversight committees; (v) putting in place management oversight committees; and (vi) having functional and effective supportive supervision processes. The different KIs perceptions on the mechanisms were uniform. Of specific note, however, is that public-sector KIs tended to prefer multiple mechanisms as compared to the non-public KIs. This is possibly a result of lack of confidence in specific mechanisms, expecting many mechanisms stand a better chance of having the desired results.

### *Consolidation of findings from both case studies*

The wide range of mechanisms mentioned is a testament to the importance placed on this construct by stewards and managers. These different mechanisms spanned the whole range of the dimensions of policy/legal, and structural/process products. This wide range of mechanisms was seen across both case studies. I summarize all these mentioned mechanisms in table 4-7 below.

**Table 4-7: Classification of health sector actions to improve the control of corruption**

| | **Policy instruments** | **Legislative instruments** |
|---|---|---|
| **Structures / tangible products** | ▪ Facility oversight committees<br>▪ Management oversight committees<br>▪ Chief's baraza's (gatherings) | ▪ Financial audits |
| **Processes / intangible products** | ▪ Mechanisms for facility/community communication<br>▪ Effective supportive supervision | ▪ Adequate capacity for laws enforcement<br>▪ Adherence to financial management procedures |

### 4.6.3 Expected actions by other sectors to facilitate control of corruption

*Perceptions from County B (inefficient) case study*

Several factors were highlighted, which promote the control of corruption to influence the health governance. These were focused on putting in place ways to shift planning, budgeting and monitoring from the individuals, towards more institutionalized mechanisms that are difficult to manipulate. Some of the contextual approaches to facilitate this that were mentioned include approaches to ensure collectivization of decision-making, away from individual based decisions; putting in place an evidence-based priority setting and resource allocation process in the health sector; or strengthening the support and oversight of stewards to ensure they adhere to and implement financial management protocols.

*Perceptions from County A (efficient) case study*

The contextual mechanism mentioned by the different KIs related to supporting the establishment of institutional systems that promote sharing of information between the communities / clients and the health stewards at all levels. When both sides have adequate information – communities with information on health stewards' focus and actions, while health stewards have information on community demands and expectations – then the transparency is improved in the prioritisation and budgeting processes. Such systems for improving communication were highlighted as either political such as rallies or consultations, or institutional such as regular community meetings. Other sectors need to facilitate their establishment.

*Consolidation of findings from both case studies*

The KIs highlighted the importance of initiatives that would discourage individual decision making and encourage clear mechanisms that allow information to flow within, and between different stakeholders. This points to the need for systems that ensure collective decision making around priority setting, resource allocation and implementation as important for other sectors to ensure are in existence. These are most effective when determined by other sectors as opposed to having them defined within the health sector, to ensure they are not designed with internal biases. This points towards democracy and participation construct as important for the control of corruption.

In addition, the findings particularly in County B case study highlighted the need for support and oversight over stewards to ensure they adhere to and implement agreed actions. This expectation again highlighted the need for other sector institutional support to facilitate control of corruption. The health sector on its own may not be able to actualize this construct however many systems and processes it puts in place, if the wider government is not facilitative in the efforts to control corruption. For example, if persons arrested for corruption are let free by the legal system, then the mechanisms in the health sector will lose their ability to achieve results.

# 5. CHAPTER 5: DISCUSSION OF FINDINGS

In this chapter, I explore the implications of the findings from my research on the overall field of governance. How do they add to the existing debates, and what would be the take home message from my research. I structure this discussion in a logical manner. First, I present a summary in a nutshell of the messages from my results. Secondly, I explore how this information relates to what is known in literature, specifically what I found in my literature review. Third, I summarize the implications of my results on the way governance is applied. Forth, I propose a way to structure and apply governance for health stewards and managers based on my findings from Kenya. I conclude the chapter with some reflections on the overall process, limitations, and lessons I have learnt during the process of conducting this research, which would be of use in future studies relating to governance.

It is important to reiterate that my study is focused on a specific framing of governance. Other framings of governance, for example liking at it from the perspective of a citizen would lead to a different set of results and their interpretation. This reflects the complexity of the subject, and how it can be applied in practice.

## 5.1 Summary of research findings

I sought to find out how stewards and managers in health are interpreting governance, with an aim of consolidating a perspective of governance that would be 'speaking their language'. I explored this through three main thrusts: firstly, building an understating of how they interpreted governance; secondly exploring what they thought the health sector needed to focus on, to facilitate action of each of these constructs, and finally to also explore what other sectors needed to do, to facilitate action of the same constructs. For practical reasons, I explored these three thrusts for each of the constructs of governance that are within the responsibility of health sector stewards and managers, as I wanted to have guidance that was actionable.

The overall understanding of governance reflected both normative and descriptive elements in it. The emphasis only on normative understanding of governance by bureaucracies and international development agencies as seen in my literature review is therefore not warranted. This dual perspective is reflected not only in their overall perspective of governance, but also in how they understand its different constructs.

The findings for voice and accountability point to an interpretation that looks at both answerability, and enforcement capacity as an effective way to interpret this construct. Stewards and managers need to know that they have an obligation to citizens and other stakeholders and need to answer for their actions. The health sector actions that need to be done to facilitate voice and accountability were quite varied, but largely related to policy actions. There were a similar number of structural and process actions highlighted. On the other hand, the actions other sectors need to do to facilitate voice and accountability were related to the constructs of community engagement, and democracy / participation.

Looking at the construct of political (steward) stability, the KIs interpret this from the need to have continuity of both individuals and institutions. This continuity is important, to ensure a strategic focus is applied in the sector. Health sectors need to prioritize several suggested actions that are largely processes that need to exist for effective steward stability. On the other hand, actions from other sectors need to ensure democracy /participation, and decentralization for effective steward stability. A more participatory process reduces the potential for political interference, while decentralization ensures decisions relating to changes in individuals / institutions are localized.

Government effectiveness is interpreted by the respondents to be the ability of government actors to both do the right thing, and to do it right. What is right, and the right way to do it would be context and country specific, as opposed to having globally defined norms that countries are forced to adhere to. The health sector actions to facilitate this are primarily policy related, with both structural and process driven actions important. The actions from other sectors on the other hand are focused on ensuring decentralization, and presence of government institutional support to health sector actions.

Regulatory quality from my findings is interpreted as designing and applying the policies, legal and professional mechanisms to guide health service delivery – the rules of the game. This is facilitated health sector actions that are primarily process driven, as opposed to having structures in place. The other sectors need to put in place the overall government institutional support needed to define and enforce the rules governing health service delivery.

The rule of law is interpreted as the way the wider set of written and unwritten instruments and values of the society that influence health are applied in the attainment of health results. The focus is not on their definition, but rather on their application in health. The sector actions that influence the application of these instruments and values are primarily process driven actions. On the other hand, other sectors have a main role to play in supporting the application of these written and unwritten societal instruments and values through ensuring constructs of democracy / participation, community engagement and the presence of government institutional support to health sector actions.

Finally, the control of corruption in my findings is interpreted as the level of openness in the decision-making process. The informants suggested a multitude of mechanisms the health sector needs to focus on to facilitate this openness in decision making, ranging across all the dimensions of policy / legal instruments and structural / process products. However, the wider government actions suggested were limited just to democracy / participation and presence of government institutional support to health sector actions as constructs of importance.

## 5.2 Relation of findings with existing literature

My research findings relate to existing literature in three unique ways: they are corroborating mainstream knowledge, bringing to the fore some knowledge that is not mainstream, or suggesting new ideas. I discuss these elements based on the study objectives.

### 5.2.1 Relation of the understanding of governance to existing knowledge

The overall views about what governance means leans more towards the administrative governance perspective. The focus on both the hardware (structures, tools) and processes (reporting lines, responsibilities) links well with the need to focus both on descriptive and normative elements when understanding governance – as I highlighted in my literature review (section 2.3.5, page 39-40). This is an encouraging finding, as it suggests our health stewards and managers understand governance more broadly than the way it is usually championed by the international development actors as a primarily normative concept (Kaufmann et al., 2011; Travis et al., 2002; UNDP, 1997). This presents a god opportunity to ensure its interpretation reflects these different perspectives of governance.

Looking at the understanding of the different constructs that make up governance, I find each of them has some differences in their interpretation by health stewards and managers compared to literature.

#### *Voice and accountability*

The interpretation of this construct by the health stewards and managers varies from that commonly used. The common definition of the extent to which a country's citizens are able to participate in selecting their government, as well as freedom of expression, freedom of association, and a free media (Kaufmann et al., 2011), together with my study definition of the extent to which the population can participate in decisions relating to provision of health services were different from the way they were perceived by my respondents. The interpretation emerging from my findings has been proposed before, with Shapenhurst & Brian (2005) suggesting accountability needs to address both answerability, and enforcement for effective governance (Shapenhurst & O'Brien, 2005). In addition, Bovens (2007) proposed accountability needs to place emphasis on understanding the relationships amongst elements of responsiveness, effectiveness, and/or responsibility has been proposed before (Bovens, 2007). This understanding of accountability shifts the debate just from a participation concept to one that ensures answerability has been proposed in the need to focus on the need for government to create space for deliberation not only of their proposed actions, but also for the justifications of these actions – being answerable, not token participation (Lakin & Nyagaka, 2016). The interpretation from my study thus has examples from literature that highlight this dual need for answerability and enforcement capacity for accountability. The current interpretation focusing on

'participation' is limiting and may lead to loss of interest as it becomes an end, especially if there are no real answerability and enforcement mechanisms.

### *Political (steward) stability*

The findings from my study that emphasized a focus on continuity of both individuals and institutions was interesting. It differed from the consensus definition and the definition used in my study, which focused on avoiding government destabilization by unconstitutional means, and a focus on presence of a real mandate to lead the sector respectively. The concept of a stable steward is relatively new in health, having only been used in one normative framework before also as an interpretation from the wider perspective of political stability (Islam, 2007). Most of the literature on steward stability has been in the context of governance at the health institution level, and not at the system where it has focused on the need for decision-making autonomy for the institutional managers to allow them govern (Filerman, 2004; Rod Sheaff, Joan Gené-Badia, Martin Marshall, & Igor Svab, 2006; Savedoff & Gottret, 2008). My findings not only go beyond the need for institutional stability but add to the literature by emphasizing on this institutional stability as needed also at the management / stewardship level, but also bringing in the need for individual stability. Governance therefore needs to integrate thinking on continuity of decision makers and institutions at the sector level for it to be effective.

### *Government effectiveness*

This construct encapsulates a lot of the interpretation of governance in literature. When I look at particularly the normative perspective of governance, many of the ways it is constructed are around ensuring government effectiveness. Of the four papers applying governance in a normative lens which I reviewed (table 2-2), only one (Islam, 2007) had government effectiveness as a distinct construct, though they also included information, and policy formulation which are elements of government effectiveness as standalone constructs. All the other authors built their normative governance constructs around different elements of government effectiveness (Lewis & Pettersson, 2009; Mikkelsen-Lopez et al., 2011; Siddiqi et al., 2009). These different constructs include resource management, provider incentives, facility performance, informal payments, strategic vision, intelligence and information, responsiveness, effectiveness and efficiency. This same challenge is seen with the approach to focus on actions as opposed to constructs, which again defines actions for governance around actions for government (Health Systems Governance Collaborative, 2018; World Health Organization, 2014).

Therefore, while literature has focused on unpackaging elements of government effectiveness, which is reflected in my study definition, my findings suggest a look at this from the perspective of what one would expect from an effective government – it is doing the right things and doing them right. This view – focusing

on the expectations of government effectiveness as opposed to attempting to define the different ways it can manifest – has been suggested before. Yang and Holzer (2006) suggested a focus on the presence of both institutional capacity, and processes needed to ensure government is doing what people expect, is systematic and participatory manner – doing the right thing (Yang & Holzer, 2006). This understanding of government effectiveness takes it beyond just a focus on capacity as is usually thought, to also encompass processes relating to quality of services given, quality and independence (from political pressures) of the decision making process and the level of adherence to decisions during implementation – doing it right (Lee & Whitford, 2009).

My respondents therefore propose a way of interpreting government effectiveness that allows the health sector to define which elements to focus on, based on what is critical for them. The normative lens is not lost, as there is need to have some indicators of a government that is doing the right thing and doing it right. However, health sectors can integrate descriptive elements for them to focus on, when the interpretation is focused on the expected result and not being prescriptive in terms of constructs.

### *Regulatory quality*

The construct was perceived form the results as the mechanisms to put in place the 'rules of the game' that guide service delivery – the presence and comprehensiveness of the policy, legal, and professional instruments that guide the process of service provision. This understanding links with the wider interpretation of the regulatory quality as the ability to formulate and enforce implementation of policies and regulations. However, my findings highlight some variations. The common understanding limits the scope to policies and laws, while the respondents perceived this in a wider perspective, including professional codes and values. It also is focused on the private sector, while in the study the target was highlighted as all actors in health – public and non-public. Finally, the literature places emphasis on the factors 'exterior' to the practice or management of health (Brennan & Berwick, 1996), while in the study the factors 'interior' to the management of health are the focus.

I see the perception of regulatory quality as taking a broader perspective, becoming a construct to define and enforce the rules of the game, crafted by, and applied to all stakeholders. These rules encompass whatever is needed to facilitate effective delivery of services, be they political, policy, legal, regulatory or professional. Regulatory quality also encompasses the actions by public and non-public health sector stakeholders to define & enforce these rules

### *Rule of law*

The perception of this construct was indeed quite interesting, vis-à-vis the previous one on regulation. While the view on regulation was largely around the 'rules' governing service provision, this construct was

perceived to focus more on the application of wider set of laws that are not specific to service delivery, but influence health outcomes. The findings show this is not limited to the written legal instruments, but also the unwritten laws relating to basic human dignity morals and culture.

This perspective complements the regulatory quality that is focusing on the way the bureaucracy provides services, by focusing on the way citizens expect services to be provided. It relates with aspects of the responsiveness of services and ethics highlighted by Siddiqi *et al* (2009) as important governance construct. It also brings in the descriptive processes and rules perspective, particularly in understanding the mechanisms needed to ensure the societal values are translated into the attainment of health results.

#### *Control of corruption*

The perspective of open and involving decision making to interpret corruption is supported by literature. Ball (2009) suggested three areas of transparency in governance: a public value against corruption; openness in decision making; and a programming tool (Ball, 2009). My study findings are an interpretation of the second area – a tool for open decision making.

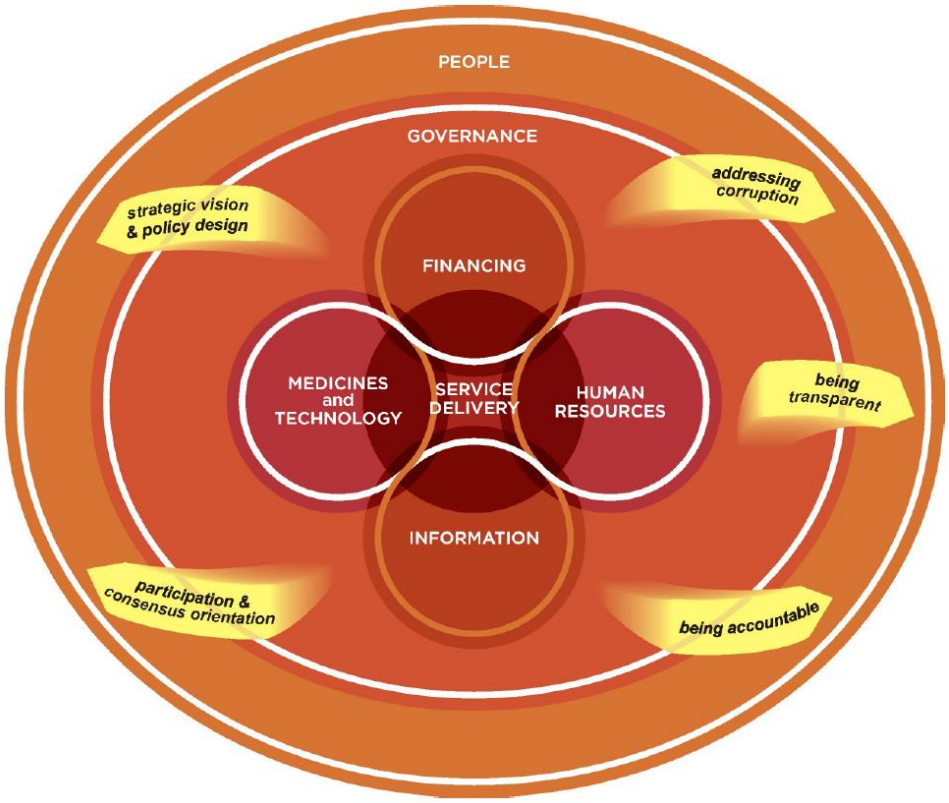
The current definition of control of corruption, together with my definition used in the study place emphasis on the need for transparency to ensure there is no wastage of resources – a policing perspective that assumes health stewards and managers need to be monitored as they are inherently not trustworthy. Thus, emphasis in literature is more on first perspective of transparency and corruption control proposed by Ball (2009) – how well the system is designed to prevent misuse and be more accountable to the population (Fox, 2007; Hale, 2008). My findings though are that health stewards and managers interpret this from the perspective of the second area – openness in decision making. This difference in perspectives has a magnified effect on the application of strategies to control corruption. The difference in understanding leads to the real situation on the ground, where many health managers / bureaucracies are usually of the view that their systems and processes are transparent enough, while their partners and stakeholders feel the same systems are not transparent enough – a view expressed in my findings. A difference in expectations of the construct of transparency is the cause of this disjoint.

### 5.2.2 Expected actions by the health sector to facilitate governance actions

The existing literature has not focused on identifying these actions that strengthen the effects of governance on health results. Published literature however recognizes the influence of other health actions on governance. In the elaboration of the health system building blocks of which governance is one, WHO acknowledges that the different building blocks influence and act on each other to accentuate their specific effects (World Health Organization, 2007). A revision of this framework proposed a systems thinking view to better understand the synergies and interactions across the building blocks of the system as the best way

to link investments (including governance) to health results (de Savigny & Adam, 2009). This systems' thinking approach with governance as one of the six inter-dependent blocks provides a useful way to reflect this interaction of governance with the rest of the health system. This perspective was further refined into an approach that places governance as an over-arching building block different from the other building blocks of the system, with it exerting its direct action on all the other building blocks onto the eventual beneficiaries (Mikkelsen-Lopez et al., 2011). In this framework, governance is seen as central to attainment of results from investments in the building blocks, and its actions lead to the impact on the people of these investments (see figure 5-1 below).

**Figure 5-1: Systems thinking: A framework for assessing governance across the health system**




*Source: Mikkelsen-Lopez et al (2011)*

This systems-thinking lens however is looking at the effect of governance on other building blocks from the perspective of the governance constructs themselves. It supposes an approach where the constructs of governance themselves work through other building blocks to attain their desired effects. It does not explore any other system aspects beyond the constructs of governance that may improve the effect of governance on health results, focusing instead on how to interpret the effects of the governance constructs on the other building blocks. My study takes a different approach, and focuses the systems thinking on identifying the other non-governance actions needed to strengthen the effects of actions in governance on health results.

The functionality of the sub national (district) system seems an important overall focus needed to get the best out of actions to improve governance. As seen in the literature review (figure 2-3, on page 34), system functionality was defined from the perspective of its ability to improve access to services, quality of care, demand for services and resilience towards shocks (World Health Organization, 2016). From my literature review (section 2.4.2), we see limited evidence on how governance affects health system performance, even though there is evidence it influences health results. My study however is proposing that health system performance is the one that strengthens the effects of governance on health results – not vice versa as is being explored in literature. This perspective is problematic, as it distorts our logical framework that assumes governance (as an input / process dimension of the logical chain) influences health system performance (as an output dimension of the logical chain). The arrow of causality moves from input / process to output and finally outcome and not the other way around. This would suggest elevating governance to an output dimension of the logical chain at the same level as health system performance. This is an area of further research; the cause – effect relationship between governance and performance.

The classification of the different health sector actions influencing governance effect on health results into two spectra spanning policy to legal actions, and structural to process related actions is inherently a new way of thinking. Instead of having a list of possible actions, it presents researchers and countries with a range of possible actions that could exist within a given system.

Finally, while the findings were not aiming at apportioning weights to different mechanisms, I need to specially highlight four mechanisms that were reported very frequently. These are supportive supervision, establishing facility / community communication, facility oversight committees and having law enforcement capacities is interesting.

**Supportive supervision** was originally perceived as a process that promotes quality at all levels of the health system by strengthening the relationships within that system, with an emphasis on identifying and solving problems and contributing to the optimization of the allocation of resources – promotion of high standards, teamwork and better communication in both directions (Marquez & Kean, 2002). This definition fits better with an action to influence health results, as compared to the current focus on improving health workforce productivity.

The focus on **facility / community communication mechanisms** arises from the stronger role community interventions are having in providing health results, and the involvement of communities in governance. The interpretation of primary care as envisioned in the Alma Ata declaration (WHO, 1978) has tended to emphasize community health systems as an independent part of the health system for attainment of health results (R. A. Goodman, Bunnell, & Posner, 2014). This focus on community health services has of late taken a stronger emphasis, with it being perceived as an independent driver for attainment of health results

(H. Schneider & Lehmann, 2016). The health stewards recognize this, and the need for seamless communication between community and formal health systems as an important action for governance. Where there is good communication, the community and institutional health systems work in sync to produce the desired health results.

**Facility oversight committees** provide oversight over actions of health facilities (Arnwine, 2017). In Kenya, where my case studies were, studies have shown they are critical in facility operations and attainment of results, particularly when their breadth and depth of engagement was high (C. Goodman, Opwora, Kabare, & Molyneux, 2011). This experience probably informed the identification of these committees as critical for ensuring governance can facilitate attainment of health results.

Finally, the presence of **capacity for enforcement** of laws as an action influencing attainment of health results is interesting, as it is close to the construct relating to regulatory quality. However, with regulatory quality, the findings were focused on the definition of these 'rules of the game', while here the action to accentuate the effect of governance is instead focused on the capacity to enforce the rules of the game. It is interesting that this was not only highlighted with regulatory quality construct (where it could be interpreted as an extension of the findings), but also with constructs relating to control of corruption, accountability, steward stability and the rule of law. This suggests that the need for this enforcement capacity is cross cutting across governance – and not just related to regulatory quality.

### 5.2.3 Expected actions by other sectors to facilitate governance actions

The findings from the study have some significant differences from the suggestions from literature (Ciccone et al., 2014) which suggested democracy/participation, community engagement, economic opportunities / social capital, decentralization and the right to health as the actions that would facilitate actions of governance.

Firstly, the findings did not raise findings to do with two areas: economic opportunities / social capital, and the right to health. This may reflect the fact that the findings were open ended, allowing respondents to share their views which were then organized across the known areas. The absence of these two areas amongst respondents is quite worrying, as it suggests the health stewards are not prioritizing these as areas for action.

*Sustainable economic opportunities and social capital* were highlighted in my literature review as important in ensuring functional safety nets that are important for uptake of health services. (Szreter & Woolcock, 2004). respondents may have linked this with community engagement and the effort to build community's capacities to own their own development. However, these two concepts are very different. The need to

distinguish a clear approach to facilitate bonding, bridging and linking across vulnerable groups in a community needs to be emphasized with health stewards

Equally troubling is the lack of responses relating to the *right to health*. As shown in the literature review, this has been a cornerstone of health actions since the 1948 universal declaration of human rights (United Nation General Assembly, 1948) and enshrined in the WHO constitution. That health stewards and managers – from both public and private sectors do not raise this suggests they are still not yet linking the right to health with their day to day governance improvement actions. This is reflected in the low priority given to equity initiatives by health stewards in practice and the persistence of the 'inverse square law' in health systems (Fiscella & Shin, 2005; Tudor Hart, 1971; Watt, 2002).

Secondly, the findings of several actions that did not fit with any of those suggested in literature. These were all related to the available government-wide institutional support for governance in health. This finding is important as it emphasizes the need to contextualize governance in health actions within the overall governance actions a country is carrying out. Four areas around which proposed government institutional actions are capture these wider governance pre-requisites for effective health governance: the presence of supportive processes; enforcement support; enforcement mechanisms and complementary institutions. Health governance actions can only be as successful as the wider public governance actions allow it to be. This finding strengthens the argument for collaborative governance, where emphasis is placed on the multisectoral nature of governance and identifying / mapping those cross sectoral elements for which collaboration across sectors is critical (Emerson, 2018; Emerson et al., 2012). The need for collaborative governance in health is driven by the interdependence between the health actors and other wider government institutions which would better achieve their results by working together – integrative leadership for joint attainment of results (Crosby & Bryson, 2010). By working closely with government institutions particularly responsible for building stewardship capacity, enforcing regulations, establishing judicial and other institutions and establishing complementary government functions, the health sector collaborates across government to complement health governance actions.

Third, the findings are very specific about the nature of actions needed in the identified actions. The constructs – democracy, community engagement and decentralization – are not sought for because they are good, but because of specific characteristics they bring to health governance

For *democracy and participation*, the sought-after characteristics relate to enforcing transparency and collective decision making, results driven focus, stakeholder engagement. There is no emphasis on the traditional liberal democratic focus of democracy. As such, some countries that may score low on a democratic index such as Rwanda or Ethiopia (The Economist Intelligence Unit, 2018) may possess the

characteristics sought for in terms of collective decision making, results driven focus, stakeholder engagement and transparency to allow for this construct to positively influence governance.

Looking at *community engagement*, the focus was on enhancing community capacities as compared to the desired focus on ensuring community transformation as the desired output I had identified in my literature review (Baisch, 2009). This corresponds more with the most basic form of community engagement as structured by Bowen *et al* (2010) – the transactional form of engagement. The health stewards still perceive community engagement from this transactional lens, limiting the eventual effect of community engagement.

Finally, for *decentralization*, the health stewards focus not on the relations across levels of the sector but rather on those within the given level. It is important for appropriate decision space to not only be defined at a level of the system, but also defined for the actors operating at that level. In Kenya the country for my study, there is literature documenting the phenomenon of 'recentralization within decentralization', where decision space has reduced for some health stewards and managers following devolution, due to the political actors encroaching on the decision space of the health technical stewards (Barasa, Manyara, Molyneux, & Tsofa, 2017; Tsofa, Goodman, Gilson, & Molyneux, 2017). Thus, a decentralization construct needs to be explicit about how decision space will be shared amongst actors at a given system level, for it to be useful in facilitating the effects of governance on health results.

### 5.3 What the findings mean for deciphering governance

The study findings have several implications for governance. My study suggests an approach to construct an understanding of governance from an understanding of how it is interpreted, together with the actions needed by the health sector and other sectors to facilitate its effects on health results.

The global discussion around health sector governance is currently shifting away from a dichotomous approach of either a descriptive (process based) versus a normative (rules based) understanding towards one that combines both perspectives to define actions needed for effective governance.

To fit my study into the current discourse on governance, I need to shift the interpretations of the findings towards providing the actions health stewards and managers need to focus on, to facilitate the effect of governance on health outcomes. As I highlighted in my literature review (section 2.3.4, page 39), actionable governance work is currently coalescing around five actions that it is felt need to be put in place for governance to be effective (World Health Organization, 2014). These actions are primarily relating to ensuring government effectiveness, which is quite limiting in the scope of actions needed to ensure effective governance. My study suggests a wider range of actions are needed. These I can decipher from the analysis of my findings.

The findings show that the actions of health stewards and managers alone do not provide the comprehensive picture of health governance. Actions by the health sector, and other sectors too are important.

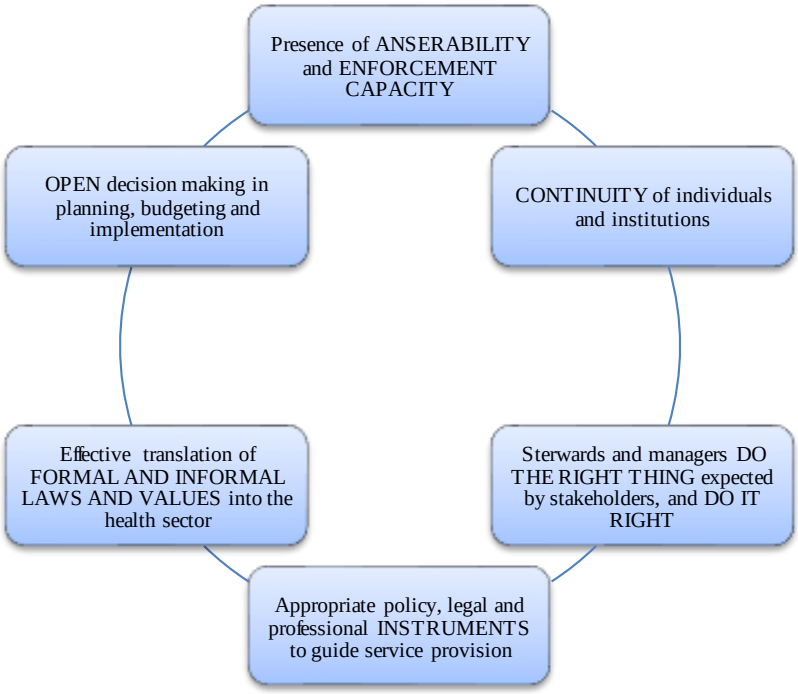
### 5.3.1 Study objective 1: Interpretation of governance

From my first objective, I see the following characteristics emerging as important in interpreting the concept of governance for health stewards as managers.

1) Facilitating the presence of tools and processes to ensure both answerability, and enforcement capacity – answerability to stakeholders and enforcement by stakeholders
2) Ensuring continuity of both individuals and institutions – allowing stewards and managers effective decision space and limiting political influences on stability
3) Enabling stewards and managers to do the right thing, and to do it right – as expected by health stakeholders
4) Ensuring the appropriate policy, legal and professional instruments exist to guide the rules of the game
5) Assuring effective translation of into the health sector of the formal and informal laws and values of the populations that have an influence on health
6) Adhering to open decision making in planning, budgeting and implementation of health actions

I consolidate this interpretation of governance actions for attainment of health results in figure 5-2 below.

**Figure 5-2: Characteristics of governance actions by health stewards / managers for health results**



These characteristics are not new, having been applied in different ways in the past. However, my study brings them together as an integrated way to characterize governance for the first time. They represent an actionable way to characterize governance, that goes beyond the characteristics of government. The use of the interpretation by health stewards means the characteristics are structured in a manner most likely understandable to the practitioners, as compared to an interpretation by persons not involved in direct implementation of governance.

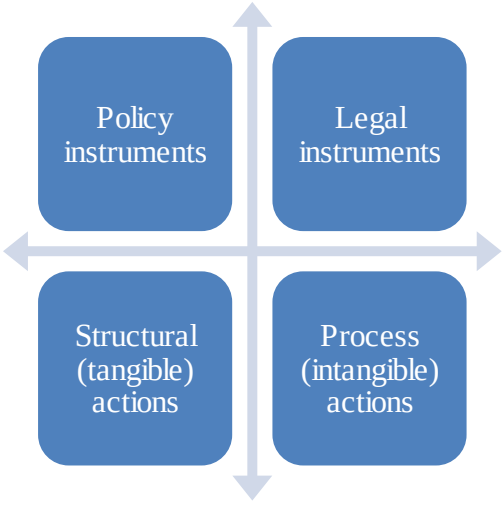
### 5.3.2 Study objective 2: health sector actions influencing governance

From my second study objective, there were a total of 29 different mechanisms highlighted that health sectors need to focus on to strengthen the effect of governance. These actions are independent of governance actions, but where present improve the potential for governance actions to influence health results. Policy related instruments were more commonly mentioned (22 out of 29 actions), as compared to legal instruments. In addition, many of these actions were presented with qualifiers, as the KIs wanted to emphasize what is important about it. For example, clear management structures and processes were placing the emphasis on the 'clear', as it was highlighted management structures and processes are always there – but they are just not clear.

Looking across the types of actions highlighted, I see a preponderance of actions that build towards a functioning health system that would be important for governance to influence attainment of health results. The legal instruments mentioned (7 out of 29) primarily focused on improving management of finances.

My findings and discussion qualify the need for health sectors need to define actions they need to take to improve the effects of governance on health results. These actions cover a wider range of possible options, but represent four possible themes as shown in figure 5-3 below.

**Figure 5-3: Thematic areas around which actions by health sector need to be defined**



Specifically, four mechanisms need to be specifically looked at as they appear to have a cross cutting effect across governance: supportive supervision, establishing facility / community communication, facility oversight committees and having law enforcement capacities. These were the most commonly mentioned mechanisms and need to be considered during definition of these health sector actions to influence governance.

### 5.3.3 Study objective 3: other sector actions influencing governance

With my third study objective, having the queries open ended allowed me to better understand the context and definitions of the actions mentioned. From all the responses, three out of the five other sector areas I expected to have an influence on health results were highlighted. These were democracy / participation; decentralization and community engagement. In addition, the need for effective and functional wider government institutions to support the health governance actions was highlighted as an additional mechanism – institutions such as the police, judiciary or public administration. I highlight the constructs where the KIs highlighted the different constructs of governance as important in the table 5-1 below.

**Table 5-1: Other sector actions mentioned that would facilitate the effect of governance on health results**

| | Constructs where specific facilitating actions were highlighted | | | | | |
|---|---|---|---|---|---|---|
| | Voice and accountability | Political / steward stability | Government effectiveness | Regulatory quality | Rule of law | Control of corruption |
| Democracy and participation | ✓ | ✓ | | | ✓ | ✓ |
| Community engagement | ✓ | | | | ✓ | |
| Social capital / opportunities | | | | | | |
| Decentralization | | ✓ | ✓ | | | |
| Right to health | | | | | | |
| Government institutional support | | | ✓ | ✓ | ✓ | ✓ |

Democracy and participation are highlighted as having an influence on governance in multiple ways. From the findings, we find four distinct ways it does this: it promotes transparency (voice / accountability), forces politicians to focus on results desired by citizens (steward stability), encourages engagement of stakeholders (rule of law) and promotes transparent and collective decision making (control of corruption).

Community engagement is seen to influence governance primarily through mechanisms to improve community capacity and voice (voice and accountability, and rule of law)

The focus for decentralization is on ensuring there are appropriate inter-relations amongst decision makers at a given level – in this case at the county. Decentralization reform should not just focus on shifting decision making authority to lower levels, but also focus on the way the different stewards and managers will interact to ensure appropriate decision making for the citizens. Where health technical stewards have appropriate decision space away from the higher levels of government and the other stakeholders at their level, appropriate governance is enhanced.

The wider government institutional support arose as a combination of different issues that were not related to the already defined 5 constructs. These related to the presence of supportive processes in government to build appropriate health stewardship capacity (government effectiveness), presence of institutions to enforce health regulations (regulatory capacity), presence of government institutions to enforce government and societal norms within the health actors (rule of law), and the presence of complementary government institutions to strengthen effects of health actions (control of corruption).

These findings have major implications for how health stewards and managers will engage with the wider government to facilitate governance actions. The health sector cannot initiate and apply governance actions independent of what is happening in the other sectors. From my findings, it is important for them to consider four actions.

First, the need to build a succinct understanding of the instruments and processes in the wider government, which are facilitative towards health governance. It is important to establish mechanisms for engaging with these, to ensure their actions are facilitative of health governance. In my research, I have identified four possible instruments / processes: those which build steward capacity, such as public administration training institutions, scholarship opportunities; those that will facilitate enforcement of health regulations, such as the judiciary and policy; those that define and enforce the written and unwritten laws guiding wider societal norms and values, such as traditional institutions or the legislature, and those that are complementary to actions in improving governance in health such as anti-corruption commissions, community development bodies and others.

Second, they need to explore mechanisms in other sectors that will enhance aspects of democracy that enforce transparency and collective decision making, results driven focus, stakeholder engagement. These mechanisms can be applied in the health sector – for example a performance contracting process in the wider government aimed at having a results focus can be deepened in the health sector.

Third, the need to support initiatives to move community engagement from a transactional engagement towards total transformation of the communities, as a fully empowered community will contribute to governance in a sustainable manner.

Forth, the should explore means for expanding the decision space for health stewards at the devolved level of government, and initiate mechanisms to monitor this effect over time as part of an evidence base establishment.

Fifth, the need to build the understanding and application of the right to health particularly focusing on planning and monitoring the application of equity in resource allocation and achievement of results.

Finally, they need to work through existing community development structures to take advantage of existing social capital initiatives, allowing vulnerable groups better engage in their health and development.

## 5.4 Study consolidation into a proposed framing of governance for health stewards and managers to facilitate attainment of health results in LMICs

From the research findings, I have validated the value of having a clear definition, plus understanding of actions by health stewards / managers, the health sector and other sectors to improve governance effects on health results. It is important for a health steward / manager to interrogate this wide range of actions for them to appropriately address health governance.

Governance as highlighted from my findings remains a complicated concept with multiple perspectives and ways of framing it. My interest in my study was how to frame it for a health steward or manager in a low- or middle-income country. The quintessential health steward / manager I am targeting my findings at is one either newly posted or has been working at the sub national level – for example as a hospital superintendent, a district health management team member, a county executive officer – that wants to improve health governance to facilitate attainment of their health goals.

In coming up with a way to frame the different concepts arising from my study, I focus on providing action-oriented guidance, as opposed to identifying descriptive or normative elements as is done in literature. The health steward or manager needs guidance on actions to take, not concepts. I also consolidate all the range of actions arising from my study. These actions, just as in my study, are built at 3 levels:

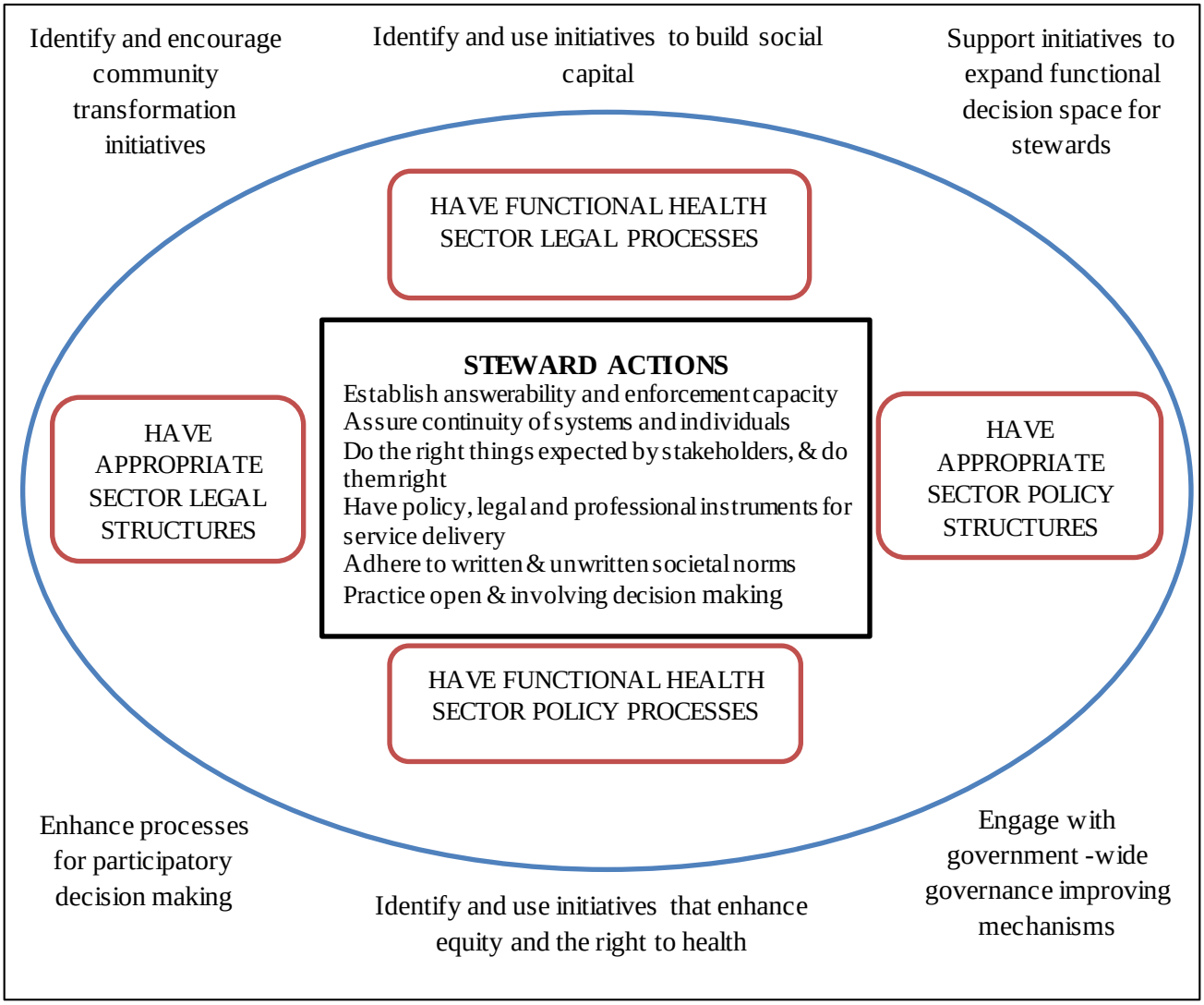
a) Actions by the health stewards and managers – informed by their interpretation of governance,
b) Actions by health sector in general that facilitate the effects of governance, and
c) Actions by other sectors that need to be lobbied for, which will facilitate the effects of governance.

I propose a way to construct governance that consolidated all these principles and is directly derived from my study findings in the figure 5-4 overleaf. Its purpose is two-fold:

i) The highlight the wide range of issues the steward needs to consider for improving governance. This should remove any remaining ideas about the complexity of the task; and

ii) To provide a pointer for issues to analyse to develop a governance improvement roadmap

**Figure 5-4: Construction of governance actions by a health steward / manager, for attaining health results**




The construction brings together all the study findings. The actions, as emerging from my study, are based on those they need to carry out themselves (from study objective 1), those that the health sector needs to act on (from study objective 2) and those other sectors need to act on (from study objective 3). The findings from objective 1 are in the middle square; objective 2 in the circle and objective 3 in the outer box.

My construction differs from existing ways governance has been constructed in several ways, all informed by its need to inform health stewards and managers actions to facilitate attainment of their defined health

results. First, it is quite specific in terms of its audience (health stewards and managers), and purpose (for attainment of health results). Many of the current approaches to construct governance do not take cognizance of the fact that governance means different things to different audiences and is for different purposes. Second, it differentiates actions by stakeholders in a manner unique from that usually used in literature – health stewards / managers, the wider health sector and the other sectors. The usual differentiation is into government agents, citizens, civil society, and partners. These stakeholders are subsumed into the stakeholder groups I use in my construction – for example actions by health sector stakeholders refer to all actors influencing health sector deliverables, not only government agents. A third way my construction differs from how governance has been constructed is it does not focus on a specific theoretical interpretation, but rather attempts to integrate elements of each based on where they are applicable. Thus, there are some actions based on the conceptual understanding of governance, and others on the institutional or theoretical perspectives. Finally, it is focused on actions needed, as opposed to descriptions of constructs.

To make it operational, the steward or manager will review each action, map its status, and so identify the expected actions they would want to initiate. The range of actions they need to initiate for each of the actions would form their comprehensive roadmap for improving governance.

However, I need to emphasize the fact that my construction does not define what is needed to make it operational. It only highlights the actions health stewards and managers need to focus on, as this was the focus of my study. Making it operational would require a health steward or manager to identify for each action, what they need to do in their context. The response to the actions may be different depending on the context. Thus establishing answerability and enforcement capacity as an example may mean recruiting more civil society entities on oversight teams to one steward, while it may mean more capacity of existing civil society groups to demand accountability to another. The health steward will need to appraise each of the proposed actions to decipher what they would entail in their specific context. To facilitate this, I would propose two supportive actions that would facilitate this process

First, the identification of indicators that can provide a more standard status for the different actions. This strengthens the normative perspective of each action, in a manner that is not prescriptive. The indicator is primarily aimed at guiding the steward / manager about which actions they need to place emphasis. Such an indicator may be as simple as a description of the action that would allow for it to positively influence health outcomes. Second, a compendium of possible activities in each action may need to be elaborated over time, preferably from the different activities stewards and managers are identifying under each action. Such a compendium can only be elaborated over time and would never be complete as the activities may

be quite varied. However, it could act as a guide for health stewards and managers, about the kinds of activities they need to be thinking about.

## 5.5 Reflections on the study

The study has explored a topical issue, which is influencing the way universal health coverage and other health sector priorities are being addressed. The need to explore ways to improve governance in health is universally agreed to be an important area of focus if countries are to move towards achieving their agreed health goals. All aspects of the research – from its design, fieldwork and analysis represented challenges one would find in a research area that is still evolving. I therefore feel it is important to reflect on the different aspects of the study, which would be important for future researchers in the area.

### 5.5.1 Background and study site

The subject of governance itself is not intrinsic to the health sector, having evolved primarily from the corporate world. It therefore presents a poor fit with other building blocks of health systems, each of which have a long history and are well defined and integrated within the health sector. This may be a contributory factor to why it has remained difficult to decipher particularly for health stewards and managers. Health managers and stewards remain committed to it but are constantly perceived to practice poor governance despite their efforts at doing what is expected.

By choosing a study site that had just established its stewards and managers, I hoped to get informants who were still quite fresh in their ideas about what needed to be done but had already some practical experience in applying these concepts. The views and perceptions at this stage are quite fresh and real for the respondents, and so would be captured extensively. I however have not had a chance to compare the findings with a country that is not devolved or has a mature devolution system and so am not sure ow much of the findings I could attribute to this unique Kenya situation. This could be a potential area for future work.

### 5.5.2 Literature on governance and health

From my literature review, I found a wide range of literature on governance in general, and health specifically. This literature has been consolidated from a variety of authors: general researchers, governance researchers, general health practitioners; to mention but a few. This could potentially make the perceptions, approaches, and interpretations of an already complex subject like governance even more complicated, if the authors were not careful to ensure personal views were not influencing their work.

It was a struggle to structure all this literature in a manner that is coherent, due to the multiple ways the subject has been handled. I however was eventually able to structure it around the five sections of the

literature review. While this meant I was better able to structure the literature, it implied I had to conduct five different literature searches for each of the sections. Each literature search on its own was complicated due to the lack of standardization of terms used in governance. The conduct of the literature review as a result took much longer than would usually be for such a study.

The emerging conceptual framework also had to evolve as the literature review was going on, to try and capture the different perspectives of the subject that I was finding in literature. I eventually settled for a simple conceptual framework, which I found very useful in framing and targeting my study throughout till the end.

### 5.5.3 Study methodology

I had several options to consider with the methods for the study. Starting with the study site, the identification of the counties to be my case studies was difficult as I had multiple options to choose from. I was eventually happy with the countries selected, as there were several areas where the variation in findings was clearly informed by the fact that the country was good or poor performing. If I were to select the case studies again, however, I would identify a much poorer county, for example one in the arid / semi-arid regions. I believe the variations in responses would be even more marked.

The choice of KIs as the study population was correct, as I was able to elicit a wide range of views. It would be interesting though to see what kind of responses I would receive from a focus group as opposed to KIs.

The use of framework analysis method to consolidate the findings was important especially for me who had worked within the Kenya health sector previously and could potentially have views that would bias the analysis process. In addition, the efforts I took to ensure validity and reliability were useful, with the results I received being quite different from what I knew previously (evidenced by the differences in perceptions of governance as compared to my initial working definitions). It is an area that I would recommend be further entrenched in all qualitative research – I could see how easy it was to revert to my own ideas and positions which the efforts I put to ensure validity especially helped to avert.

### 5.5.4 Study results

The presentation of the results followed the findings from each construct, with the results presented by study objective. I had initially presented the results by case study. On review of the completed draft section, the reading was difficult to follow – a finding corroborated in the first review of my thesis. Therefore, despite this being a case study design, I elected to present the findings based on how the subject I was investigating was constructed. While this lost the focus on each case study, it allowed for a much easier read of the findings.

In addition, my focus on having different case studies was to broaden the range of possible responses I could get, and so increase the applicability of my study. I wanted results that could be used in a range of low- to middle-income countries, and not only Kenya or the specific case study sites. I have not tested how well the results are applicable in other low- and middle-income countries, even though I was able to get a wide range of results. My assumption that the results are applicable to other countries is therefore only because I considered a wide range of respondents that would represent the kinds of stewards and managers I would find in these countries. This assumption needs to be tested.

### 5.5.5 Discussion of the study results

I had to revert to the literature review for placing my findings into the current literature for an effective discussion. I noted however that the challenge I highlighted above with the existing literature – that it is quite varied and not well organized – carried on in trying to link my findings to the current literature. This was helpful in some instances, when for example I felt I found a new way to interpret a given perspective of governance, only to find it had previously been proposed by someone else. I was therefore having to introduce new literature which did not come up in my literature search, but which was now manifesting itself when I searched using the new terms (answerability for accountability as an example).

Related to this, I also felt that my findings had highlighted some ways of looking at governance that were not mainstream in the current literature but appeared important for health stewards. Issues such as individual continuity as part of the interpretation of steward stability are not usually highlighted when thinking of governance. In addition, the multiple issues highlighted as sector actions were particularly difficult to organize, and further research would be needed here. However, because of all these different dimensions coming together from my findings, I was able to construct a perspective of governance that brought them all together for a health steward or manager. This helped me consolidate all the study findings around a clear and succinct result for the health stewards and managers in countries.

## 5.6 Study limitations

The study has provided very interesting perspective of governance in health. However, the findings should be viewed in the context in which it was designed – providing guidance to health stewards and managers on how to apply governance actions to attain their desired health results. My study does not aim to look at governance in all its perspectives and expected outcomes. I highlight the limitations that need to be considered, when reviewing the findings and recommendations.

1) My study was focused on information from a lower middle-income country. My intention was to have them able to be extrapolated to low, or middle-income countries. However, the findings need to first be validated in these countries before they can validly be applicable to them.

2) My study was based on a case study approach. I selected two vastly different case studies to get as broad a range of responses as one would expect in a similar country. However, I did not have the means to verify that the range of responses are indeed reflective of the scope of findings one would expect.
3) My study was based on a perspectives approach informed by select KIs. I attempted to select a broad range of KIs – from political to technical; macro to micro level of management – to ensure I get as broad a range of inputs. I believe I reached a good level of saturation as many responses were repeated after a few KIs. However, the possibility of different findings if a different methodology is used cannot be discounted.
4) I did not include amongst my KIs some stakeholders important to governance. These included the national level, and individual community members. The national level I omitted due to my engagement at that level that I could not guarantee would influence the views of the KIs. On the other hand, I did not include any community members as KIs as I wanted to focus on stewards and managers who would be making operational my recommendations. However, I do recognize I may potentially have got some other views from these groups.
5) My study also did not explore further how governance was evolving within the changing context of devolution in Kenya. The situation in Kenya provided a good opportunity for this, and it could have provided a different perspective of governance. However, I needed to focus my research and taking this perspective would have stretched it – possibly at the expense of depth of findings. In addition, I felt the understanding of governance by health stewards was the first area to explore, following which I could use the results to better understand how governance was evolving in a changing context.
6) In line with the above, I did not assess the governance practices and processes – instead focusing on collecting perceptions and views of stewards and managers. This again was done as I did not want to stretch my study beyond the expected capacity
7) I used the constructs of governance as a normative entry mechanism to explore in depth the issues I felt were related to governance in health. This however meant I was limiting the KIs to discuss only issues relating to these constructs. If there were other issues or constructs, the design did not allow me to explore these.
8) The identification of good or poor performing case studies was based on coverage performance and efficiency. I do recognize that equity is another important dimension of performance, as shown in figure 2-3. Inclusion of equity in assessment of counties performance may have yielded a different set of good or poor performing counties. However, such data on equity was not available, or used in measuring performance at the time.

9) I have not made any attempt to compare relative importance of the different attributes and characteristics of governance. Such a weighting would help managers and stewards know how to prioritize their efforts. At present, I am taking the view that they are all important and need to be considered.

These limitations provide guidance on areas for further research to test and expound on the proposed governance characteristics arising from my study.

## 5.7 Contribution of the research to existing knowledge

My research has expanded the knowledge around application of governance in health in two broad ways. Firstly, it has for the first time provided a construction of governance that is focused on the health stewards and managers. Most of the way's governance has been constructed has been from a conceptual, or an analytical perspective. My study provides an operational perspective designed by the same operational people that will apply it. The application of governance is now possible in a coherent manner. Secondly, my research has brought together all the theoretical perspectives relating to governance under a single framing. The disaggregation between descriptive and normative for example become moot when the research is proposing actions. In addition, it is not just focusing on actions expected of health stewards, but it recognizes governance is a function of these stewards, plus other health sector actors and other government sectors. By bringing all these perspectives into one construction, my research is adding to the existing understanding and application of the concept. Moving forward, my study suggests a number of areas for future research. These include:

a) Exploration of how these proposed actions for health governance that attains health results would be influenced in a changing context, such as was happening with devolution in Kenya. In such a situation where the context is rapidly and systematically evolving, what kinds of activities would need to be prioritized, vis-à-vis a situation where the context is static?
b) Test of how the activities against the proposed actions for health governance that attain health results change in low income, or middle-income countries.
c) How the activities associated with the proposed actions for health governance that attain health results are affected at different levels of health results.
d) How well the proposed actions for health governance that attain health results change with other perspectives of governance. for example, if we look at governance from a citizen's perspective, or we look at good governance as an end, and not just an action to improve attainment of health results.

# 6. CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

## 6.1 Conclusions

The study of governance in general, and in health specifically is a difficult subject. It is however critical to understand it, for better attainment of health results. The current drive to attain health and wellbeing for all at all ages (SDG 3) through ensuring universal health coverage calls for innovative and new ways of using available resources. Countries can no longer focus only on specific age groups (such as children) or conditions (such as HIV, or Malaria). They need to expand the reach of health services to all persons for all their health needs. The kind of governance systems – how authority and mandate are exercised – take on a more central role in assuring achievement of the health results in the SDG era.

By framing my study around how to structure and apply the concept of governance for health stewards and managers in low- or middle-income countries, I provide a clear target audience and message I am aiming at – people tasked with making governance operational and appropriate. Several insights are coming from my study.

First, it confirms that governance is a constructed concept. However, for a health steward or manager, I have constructed it differently from the way it is usually provided in literature, by constructing it from actions needed by health stewards and managers, by health sectors in general and by other sectors. By having an action focused construction of governance, I align my study with the current thinking on how to approach health governance.

Secondly, a distinction of perspective of governance into normative or descriptive is largely an academic one. The health stewards and managers recognize the value of both and apply them where needed. My focus on actions for governance to facilitate health results attainment helps health stewards and managers to avoid this distinction, as the actions they will identify cut across both.

Third, that governance is perceived differently even by stewards and managers in a given service unit. I explored perceptions amongst stewards / decision makers, managers / implementers, public, civil society and private actors within a service unit (county). From my findings, there were several areas where different perceptions and interpretations arose amongst these different actors.

Forth is that using the perceptions of the stewards and managers elicits a comprehensive and detailed view of governance, which is usually missed when perceptions of other stakeholders are used.

## 6.2 Recommendations from the research

My study adds to the growing field of governance in health, focusing on actionable governance from the perspective of a health steward or manager. It provides guidance on how it needs to be applied in a comprehensive manner, to ensure it facilitates attainment of health results. For taking the research forward,

I present a set of recommendations for my study site, for other low- and middle-income countries, for stakeholders supporting health, and for academia.

Recommendations for the study sites are as follows:

(1) Consider adapting the resulting construction of governance, to plan and address health governance challenges. The results are most sensitive in the case study sites, as they directly relate to them.

Recommendations for other low- and middle-income countries:

(2) Appraise the construction of governance I present (figure 5-4) in terms of your experience, to identify whether it resonates with your understanding and experience. Focus groups comprising health stewards and managers could be formed for this;
(3) Consider development of a governance improvement roadmap in line with the approach presented in my study (table 5-7) to comprehensively plan and monitor initiatives to improve governance;
(4) Share experiences with peers – other health stewards and managers – on application of governance roadmaps to improve on the approach and expand knowledge on its application.

Recommendations for stakeholders working with health stewards in low- and middle-income countries:

(5) Donors to consider supporting elaboration of health governance improvement roadmaps in countries, to plan and support governance strengthening in a comprehensive manner;
(6) Communities should engage with the health stewards and managers, to advocate for having governance improvement roadmaps that are comprehensive and address all characteristics important for governance improvement.

For health researchers, I recommend further research on the following areas:

(7) Facilitate the process to make the construction of governance operational through consolidation of a compendium of activities feasible under each action, based on field experiences and identifying indicators or milestones that define appropriateness of each action;
(8) Explore the reliability of the construction, particularly from the context of other LMICs or use of other study methods such as FGDs;
(9) Application of the proposed construction of governance in a whole country, to compare different service units (for example across different counties in Kenya);
(10) Explore the possibility of weighting of the different actions, to identify if there are variations in relative value of each to governance overall; and
(11) Examine the cause – effect relationship between governance and health system performance (recommendation from section 5.2.2).

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# ANNEXES

## ANNEX 1: INFORMED CONSENT FORM

**Informed Consent Form (ICF) for analysing the role of different constructs of governance in supporting governments in developing countries attain their health goals**

This consent form is for Key Informants in the counties that are part of this study.

**Principle Investigator: Humphrey Karamagi**

**This Informed Consent Form has two parts:**

- **Information Sheet (to share information about the study with you)**
- **Certificate of Consent (for signatures if you choose to participate)**

**You will be given a copy of the full Informed Consent Form**

**Part I: Information Sheet**

**Introduction**

I am carrying out a project that is **analysing the role of different constructs of governance in supporting governments in developing countries attain their health goals, case studies in Kenya.** I am going to give you information and invite you to be part of this assessment. You do not have to decide today whether or not you will participate. Before you decide, you can talk to anyone you feel comfortable with about this process.

This consent form may contain words that you do not understand. Please ask me to stop as we go through the information and I will take time to explain. If you have questions later, you can ask them of me.

**Purpose of the research**

The process of establishment of counties has created autonomous governance units in the country, with the function of health fully devolved. This has provided us with a unique opportunity to track the effects of good health sector governance on the desired health goals. As a result, it should be able to better understand the expectations of health sector stewards in driving the health agenda at the county level in a manner that leads to the desired health goals. The research is therefore aimed at understanding, in a systematic way, the expected focus and functioning of health stewards in guiding attainment of health objectives.

**Type of Intervention**

The project will use qualitative methods, with information collected through Key Informant Interviews

**Participants**

You have been invited to take part in this process, as you are one of the key actors in health at the county level.

**Voluntary Participation**

Your participation is entirely voluntary. It is your choice whether to participate or not. Your choice does not affect you, or your activities in the health sector.

**Confidentiality**

Given the sensitive nature of some of the issues we are going to discuss, I have taken precautions to ensure your responses are fully confidential, and cannot be traced back to you. This includes ensuring we conduct this interview in private, non-use of your name in any recording, storing of the data based on a coded reference number that does not allow anyone that accesses the data by mistake to be able to identify you. In the report, I will be using reference numbers, not your name and will share the report with you prior to putting it in the public domain, to ensure you are aware and comfortable with how I have used the data you provide.

**Procedures**

We are asking you to help us learn more about health sector governance from the perspective of your status. If you accept, you will be asked to be a key informant. If you do not wish to answer any of the questions during the interview, you may say so and we will move on to the next question, or terminate the interview. The information recorded is confidential, and

no one else will access to the information documented during the interview. The entire interview will be tape-recorded, unless you expressly request otherwise. Information from the recordings will be analysed, and information will be anonymized. Where direct quotations are used to illustrate a point they will be non-attributable, though you will still be asked to provide approval for their use. No quotes will be included without your prior approval.

**Duration**

The project takes place over 2 months. All the interviews will take place within this period. Our interview will last not more than one hour.

**Benefits**

Your participation is very important for the sector, as it will enable a better understanding of how health sector governance needs to be structured to lead to desired health goals.

**Reimbursements**

You will not receive any financial reward or compensation for your involvement with the project.

**Who to Contact**

If you have any questions, you can ask them now or later. If you wish to ask questions later or have any issues you want to have clarity on relating to this study, you may contact the Kenyatta National Hospital – University of Nairobi Ethical Review Committee Secretary, Email: uonknh_erc@uonbi.ac.ke or the Principal Investigator for the study on email karamagih@gmail.com

## Part II: CERTIFICATE OF CONSENT

| STATEMENT BY INTERVIEWEE | STATEMENT BY RESEARCHER |
|---|---|
| **I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction.**<br><br>**I HEREBY CONSENT TO (circle your choice):**<br><br>**A) Voluntarily participate in this study (YES / NO)**<br>**B) Have the interview electronically recorded (YES / NO)**<br>**C) Have the statements I make in this interview quoted in any emerging reports and papers (YES / NO)**<br><br>**Print Name of Interviewee:**<br><br>_____<br><br>**Signature of interviewee**<br><br>_____<br><br>**Date** _____<br>**Day/month/year** | **I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands what will be done.**<br>**I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily. A copy of this ICF has been provided to the participant.**<br><br>**Print Name of person taking the consent:**<br>_____<br><br>**Signature of person taking the consent:**<br>_____<br><br>**Date** _____<br>Day/month/year |

## ANNEX 2: INTERVIEW GUIDE AND TOOL

The purpose of this interview is to understand your perceptions about the importance of different constructs of governance. The interview will be conducted in two parts:

Firstly, I will want to understand your overall perspectives on health governance and its importance to the work you are doing,

Then, I will probe more deeply into different constructs of health governance, to understand better your perceptions on their importance, and how they function

**INTERVIEW PART ONE**

i) To start off this interview, please tell me, in your own words, what goals you and your team are working to attain in health

ii) How would you describe governance in health?

iii) How do you think this influences your ability to achieve your goals?

iv) What is it about governance in health that makes it important for you in achieving your desired health goals, and why is this so?

**INTERVIEW PART TWO**

Let us now turn to the specifics relating to health governance. From published literature, there are specific constructs that have been identified as having a most direct and positive association with health outcomes. These are:

- Control of corruption
- Government effectiveness
- Accountability to the population
- Steward stability
- Regulatory quality
- Rule of law

I have provided a working definition for each of these constructs with the consent form. The interview will focus on getting your understanding of two key issues for each of these constructs of governance:

- Understanding the importance of each on attainment of your health goals, and
- Understanding your perceptions of the mechanisms by which each of these contribute to the desired health outcomes

The interview hereafter proceeds with the following questions asked against each of the above-mentioned constructs of health governance:

v) What is the understanding of the construct in the specific context in which you are working? (how do you define it?)

vi) Do they feel the construct is important in attaining your desired health outputs, and why?

vii) What do they feel are the components of the construct that would be useful in the specific context in which you are working?

viii) What needs to be present for the construct to positively influence achievement of your health outputs?

ix) How does this construct influence your ability to attain your desired health outputs?

x) What other factors in your environment need to exist, for this construct to positively influence attainment of your health goals?

xi) In your opinion, which of these health outputs are most influenced by this construct of governance and how?

a) Improvement in access to services (physical, financial, or socio-cultural access)
b) Improvement in quality of services (client experiences with care, client safety, or effectiveness of care provided)
c) Improvement in demand for services (client awareness, or client health seeking behaviours)
d) None of these

Are there any other issues important for my understanding of health sector governance and its importance in supporting attainment of health goals you would wish to highlight?

THANK YOU, and MOST KIND REGARDS