Examining Health System Responsiveness to Public Feedback in Kilifi County, Kenya

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Abstract

Responsiveness is a core element of WHO's health system framework, judged important in ensuring inclusive and accountable health systems. However, responsiveness as a health system goal has been under-researched. I conducted a policy document analysis and a qualitative case study to examine how policy, context, and power dynamics impact responsiveness in the Kenyan health sector. I collected data in two Sub- County Health Management Teams (SCHMTs) and four Health Facility Committees (HFCs), selected as cases of spaces for processing and responding to public feedback, in Kilifi County. This case study work involved interviews with county and sub-county health managers, facility-in-charges, and local politicians, focus group discussions with HFCs, observations and document review.

Study findings suggested limited responsiveness, which was a consequence of interactions between i) a macro-policy context that adopted a narrow health service-focused framing of responsiveness, lacked a coherent strategy for system-wide responsiveness and had inadequate detail on the functioning of feedback mechanisms, ii) actor interactions and power dynamics that contributed to the public -particularly vulnerable groups being constrained from sharing feedback and health system actors being oriented away from public feedback, and iii) meso-level contextual factors such as under-resourcing of the health system and low resourcing of feedback mechanisms that worked to entrench provider norms and hierarchical relationships, and that were not supportive of system responsiveness. Informal feedback mechanisms that evolved from public efforts to leverage responses were not sufficient to generate system-wide responsiveness.

By adopting a systems lens, this work has identified interacting influences on responsiveness. Responsiveness could be strengthened by adopting policy adjustments that reflect its breadth and complexity. Policymakers and health managers should also appreciate and leverage the lived realities of actors and address the meso contextual factors that interact to hinder the processes of receiving and responding to public feedback.

Dedication

To Chris and Christina for being a constant source of joy even when being ‘without Mum’ was hard.

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List of Abbreviations

ACC	Area County Commissioner
AIDS	Acquired Immune Deficiency Syndrome
AWP	Annual Workplan
CBEF	County Budget Economic Forum
CBOP	County Budget Outlook Paper
CCC	Comprehensive Care Centre
CEC	County Executive Committee
CGA	County Government Act
CHA	Community Health Assistant
CHC	Community Health Committee
CHEW	Community Health Extension Worker
CHMT	County Health Management Team
CHPS	Community Health Planning and Services
CHSF	County Health Stakeholder Forum
CHV	Community Health Volunteer
CHW	Community Health Worker
CIDP	County Integrated Development Plan
CLAS	Comite Locales de Administracion de Salud or Local Committees for Health Administration
CORP	Community Oriented Resource Person
COSA	Comite de Sante
CS	Community Strategy
CSO	Civil Society Organisation
DANIDA	Danish International Development Agency
DHMB	District Health Management Board
DHMT	District Health Management Team
EPI	Expanded Programme of Immunisation
FGD	Focus Group Discussion
FMN	Facility Management Nurse
FP	Family Planning
FY	Financial Year
GDP	Gross Domestic Product
HCC	Health Centre Committee
HCW	Healthcare Worker
HFC	Health Facility Committee
HFOMC	Health Facility Operations and Management Committee
HIV	Human Immunodeficiency Virus
HPSR	Health Policy and Systems Research
HRH	Human Resources for Health
HRIO	Health Records Information Officer
HS	Health System
HSSF	Health Sector Services Fund
HUMC	Health Unit Management Committee
IDP	Internally Displaced Persons
ITN	Insecticide Treated Nets
KANCO	Kenya AIDS NGOs Consortium
KANU	Kenya African National Union
KEMRI	Kenya Medical Research Institute
KEPH	Kenya Essential Package for Health

KHP	Kenya Health Policy
KHSSP	Kenya Health Sector Strategic Plan
KIPPRA	Kenya Institute of Public Policy Research and Analysis
LAG	Local Action Group
LHB	Local Health Board
LMIC	Low and Middle-income Countries
MCA	Member of County Assembly
MoH	Ministry of Health
NACC	National AIDS Control Council
NGO	Non-Governmental Organisation
NHIF	National Hospital Insurance Fund
OPD	OutPatient Department
PETS	Public Expenditure Tracking Survey
PFMA	Public Finance Management Act
PHC	Primary Health Care
PLWD	People Living With Disability
PLWHIV	People Living with HIV
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
RESYST	Resilient and responsive health systems
RH	Reproductive Health
RMNCH	Reproductive Maternal Newborn and Child Health
SARAM	Service Availability and Readiness Mapping
SCCO	Sub-county Clinical Officer
SCHA	Sub-County Health Administrator
SCHMT	Sub-county Health Management Team
SCHRIO	Sub-county Health Records Information Officer
SCMOH	Sub-county Medical Officer of Health
SCPHN	Sub-county Public Health Nurse
SCPHO	Sub-county Public Health Officer
TB	Tuberculosis
TOR	Terms of Reference
UACA	Urban Areas and Cities Act
UHC	Universal Health Coverage
VHSNC	Village Health Sanitation and Nutrition Committee
WHO	World Health Organisation
WHR	World Health Report

Chapter 1 : Introduction and Overview of the Thesis

1.1 Introduction

I present the first chapter of this thesis in eight sections. In section 1.2 I present an overview of the responsiveness literature which includes the conceptualisation of health system (HS) responsiveness and the various types of feedback mechanisms that have the potential to enhance responsiveness. In section 1.3 I present a critique of the approaches commonly used to examine health system responsiveness, and in section 1.4 I outline the scope of the study and the approach that I adopt in this study to examine responsiveness. In section 1.5, I present some influences on HS responsiveness that I explored as part of the study objectives. I also highlight briefly in this section why Kenya and Kilifi County are appropriate places to research HS responsiveness. In sections 1.6 and 1.7, I present the justification for and objectives of this study respectively, and in section 1.8, I define the terminology used in this study. In section nine, I describe how this thesis is organised.

1.2 Overview of the health system responsiveness literature

Health system responsiveness is regarded as an intrinsic goal for health systems, alongside service outcomes and equity [1-4]. Responsiveness is closely tied to the broader idea of citizen, public, or community *participation* in health systems –a core ideal, promulgated in the Alma Ata Declaration, and gaining renewed attention across the world in efforts to build people-centred health systems [5-7]. Responsiveness was introduced as a health system goal by the World Health Report (WHR), 2000 and defined as '*when institutions and institutional relationships are designed in such a way that they are cognisant and respond appropriately to the universally legitimate expectations of individuals '(pg 3)* [4].

The value of responsiveness is that it can contribute to health and well-being by providing an environment in which the public seek care early, interact positively with healthcare providers and incorporate health information into their lives [3]. Responsiveness could also contribute to building more inclusive, participatory, and accountable health services, in which the social rights of different segments of the population are upheld [8-10]. Beyond this instrumental value, the WHO highlighted responsiveness as a health system goal in its own right, regardless of whether it achieved improvements in population health (WHO, 2000). This view is consistent with an understanding of health systems as people-centred and a social good [11, 12]. In the context of people-centred health systems, the importance of responsiveness is that it draws attention to the need for inclusion of public voice into decision-making in health systems. A responsive health system can build trust in the health system, and trust in turn facilitates the production of health and health care [12].

The concept and practice of responsiveness have however remained under-researched compared to the other two health system goals, health outcomes and financial risk protection and efficiency

[13, 14]. A conceptual mapping of health system responsiveness shows a lack of coherence in the literature [14]. Responsiveness is often referred to as part of other concepts, such as a principle of wider governance [15], an outcome of the relationship between the people and the state [16, 17] or between users and service providers [18-20]. The term responsiveness is also frequently used interchangeably with patient satisfaction [21] [17].

Regarding practice, it is not clear what constitutes a responsive health system. The literature describes interventions towards responsiveness such as the introduction of feedback mechanisms thought to have a health system strengthening effect, for example by including the voices of those served by the health system and providing information necessary for decision making [13, 22]. However, whether and *how* these mechanisms lead to a responsive health system requires further consideration [14, 22]. Among the issues for further consideration include, first, that the public continues to experience challenges in engaging with and eliciting responses from the health system [23, 24]. Second, the literature demonstrates that there is limited receptivity to community concerns by policymakers and health providers [22]. Third, even though HS responsiveness has an equity component, studies report lower responsiveness levels among vulnerable populations [25-27]. The section below describes the evolution of responsiveness as a concept including its links with other related concepts such as quality of care, patient satisfaction equity and accountability.

Responsiveness, Quality of Care and Patient Satisfaction

The WHO framing of responsiveness comprises eight domains: dignity of patients, confidentiality of information, autonomy, prompt attention, quality of the amenities, choice of provider, provider-patient communication and access to social support networks (for in-patients)[3]. This WHO framing draws on the quality of care literature, with dimensions such as technical, process, and structural quality [28, 29] [30]. Some of these have been useful in defining responsiveness, but no single quality-of-care framework incorporates all the domains considered important to responsiveness [3]. For example, patient satisfaction surveys have sometimes been used in judging the quality of care and responsiveness of the health system. However, these are inadequate as a measure of health system responsiveness given that satisfaction data often capture general attitudes rather than experiences of actual events [30] [3] [17, 21], are strongly influenced by patient expectations [31] [32, 33] [34, 35] and focus on interactions in medical facilities [3]. Yet, it has also been argued that responsiveness can be drawn upon to evaluate the health system holistically by exploring the different types of interactions people have with the health system [13].

Responsiveness and Equity

Equity is defined as the absence of avoidable differences among populations defined socially, economically, geographically or demographically [36]. In the WHR 2000, both the levels and distribution of health outcomes and responsiveness are important, however, inequities in

responsiveness have not received much attention in the literature [25]. There is little empirical evidence on responsiveness to vulnerable groups such as refugees, indigenous communities, key populations, or ethnic minorities, particularly in Low and Middle-Income Countries (LMICs) [37, 38]. Responsiveness is also most likely to be undermined and disrupted (especially for vulnerable populations) in periods of major and unexpected shocks to the health system, including for example health worker strikes and emerging epidemics [39, 40]. A current example is the global pandemic COVID-19, with potentially wide-ranging and long-term implications for health system responsiveness globally and in terms of equity.

Responsiveness and accountability

Bovens defines accountability as the relationship between an actor (a public institution or government agency) and a forum (such as the general public) in which the actor has an obligation to explain and justify their conduct [41]. The literature on accountability describes long-route and short-route accountability mechanisms [41-43]. Long-route accountability often involves broader social and political change; an example is the public voting out a government. In this case, the relationship between service users and service providers is mediated by an institution(s) that shapes the incentives and behaviour of state actors [10, 44]. Short-route accountability mechanisms are closer and direct relationships also referred to as social accountability between public agencies and citizens [41] [42] [10, 44]. These include *community-level* feedback mechanisms such as clinic committees, intersectoral health forums, or community monitoring [19, 45-47] and *individual-level* feedback mechanisms such as complaint boxes, exit surveys, and incident reports. Other mechanisms include score/report cards, social audits, toll-free hotlines and web-based portals [48, 49]. Bovens (2007) argues that the extent to which these more direct mechanisms are full accountability mechanisms is unclear as the possibility of judgment and sanctioning in practice appears to be lacking [41]. However, reviews of social accountability mechanisms suggest that the more direct mechanisms can use sanctions such as public shaming and transfer of staff to elicit responsiveness from service providers [18, 50].

In clarifying the relationship between accountability and responsiveness, Mulgan points out that accountability is often described as the extent to which governments pursue the needs or wishes of their citizens, but that this in fact refers to responsiveness, to which accountability is a means [51, 52]. In this thesis, the long and short accountability routes described above are considered *formal* feedback mechanisms between the public and state actors. Formal mechanisms are those that are mandated within legislation or policy documents. However, there also exist *informal* mechanisms through which the public provides feedback to state actors. These are not necessarily mandated or legislated and might appear in contexts where formal mechanisms are absent or are

considered ineffective by citizens [53-55]. Informal mechanisms include individual complaints or compliments shared directly or via an intermediary and collective feedback such as public protests or 'public buzz' (conversations in public places)[53, 54].

Influences on the practice of health system responsiveness

Existing responsiveness literature describes power asymmetries between health system actors and citizens as a distinct feature of health systems [56, 57]. It is suggested that as these asymmetries diminish, the ability of the public to make their voices heard may rise, potentially enhancing responsiveness [57]. It is however unclear how collective action influences system responsiveness particularly when there is a risk that participation could be used as a tool for state actors (and donors in the case of Civil Society Organisations (CSOs) to implement their priorities. An examination of power dynamics, exploring actor interactions and practices is therefore pertinent to understand the extent to which public feedback results in enhanced health system responsiveness.

Broader health policy and systems literature highlights that context influences how policy is implemented [58-60]. Thus, contextual analysis is important to better illuminate a phenomenon of interest [61, 62]. Concerning HS responsiveness, Mirzoev and Kane highlight that it is important to consider not just the environment in which individuals receive services and interact with health systems, but broader contextual influences [13]. These contextual factors can shape the functioning of the health system and therefore the ability of feedback mechanisms to channel public feedback. These broad contextual features include political culture, a history of conflict and authoritarian regime [24, 63], health worker strikes [64, 65] and disease outbreaks such as the 2014-2015 Ebola epidemic in West Africa [40, 66]. More recently, when COVID-19 was declared a global health threat in March 2020, health systems across both high-income and low and middle-income countries (LMICs) were forced to re-organise service delivery, to ensure adequate COVID-19 response and continuity of essential services [67, 68]. Given the nature of the virus and the COVID-19 response strategies adopted by multiple countries, many of the participatory feedback mechanisms that could enable health system responsiveness were constrained as face-to-face public engagement was discouraged [69]. This draws attention to the influence of context, and the potential for responsiveness to be undermined and disrupted (particularly for the most vulnerable populations) during times of health system crises.

1.3 Examining health system responsiveness

The WHO framing of responsiveness is the most used framework for examining health system responsiveness. However, although this framing uses the term 'system' responsiveness, it is mainly focused on the interaction between individual users or patients, and health *services* [4, 13]. Studies that have examined such responsiveness have tended to adopt an evaluative approach, commonly

utilising surveys to collect feedback from patients after using services [26, 27, 70, 71]. These studies also commonly report on a composite satisfaction index or proportions of patients satisfied with dimensions of responsiveness [8, 26, 27, 70]. As a result, responsiveness is predominantly depicted as an outcome of reactions to individual-level feedback from service users and could be termed 'health *service* responsiveness' (Fig. 1).

The literature suggests a broader systems lens that goes beyond patient-provider interactions could be more appropriate to examine health *system* responsiveness [13, 72]. This is because, first, a systems lens demands consideration of public interest not just patient interests. Valentine et al (2003) point out that focusing on health service use and satisfaction overestimates responsiveness by focusing only on those that have accessed the health system while excluding the experiences of those who have not accessed health services [3]. Further, patient interests are important, but these sometimes differ from public interests [42]. It may, therefore, be necessary to balance the narrower interests of patients against the greater public interest and common good, to ensure equitable responsiveness [42]. Second, a systems lens also recognises multiple interactions between the public and the health system. While service use is the most common citizen interaction with the health system, there are other interactions such as priority-setting and oversight arrangements which need to meet the needs and values of the public [13]. Further, these multiple interactions occur through both formal and informal mechanisms. A system lens would include informal feedback mechanisms, as these appear to be important in practice, especially in contexts where formal feedback mechanisms exclude certain population groups [54]. These informal mechanisms are barely considered in the current literature [37].

Third, a systems lens would go beyond the collection of data on patient and public experiences to examine micro-processes within feedback mechanisms, such as what happens to the feedback that is received, how (or whether) certain feedback is prioritized and eventually whether the health system generates responses. A focus on responses is important because it directs attention to closing the loop between feedback received and action taken. However, a review of the responsiveness literature suggests that more attention has been paid to the collection of feedback than to how this feedback is used to generate a response from the health system [37]. Fourth and related to learning about what happens with feedback that is received, a system lens demands focus on actors and their interactions across levels of the health system. Processes related to responsiveness including the generation of responses are enacted by people. Given the social nature of health systems [6] these actors are likely to bring their values and interests into these processes and therefore shape HS responsiveness.

Fourth, a systems lens recognises that the health system is complex; power relations and contextual factors such as history and organisational arrangements influence what information or feedback

the health system receives and responds to [10, 13, 73-75]. These are therefore important considerations when examining health system responsiveness, but these have not commonly been studied. In summary, in this study, I applied a systems-lens approach to examine responsiveness by considering the influence of the macro-level policy context, the meso-level county and health system organisational context and micro-level actor interactions on health system responsiveness.

1.4 Scope of this thesis

The focus of this study was responsiveness to public feedback at the sub-national level in Kenya. Drawing on document analysis and case study methodology, I set out to examine the policy and practice of responsiveness in Kilifi County in Kenya to generate an understanding of how public feedback is received and responded to and what influences come into play, to inform policy recommendations to strengthen responsiveness.

As noted above, our understanding of health system responsiveness can be deepened by adopting a health 'system' rather than a health 'service' lens. In this study, I adopted a systems lens to examine the practice of responsiveness. Figure 1.1 below, summarises what adopting a health systems lens entailed in this thesis. First, this included recognising that service responsiveness remains part of health system responsiveness. Other elements that formed part of this systems lens included: considering interactions between the public (not only patients) with the health system and exploring the functioning of formal and informal mechanisms (chapters 5 and 6); and explorations of policy and legislative context and organizational context (chapters 4 and 8).

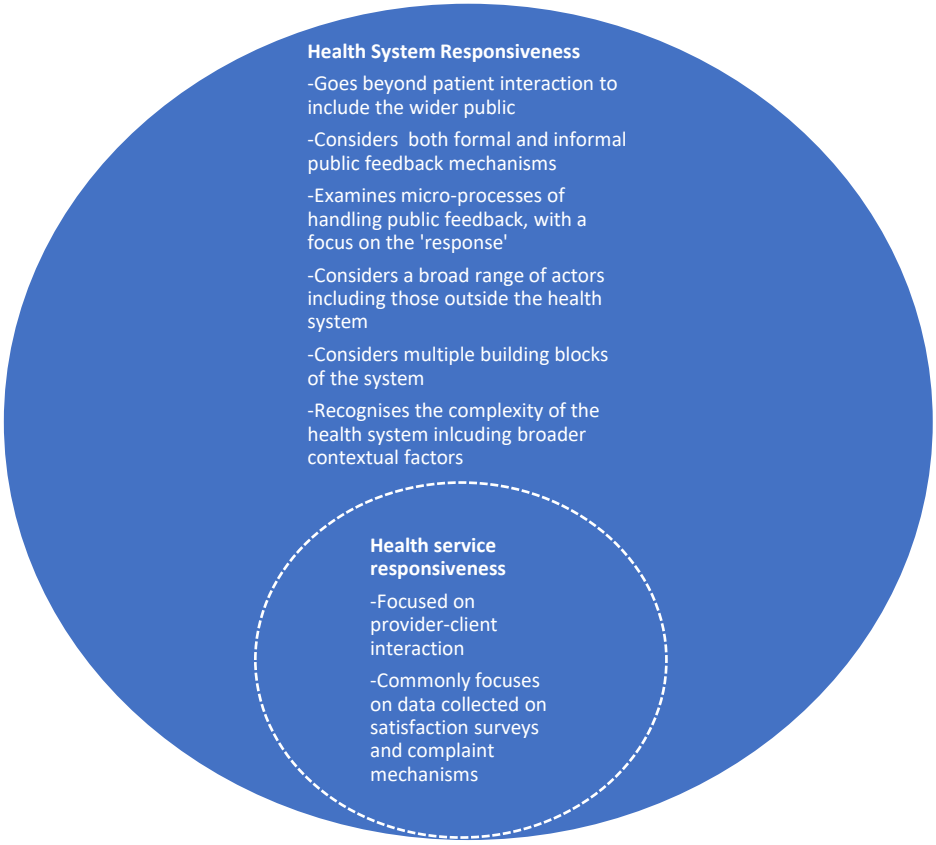

Figure 1.1: Relationship between health service and health system responsiveness

1.5 Background: Kenyan context

In this section I provide a brief history of the Kenyan context, as relevant to considering health system responsiveness. More detail about Kenya as a study setting and Kenyan national policy concerning health system responsiveness are presented in Chapters 3 and 4 respectively.

Kenya has a history of health system reform that includes varying levels of decentralisation [76-78], and the introduction of feedback mechanisms aimed at enhancing responsiveness [79]. In section 1.2 above, I referred to long-route accountability mechanisms such as elections that may be used to enhance responsiveness to the public. Long-route accountability in relation to responsiveness in Kenya is illustrated by how the post-independent government used health policy to achieve both political and health objectives [76]. The Kenyan government in 1963, abolished user fees at public health facilities. This served two purposes, first, to be *responsive* to the health needs of Kenyans who faced racial discrimination in the provision of healthcare under colonial rule. Second, there was an agenda to make the government popular among the people [76]. The government also adopted a centralised mode of healthcare service delivery, organised around the Ministry of Health (MoH), aiming to provide uniform services across all the regions of the country [76].

Kenya's health status indicators improved with the early independence economic boom. These include an increase in the number of health facilities and trained medical personnel, declines in the crude death rate and infant mortality rate, and increases in immunization coverage and life expectancy between the 1960s and 1970s [76] [77]. Specifically, the crude death rate improved from 20 per 1000 persons in 1963 to 13 in 1987, further improving to 12 per 1000 persons in 1991; life expectancy increased from 40 years in 1960 to 58 years in 1994; infant mortality improved from 126 per 1000 in 1962 to 60 per 1000 in 1994; and the immunization coverage rose to 70 percent in 1994 from less than 40 percent at independence in 1963' [76, 80].

However, there was a decline of health indicators in the 1980s owing to the harsh economic times and debt crises that faced many developing countries [62, 76]. The Kenyan economy in the 1960s and early 1970s was oriented towards exports of agricultural products and dependent upon favourable prices being paid by foreign consumers. While these policies led to growth and contributed to improved standards of living, they left the country vulnerable to shifts in the global economy [81]. The global recessions caused by the oil crises of 1973 and 1979 had devastating effects on the economy of Kenya and other countries across the African continent, with negative implications including for the health sector [76]. In 1979, a sharp decline in the price of coffee coupled with a doubling of the price of imported oil compelled Kenya led to severe foreign exchange shortages and payment challenges [82]. Consequently, Kenya adopted structural adjustment economic policies to obtain World Bank financing [82].

The government was unable to continue financing the broad-based Primary Health Care (PHC) and health services in general [76, 83]. The economic and political context appeared to influence the extent to which government could be responsive to the public's health needs and expectations. For example, due to the economic challenges mentioned, user fees were introduced in all levels of care in 1989 under the umbrella of the Structural Adjustment Programme, to supplement health financing. The introduction of user fees -despite the concurrent introduction of waivers and exemptions- decreased facility utilisation by the poor [76, 83]. User fees were suspended in 1990 and re-introduced in 1992 after setting up institutions to address the administrative and management problems of collecting and re-directing user fees to facilities. These included the Health Care Financing Division set up to improve revenue generation and utilisation of user fees [76]. The re-introduction of user fees coincided with the introduction of multi-party politics in Kenya, threatening the popularity of the ruling party Kenya African National Union (KANU) among the masses. In response to growing discontent with the government at the time, political opposition parties[1] challenged the government's inability to provide 'free' health care services to its citizens. Given the political context and a desire to maintain popularity with the masses, revisions to the user fee policy were continuously announced, mostly at public rallies [76]. Despite the revisions, user fees were not completely abolished, instead, charges were reduced.

Despite the reductions, evidence suggested that user fees significantly hindered access to health services, particularly for the poor [84, 85]. Therefore to address equity concerns and to fulfill election pledges (reflecting the functioning of a long route accountability mechanisms to impact responsiveness) the Ministry of Health (MoH), in 2004, introduced the '10/20' policy which stipulated payment of registration at dispensaries and health centres for 10 and 20 shillings respectively; individual services were not to be charged [86, 87]. A waiving policy was again put in place to protect the poor, children below five years and patients requiring TB/HIV treatment were exempted from all charges, but, waiving and exemption mechanisms were not effectively implemented resulting in compromised access for the poor [86].

More recently, following political agitation for greater democracy, public accountability and equity, Kenya adopted a new constitution in 2010. In 2013, health sector service delivery was devolved to the counties in line with the 2010 constitution. The new governance architecture comprises a national government and 47 county governments. Devolution introduced new political actors who include Governors (elected heads of county governments) and Members of County Assembly (local political representatives). Public participation in policymaking and implementation is enshrined in the 2010 Kenyan Constitution. Various legislative instruments (described in Chapter 4) further

[1] Kenya had resumed multi-party politics following an announcement by the President on 3rd December 1991 that one party system was to be dismantled (Branch, 2011)

entrench the participatory principles outlined in the Constitution. These principles cut across the public sector including health.

The long-route accountability mechanism (operating through political actions) described above appeared to influence responsiveness to the public. In addition, over time there have also been short-route mechanisms introduced to enable public involvement in the management of their health affairs and to enhance responsiveness. These mechanisms include health facility committees (HFCs), community health committees (CHCs) and Community Health Workers (CHWs), service charters, District Health Management Boards (DHMBs) and more recently public participation forums [88]. Robone et al, suggest that a country with more avenues through which the public can voice their views could potentially have a more responsive health system [89]. Given the brief political, economic and health system history described above, and the introduction of varying feedback mechanisms over time since independence, Kenya presents a favourable context to understand the practice of responsiveness. However, there is limited literature regarding the practice of responsiveness in Kenya [73, 90], even though health system responsiveness is identified as a broad goal of the health system [91-93].

Why Kilifi County?

I conducted this study in Kilifi County. Kilifi County is among the six counties in the Coast region of Kenya (Figure 2.1). It covers an area measuring 12,370.8Km2, and comprises seven administrative sub-counties namely; Kilifi South, Kilifi North, Ganze, Malindi, Magarini, Kaloleni and Rabai and thirty-five (35) devolved political units (Wards) [94].

Figure 1.2 Map of Kenya showing location of Kilifi County
Source: Kilifi County Integrated Plan (CIDP) 2018-2022

The decision to focus on the sub-national level to examine the practice of responsiveness was informed by the 2013 governance changes that introduced devolved governments, and a desire to generate findings that have local and national relevance. How policy is implemented at the sub-national level is important to the national level, given the policy-making role of the national government in the current Kenyan constitution and specifically for the health sector.

Following devolution, the Kilifi County health system displayed both strengths and weaknesses. For example, early health sector experiences of devolution included challenges with human resources, commodity management and financial planning [95, 96]. Despite these challenges, devolution led to increased decision space at the county level [96, 97], and when the county was able to procure commodities after initial challenges, there were better commodity order fill rates at facility level in comparison with pre-devolution days [95]. Further, over time there have been increases in the Human Resources for Health (HRH) numbers following devolution though these numbers remain inadequate due to concurrent increases in the number of health facilities [97]. These increases in HRH have been accompanied by local interventions and incentives aimed at retaining HRH in remote areas [97].

Studies on the devolved Kilifi County health system have examined processes of financial planning and budgeting, priority setting for commodities and HRH, and the experiences of managers at sub-county and facility levels [64, 95-100]. The improvements and challenges described in relation to management and governance processes examined in these studies illustrate some efforts to be responsive to local needs. However, none of these studies explicitly set out to examine the inclusion of public feedback into decision-making at any of the county health system governance levels. This research, therefore, intends to fill this gap and contribute to the national understanding of health system responsiveness.

Kilifi County has active and embedded health systems and policy researchers who have links both to the county and national governments. In Kilifi County, these relationships between health system researchers and health system actors, have promoted actor-researcher engagement and co-production of knowledge [101]. More details about this relationship and Kilifi County as a study setting are presented in Chapter 3. As a researcher with applied interests, this existing researcher-health manager relationship is of importance to me in eventually taking forward some of the study findings to strengthen responsiveness.

I have contributed to some of the research on the Kilifi County health system, particularly on health system resilience and the experiences of health managers. This current study therefore not only builds on some of the existing research about health system governance but is also of personal interest to me as someone who lives and works in Kilifi and is a user of the Kilifi County health services.

1.6 Study Justification

The concept of 'responsiveness' needs further development, and there is value in distinguishing between '*health service responsiveness*' (focused on responding to the articulation of patient need), and the broader idea of '*health system responsiveness'* (inclusive of all people in the health system, and the responsiveness of the whole system). There is limited information available on the generation of responses to public feedback, especially system-wide responses [18]. There are also varied informal feedback mechanisms that are rapidly emerging in LMIC systems – such as the increased utilisation of social media, mainstream press, and social protest [102, 103]. However, most of the studies on informal feedback mechanisms such as social media are from high-income country contexts [104-106] and little is known about these less traditional forms of feedback on LMIC health system functioning. In sub-Saharan Africa and Kenya more specifically, there is limited literature on how informal mechanisms function to elicit responses from the health system. For example, there have been mainstream press reports about the prolonged health worker strikes of 2017 in Kenya [107, 108] and inefficiencies in emergency medical services [109]. During the early days of the COVID-19 pandemic, there were numerous 'tweets' and several mainstream media

reports about police brutality in enforcing prevention measures and the challenges of social distancing and quarantine among low-income communities [110-112]. It is however unclear if and how this public feedback influenced health system responsiveness. In this study, I explored different feedback mechanisms including their design, who utilises them and how, influences on their functioning, including responses the public could leverage from the health system. This fills a knowledge gap in Kenya, contributes to national policy and practice discussions, and contributes to the gap in the broader LMIC literature on health system responsiveness including in times of health system crises.

1.7 Study Objectives

General Objective

To examine the policy and practice of health system responsiveness in Kilifi County in Kenya, including actor power dynamics and contextual influences.

Specific Objectives

1. To analyze the policy and legislative context for health system responsiveness in Kenya
2. To analyze the practice of responsiveness in Kilifi County
3. To critically examine how actor and power relations impact responsiveness to public feedback in Kilifi County
4. To examine the influence of contextual factors including health system shocks on health system responsiveness in Kilifi County
5. To identify and propose strategies for strengthening health system responsiveness to citizen feedback

1.8 Definitions and terminologies used in this study

For this study, I define health system responsiveness as how the health system reacts/responds to the needs and concerns of citizens [37]. The term '*feedback*' as used in this work refers to concerns, needs, views and input raised by the public about the organisation and functioning of the health system. The term feedback '*mechanism*' or '*channel*' refers to a route through which the public raises concerns and suggestions or gives information to health system actors. A '*response'* refers to any action taken (including providing information) because of the feedback received. To understand the practice of responsiveness, I considered two *spaces* within the health system: Sub- County Health Management Teams (SCHMTs) and Health Facility Committees (HFCs). These *spaces* are governance structures within the health system where I expect that public feedback would be received, processed, and responded to at the sub-national level. SCHMTs are comprised of middle-level managers within the health system, who have responsibility and oversight over service delivery in Primary Healthcare (PHC) facilities in every sub-county. HFCs have oversight and management roles at PHC facility level. They are comprised of elected community members living within the catchment area of a PHC facility and a representative of the PHC facility usually the

facility-in-charge. In practice, there are linkages between SCHMTs and HFCs because SCHMTs have oversight roles over PHC facilities where HFCs function. More details of the organisation of the Kenyan health system are provided in section 3.2.

1.9 Organisation of this thesis

The thesis is structured into 8 chapters. In this first chapter, I have introduced the thesis and presented an overview of the focus of the work, research justification, objectives, and definition of some of the terms used in the thesis.

In chapter two, I present two literature reviews that synthesise key empirical findings on studies that have reported on the functioning of 1) District Health Management Teams (DHMTs-SCHMT equivalent in other LMICs) and 2) HFCs, in relation to health system responsiveness and the influences on SCHMT and HFC practices of receiving and responding to public feedback.

In chapter three, I present the study setting and methodology. Chapter three begins with a detailed account of the study setting giving a background of Kenya and Kilifi County. In this chapter, I also introduce the case study approach, which I employed for this study, drawing on experiences from SCHMTs and HFCs within the county health system as study cases to examine the practice of responsiveness. Chapter three also presents the study conceptual framework derived from broad responsiveness literature, and two power frameworks which I applied to the collected data in my analysis to explore the influence of actor interactions and power dynamics on the practice of responsiveness.

Chapter four is the first of four results chapters of this thesis. In this chapter, I present a description of findings from a content and framing analysis of national policy documents and legislative instruments. I explore answers to the questions: How is responsiveness framed within policy documents? What procedures and mechanisms are proposed in policy documents to support a responsive health system? These questions are important because the content about and framing of responsiveness have implications for whether responsiveness is prioritised by health system actors on the ground, and for the practice of responsiveness (described in Chapter 5).

In Chapter five, I present a description of the membership, facility, and sub-county contexts of the case study HFCs and SCHMTs. I also present findings about the range of public feedback mechanisms available in Kilifi County, through which the case study HFCs and SCHMTs received public feedback. In this chapter, I also highlight the content of public feedback received and present initial findings on system hardware and tangible software factors influencing the functionality of feedback mechanisms, and the nature and spread of responses generated at SCHMT and HFC level.

In Chapter six, I aim to explain the findings presented in chapter 5 by focusing on the role of interactions between actors, their interests, and their exercise of power and how these shaped

health system responsiveness. In this chapter, I consider the general functioning of the case study SCHMTs and HFCs, as well as the specific processes of receiving and responding to public feedback in these spaces.

In Chapter seven, I present key contextual influences on health system responsiveness. This chapter explores several factors identified in preceding chapters more deeply. These factors include resource constraints and oversight mechanisms (mentioned briefly in Chapter 5), provider norms (referred to briefly in Chapter 6) and the functioning of feedback mechanisms in the study's devolved context. In this chapter, I also examine the practice of responsiveness as the COVID-19 pandemic unfolded in Kilifi County and consider its implications for responsiveness.

In chapter eight I present an integrated synthesis of the results chapters and consider the study's contribution to the literature on health system responsiveness, HFCs, and SCHMTs. In addition to proposing areas of further study, I also make several recommendations towards strengthening responsiveness.

Chapter 2 Literature Review

2.1 Introduction

In this chapter, I present two literature reviews. These two reviews advance the literature presented in Chapter one, which has focused more on the conceptualisation of responsiveness. Since this study examines SCHMT and HFC practices of responsiveness, it was important to examine the existing literature on District Health Management Teams (DHMTs) and HFCs to identify the research gaps in relation to the practice of responsiveness. The first review is a synthesis of the literature on HFC practices that contribute to health system responsiveness and what factors influence these practices. The second review examines the literature on DHMTs to identify how they receive, process, and respond to public feedback, and explores the influences on DHMTs' practice of responsiveness. Both reviews were shaped by and are presented in line with the study's conceptual framework. The conceptual framework was informed by a review of broader responsiveness literature [14, 72]. It draws on an understanding of responsiveness as how the health system reacts or responds to the public's needs and concerns [14], and is explained in more detail in section 3.3. From this conceptual framework, the responsiveness pathway comprises three processes: receiving, processing (could include analysis, integration and/or prioritization) and responding to feedback [14].

2.2 Review 1: How Health Facility Committees mediate health system responsiveness in Low and Middle-in-come countries

2.2.1 Review Methodology

Between March and April 2020, I searched 3 databases: Scopus, Pubmed and Google Scholar for articles on HFCs and responsiveness published in English between 2000 and 2020 using the search strategy outlined in Table 2.1 below. I adopted McCoy et al's definition of a health facility as a *'formally constituted structure with community representation that is linked to a health facility with a primary purpose of enabling community participation in health to improve health service provision and health outcomes'(pg 1)* [113]

Table 2.1: Search strategy for HFC review articles

Term A[1]: Responsiveness Variants combined by OR	**Health Facility committee** Variants combined by OR	**Geographical distribution**
Responsive*, Social accountability, accountability, community participation, community feedback, community participation, Community voice	Facility committee*, village committee*, facility management committee*, village health committee*, community health committee*, village health board, village health council*, village development committee* (AND health), facility management and operations committee*, health group	Low* and middle income, Low* income, LMIC, developing countr*, South, Africa, Latin America, Sub-Saharan Africa, Asia [List of countries classified as LMIC][2]

[1] The three groups were ultimately combined with AND, [2] List of country classification by economies available at https://datahelpdesk.worldbank.org/knowledgebase/articles/906519

Inclusion criteria

1. Peer-reviewed articles (reviews, empirical work, commentaries) and grey literature with substantial content on existing HFCs
2. Articles published between 2000 and 2020
3. English language articles
4. Studies conducted in LMICs

Exclusion criteria

1. Studies from High-Income Countries
2. Books and book chapters

The initial search identified 375 articles, 45 duplicates were removed, and 274 articles were discounted as not relevant after title and abstract review, leaving 56 articles for full-text review. After a full-text review, 33 were retained. After reviewing the references of the 33 retained studies, I identified an additional 7 relevant articles. Figure 2.1 below shows the screening process:

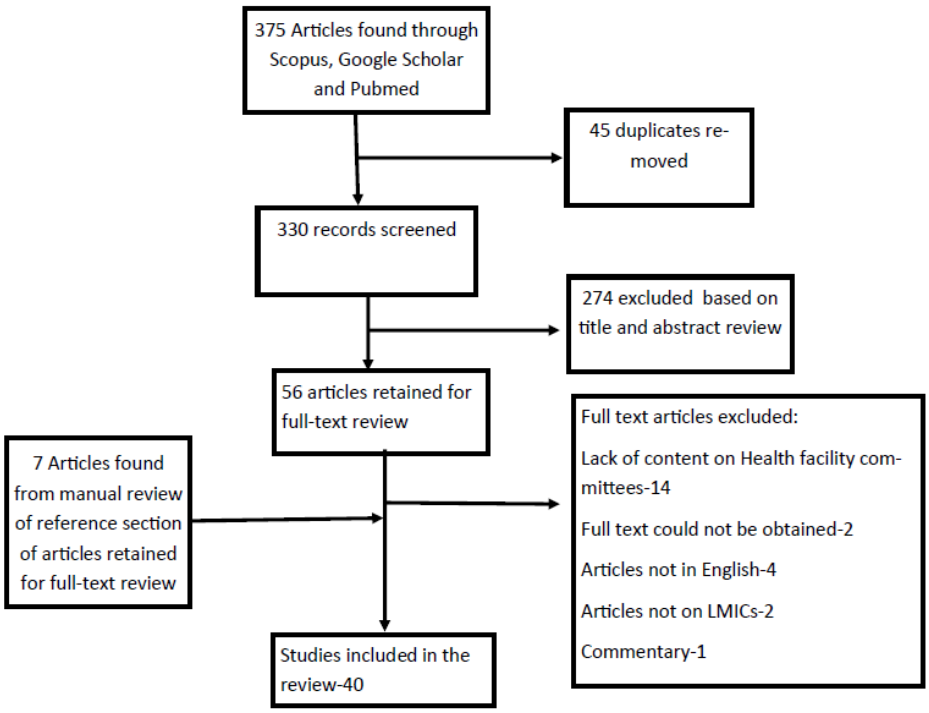

Figure 2.1: Article screening process

Data abstraction and Analysis

I retained all articles that met the criteria above for full-text reading. I abstracted data into a table, where the contents of each article were summarized and reviewed comparatively. The categories for abstraction included HFC membership characteristics, functioning, influences on functioning and process related to handling public feedback. The latter were drawn from the study's conceptual framework explained in more detail in section 3.3. From this conceptual framework, the responsiveness pathway comprises three processes: receiving, processing (could include analysis, integration and/or prioritization) and responding to feedback [14]. Box 2.1 below summarises the categories that were extracted from the various studies.

- General information regarding study setting and study design
- General HFC formation and roles
- Description of HFC Form and functioning
    - Selection criteria and processes
    - Roles of HFCs,
    - Frequency of HFC meetings
- How HFCs received public feedback
- Content of public feedback received by HFC
- Inclusion of the voices of vulnerable groups
- Processes related to managing feedback at the HFC level (such as analysis, prioritisation)
- Responses to public feedback generated by HFCs
- Influences on HFC functioning
    a. Health system context
    b. Community characteristics
    c. Wider contextual issues

Box 2.1 Summary of content extracted from reviewed articles

2.2.2 Results

In this sub-section, I will present a brief overview of the characteristics of selected studies and their study design. A more detailed summary of the study objectives and methodologies of the 40 final papers is presented in Appendix 1. Then, in line with the categories presented in Box 2.1 I will present findings on the practice of responsiveness within HFCs and influences on HFC functioning identified from the literature.

Article characteristics

Four of the papers included were reviews; two reviews focused on accountability structures, but with significant discussion of HFCs [10, 114] while the other two focused entirely on HFCs [61, 113]. One review focused on social accountability structures within Sub-Saharan Africa [114] while the other reviews[10, 61, 113] included LMICs from other regions beyond Sub-Saharan Africa. Study characteristics of the 36 empirical studies are summarised in Figure. 2.2 below.

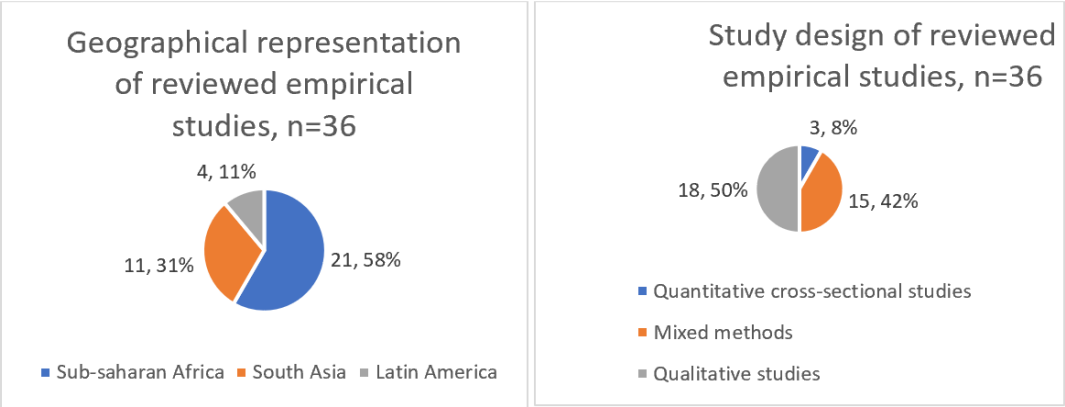

Figure 2.2: Study characteristics of empirical papers

HFC practices related to health system responsiveness

The majority (30/36) of the empirical papers discussed health facility committees typically initiated as part of broader efforts (such as decentralisation) aimed at improving health system effectiveness and strengthening community participation, but a few of the studies described HFCs supported by Non-Governmental Organisations (NGOs) [115-119]. Within the papers reviewed, HFCs' roles

mainly included health facility management and oversight including involvement in planning, resource mobilization for the health facility, and acting as a channel of communication between the facilities and communities including voicing community needs and concerns to health staff and facilities.

In the McCoy et al and George et al reviews, the inward-facing role of supporting the functioning of health facilities and the objectives of health providers was reportedly the more commonly examined role in studies reviewed [61, 113]. McCoy et al defined the outward-facing role of HFCs as one that supported user and public voice and 'integration of the public's preferences in health system decision-making' [113] [114]. In my study, this outward-facing role was the most relevant to examining how HFCs mediated health system responsiveness. I explored HFC mediation of health system responsiveness across the reviewed papers by considering four elements: whether and how HFCs received public feedback, the content of that feedback, how feedback was processed (analysed), responses generated by HFCs, and whether these responses were communicated to the public. I discuss these issues in turn below.

Receiving public feedback

In the studies reviewed, HFCs reportedly received little feedback from the public. Among the reasons for this were a low awareness among members of the public about the existence of HFCs and who comprised the membership [115, 116, 120-125], perceptions that members of the HFC were too educated to talk to [123, 124], and a low awareness among the public of their rights and entitlements in relation to health services [23]. There was also a perception amongst the public in some of the study contexts that HFCs had little power to effect change. As a result, they did not bother reporting or providing any feedback to the HFCs. For example in the Ugandan study by Golooba-Mutebi et al, the public had low expectations of the Health Unit Management Committees (HUMCs) because they perceived that political actors who had the power to take action would not acknowledge negative feedback particularly when it concerned frontline workers with whom they had social connections or who were their relatives [24].

Another reason why HFCs picked up little feedback from the public was that the HFCs themselves were oriented away from the public. For example, in four of the reviewed studies, the authors reported that HFC members were more focused on supporting health facility objectives than community representation [115, 125-127]. Information tended to flow from the health system through the HFCs to the public, and rarely from the public to the health system. For example, in the Burundi study by Falise et al, the HFCs spent more time facilitating health centre activities such as health sensitization, bringing patients to the health facility and updating their files [126], while in the Indian study by Feruglio and Nisbet (2018), the Village Health Nutrition and Sanitation

Committees (VHNSC) mainly carried out tasks and roles that service providers could not do due to lack of time, capacity and money [127]. In both cases, the extent to which the committees monitored service delivery at facility level and their orientation to public feedback was limited.

Content of public feedback

Despite the challenges to receiving public feedback described above, the reviewed studies did show that sometimes HFCs picked up some public feedback. Notably, in the reviewed studies, the content of public feedback was commonly mentioned without reference to the mechanism through which HFCs received this feedback. Box 2.2 below summarises some of the content of public feedback teased from eleven of the reviewed articles. I have organised this feedback into four broad categories: provider-client relations, infrastructure, staffing and commodity-related feedback, service delivery process concerns, and broader issues related to health sector planning and health service uptake and challenges in accessing services.

Provider-client relations

- Requests for informal payments by HCWs [128, 129]
- Absenteeism from work [24, 123, 128, 130]
- Rude, unfriendly, and disrespectful service providers [23, 129-131]
- Inadequate treatment information provided by frontline workers [23]
- Lateness to work among service providers [23]
- Lack of confidentiality of medical treatment [23]
- HCWs providing services while inebriated [129]

Infrastructure, staffing and commodity-related requests

- Requests for additional staff at health facilities [132, 133]
- Complaints about lack of drugs in facilities [127, 133, 134]
- Request for an ambulance in the facility [23, 127]
- Inadequate medicines at the facility-level [23, 131]
- Near-expiry medicines [23]
- Low quality of drugs [129]

Service delivery process concerns

- Complaints about clinic opening hours [23, 134]
- Complaints about lack of 24-hour service delivery [119, 129]
- High drug prices and consultation fees [24, 129, 130]
- Peripheral settlements being left out during community outreaches [130]

Other issues related to health planning or that impacted uptake of health services

- Priorities proposed for inclusion in health facility plans: health education, environmental & sanitation concerns; inclusion of youth in facility committees; attention to substance abuse, nutrition among the elderly, malnutrition among children, neglected diseases such as hydrocele and elephantiasis [135]
- Water and sanitation problems in the community [131]

Box 2.2: Summary of content of public feedback extracted from reviewed studies
Abbreviations: HCW-Healthcare worker

Mechanisms through which HFCs received public feedback

HFCs received public feedback in three main ways. The first, and the most common way, reported in six of the reviewed studies was informally, when members of the public approached them [23, 24, 128, 129, 134, 136]. Direct complaints from members of the public were also shared during public interactions initiated by HFCs to increase demand for use of facility services [130]. Second, HFCs received public feedback through CHWs who also served as HFC members [132]. The third way was through HFC monitoring and observation of facility service delivery [118, 128, 129, 133, 137].

The approach adopted by most HFCs for receiving public feedback was not systematic and few HFCs proactively approached members of the public or service users to find out about their experiences with the health system. In one study conducted in Nepal, HFC members received public feedback informally, and participated in public meetings where findings of social audits and community health scoreboards were shared for selected facilities in the study districts [132]. These meetings served as a platform for the public to raise concerns and for HFC members and frontline providers to respond. These social audits and community health scoreboards while valued by the HFC members and the health providers did not include all health facilities in the study districts, and women from the harder-to-reach areas often did not participate to give their feedback. Further, their conduct was mainly facilitated by NGOs who had time-limited contracts [132].

Other formal approaches were rarely utilised or accessed by the HFCs in the reviewed studies. For example, there was little use of formal feedback mechanisms such as suggestion boxes or written complaints that HFC members could access. Reasons for this included low awareness of the existence of suggestion boxes including how to use them [23, 138], scepticism that members of the public would get a response [138] and fears about anonymity [124].

Five of the reviewed studies reported monitoring and observation of service delivery as a way that HFCs received public feedback [118, 128, 129, 133, 137]. These studies also reported little evidence of a systematic approach, except in one study conducted in Malawi, where practices varied across the HFCs that were reported on but appeared to be systematic [128]. In this study, half of the 22 HFCs examined, reported visiting their health facilities at least twice a week to "*see how patients are treated"* and *"check how health workers are working" (pg 6),* five HFCs made sure at least one member of the HFC was present to monitor service delivery daily, while two HFCs maintained an observation form in which they recorded, for example, consultation time and healthcare worker (HCW) duty hours [128].

Processing public feedback

Of the reviewed studies, I identified five studies that considered what happened to public feedback in terms of processing or analysis of feedback after it was collected [23, 126, 128, 129, 132]. Two of the five studies reported some documentation of public feedback as part of HFC minutes [128, 129], but most of the feedback received across the remaining studies was often undocumented, suggesting that there would be challenges in conducting follow-up of feedback to confirm resolution and in identifying trends. There was however one exception. In the Lodenstein et al study conducted in three West and Central African countries, one HFC in the Democratic Republic of Congo had appointed one member as a complaint manager who had the task of follow-up of the decisions made and actions identified during HFC meetings. The complaint manager also kept these issues on the agenda until the facility-in-charge had implemented some action [129].

Responses to public feedback

About a third of the reviewed studies (11/36) reported on responses to public feedback generated at HFC level [119, 123, 127-133, 137]. These responses took various forms and involved multiple actors, including facility-in-charges, frontline staff, district health managers, NGOs, and political representatives. Commonly reported responses were *dialogue and mediation.* These responses were generated for issues that included HCW conduct problems and service delivery problems in four of the reviewed studies [119, 128, 129, 132]. For example, in Benin and Guinea, HFCs discussed service failures, leading to changes in the quality of services, such as improved health worker presence, the availability of night shifts, the display of drug prices and the replacement of poorly functioning health workers in meetings with health managers [129]. In Malawi, HFC members reported engaging directly with the health provider to discuss issues of conduct, in many cases resulting in a joint agreement for respectful relations at the health facility [128].

Another way that HFCs responded to public feedback was through *local regulation,* reported in one study in Benin, where the HFC introduced regulations and sanctions to enforce health providers' financial accountability. These included formal banning of the sale of parallel drugs using the health facility prescription orders or the sale of drugs on credit without approval by the HFC, and warnings of recommendations for transfer to other facilities for instances of financial misconduct [129].
Concerning public feedback related to infrastructure, commodities, and staffing gaps, HFCs also *provided explanations* to the public about some of the challenges faced by facility staff during public meetings [128, 130]. Other reported responses included *resource mobilisation* by HFC members to meet identified gaps at the facility-level [130-132]. In contexts where HFCs received funding from the government, the members used the HFCs' funding to respond to complaints about drug shortages [127, 132].

Eight of the 36 reviewed studies reported that HFCs *escalated issues to higher or more powerful authorities* such as district health managers, and political representatives [128-133, 135, 137]. For example, for HCW conduct issues when the dialogue with the staff at facility-level did not bear fruit, HFC members then reported to higher authorities [128, 129]. Other feedback that HFCs reported to higher authorities included staffing gaps, water and sanitation challenges, and drug stock-outs [130, 132, 133, 137]. In the Kenyan study by O'Meara et al, public input related to local priorities for health planning was incorporated into facility plans and shared upwards with district managers [135]. However, only those local priorities that aligned with national targets were eventually included in district plans. Similarly, issues identified by HFCs in Zimbabwe even though shared upwards with district health managers were often not considered during priority-setting at the district-level [131].

Among the studies identified above that reported escalation to a higher authority by HFCs, in six of the studies, there seemed to be difficulty in leveraging responses from these higher authorities [123, 125, 130, 132, 133, 137]. For example, In India, Village Health Sanitation and Nutrition Committee (VHSNC) members made requests to government for filling staffing vacancies, equipping facilities with supplies and medicine, training the untrained Accredited Social Health Activists, and improving access to water but received no response [133, 137]. Similarly, efforts by an HFC in Kivukoni in the Tanzanian study reported by Macha et al also received no response from district-level managers after escalating feedback about drug shortages [123]. In Zambia, even though HFCs functioned with the supervision and involvement of the DHMTs, their efforts to contact and consult the DHMT without authorisation by the secretary (the health centre in-charge) were disapproved of by DHMT officials, making it challenging to generate responses that required DHMT support, particularly when they concerned healthcare worker conduct [125].

In summary, from the reviewed studies, HFCs picked up little feedback, and relied mainly on informal interactions to learn about public views and concerns. In addition to this largely passive approach to receiving feedback, there was little documentation of public feedback across the studies reviewed. There was also little attention paid to responses to public feedback generated at HFC level, as these were only considered in a third of the reviewed articles. The studies that did consider responses, described mainly local level actions. Amongst the studies that reported some form of action taken by HFCs in response to public feedback, issues that required action at the higher system levels appeared not to have been addressed, suggesting that in the reviewed studies there was inadequate support for HFCs' in relation to generating responses.

Factors influencing HFC practices of responsiveness

Factors identified from this review as influencing HFC practices of responsiveness included HFC-level factors such as selection processes, membership, and frequency of attendance of meetings; contextual factors such as health system characteristics and wider societal factors such as culture, current political influences, and history. These are discussed in turn below.

<u>HFC level factors: Selection and membership processes, meeting attendance</u>

Within the studies reviewed, HFC membership as per government guidelines often included health workers in-charge of health facilities, local leaders, and community members. Guidelines also required that the HFCs be representative of the public that sought care in the facilities, with some guidelines specifying the inclusion of women and marginalized community members in the committees [127, 133, 134, 136, 137, 139]. Other groups required to be included in the HFCs were youth, the elderly, and people with disability [138, 139]. However, in several of the reviewed studies, there were variations from the guidelines. For example in Brazil, fewer users and health workers were HFC members than guidelines required in 50% of the municipal health councils [140].

In Burundi, the regulation of 2 representatives per *colline* (hill) in the Comites de Sante (COSA) was not observed and there was a majority male representation in up to 97% (n=100) of the COSAs that were evaluated [126]. In Zambia, Health Centre Committee (HCC) membership was reportedly male-dominated with the elderly and disabled virtually excluded [125]. Similarly, in Zimbabwe, the elderly and youth were not found on HCCs [131] and in Chandigarh state, India, membership requirements for lower caste members did not meet government guidelines [141]. In contrast, a few studies reported that membership in health committees met stipulated thresholds [123, 142]. However, one Indian study observed that physical presence did not translate to participation because in their study, women made up over 50% of attendees in committee meetings but they hardly ever spoke [133]. These challenges with membership, particularly of vulnerable groups had implications for responsiveness because they limited how much feedback was received and acted upon from vulnerable groups.

Across several of the reviewed studies, expected HFC selection processes required that community members would be elected (or nominated then elected) by the public ideally following social mobilization [23, 66, 116, 118, 122, 123, 125, 126, 129, 131, 134, 136, 139, 143]. In practice, selection processes were reportedly plagued with various drawbacks such as political interference [132, 134] and low community involvement and awareness during selection [115, 116, 120-122, 124-126, 131, 136, 139], which undermined the ability of the HFCs to act as a conduit for public feedback. For example, in Nepal, very few members of Health Facility Operation Management Committees (HFOMCs) were selected by the public. Often, the clinic manager, together with the village development committee secretary, decided who should serve on the committee in consultation with local political party representatives [134]. In the study from Philippines by Ramiro et al, the selection of NGO representatives, reportedly expected to serve as a proxy for the public, was not done democratically in three of four Local Health Boards (LHBs) [122]. Instead, NGOs were selected arbitrarily and their attendance at meetings across all four LHBs was inconsistent. In Malawi and Zambia, health facility staff often replaced community members without the involvement of the wider community after HFCs had been installed [125, 128]. Reasons reported for this practice included that some elected HFC members were considered inactive, incompetent, or too old to participate in meetings [125, 128]. Overall, low community awareness and involvement suggested 1) insufficient public involvement during the formation process, and 2) a disconnect between HFCs and the communities they were expected to represent. These undermined the legitimacy of HFCs amongst the communities they served and constrained HFC's role as a conduit for public feedback [113].

Related to the challenges of selection and representation mentioned above, were views among members of the public about elite community members in HFCs. Two studies from Burundi reported that members of the public felt that they could not approach the 'educated' members of the HFC [124, 126]. However, in contrast with this, Abimbola et al from their Nigerian study, suggested that HFCs could serve many of their functions without being representative and that the presence of high-income members in HFCs did not prevent addressing of needs for disadvantaged groups. In their study, the presence of elite members was an enabling factor for HFC functioning as elite members used their resources and influence to achieve HFC goals [130].

Several studies reported infrequent and poorly attended HFC meetings which contributed to inadequate representation and discussion of community views [24, 120, 122, 142, 143]. Infrequent meetings were linked to inadequate support from higher-level actors in the health system. Low attendance at meetings was also linked to the opportunity costs of attending meetings and HFC activities, especially for poor community members. In rural eastern India, even though Village Health Sanitation and Nutrition Committees (VHSNCs) met the threshold for membership during formation, inconsistent attendance of meetings by marginalized groups -who were mainly casual labourers (and could not afford to miss work)- compromised the inclusivity of the VHSNC [142]. Iwami and Petchey, in their Peruvian study, also considered this challenge, reporting that each community member of the Comite Locale des Adminitracio de Salud (CLAS) worked about 14 hours a week on average, and 70 per cent of women CLAS members had domestic and childcare responsibilities thus committee participation was a significant commitment with potentially direct economic costs, yet HFC membership was voluntary [121]. Other reasons for low attendance included poor communication on when the meetings would be held and committee members being 'too busy to attend' [122]. However, there seemed to be other underlying reasons beyond this, for example in India, '*a lower caste woman was not told about VHSNC meetings, in what she explained was an attempt to exclude her from the committee' (pg 3)* [133] and in the Philippines, municipal health officers reportedly had low regard for the devolution process that instituted local health boards [122].

Health system characteristics

In the studies reviewed, health providers' understanding and attitude to the roles of HFCs appeared to influence the extent to which HFCs could mediate responsiveness to public feedback, with positive perceptions of HFCs among health managers and providers being supportive of the feedback role of HFCs [128], while low awareness of HFC roles [143], and negative perceptions and relations constrained HFC functioning [10, 113, 122, 125]. Among these negative perceptions was the view among some health providers that health was a medical matter and therefore community input had low value [10, 113, 122], and that involvement of HFC members in facility health service

delivery was meddling. The Zambian study by Ngulube et al reported such strained relationships between HFCs and health providers in Zambia, that even though committees functioned with supervision and involvement of the DHMTs, efforts to contact and consult the DHMT without express authorisation by the secretary (the health centre in-charge) were disapproved of by DHMT officials [125]. This created a perception among community members that committees had no powers over health workers and were therefore ineffective in dealing with issues raised by the public at the health centre.

Another health system factor that influenced how well HFCs facilitated receiving and responding to public feedback was the issue of supportive supervision reported in four studies [24, 120, 121, 137]. For example, in Peru, variations in regional support for CLAS resulted in poorer communities receiving the least support [121]. In Uganda, Health Unit Management Committees did not send reports to the district level and the district did not press for them, so even though District Health Executive Committee members were residents they remained unaware of poor service delivery at the facilities [24]. Findings from two studies suggested that where there was support for HFCs from higher system levels, the HFCs were able to function better. For example, in Kenya, a Facility Management Nurse (FMN) post was created at DHMT-level to support links between facilities, the community, and the district resulting in the strengthened committee management [136]. Similarly, in a South African sub-district of Nelson Mandela Bay Municipality, two health promotion managers contributed to improved relations between HCCs and the Department of Health by assigning community liaison officers the role of establishing and supporting HCCs [143]. In three other studies, external facilitators such as NGOs were reportedly important in enabling HCWs and HFCs to develop effective working arrangements and for the provision of support and training [116, 119, 130]. Overall, HFCs appeared to function well in environments where they were nurtured.

Culture and political context

Five of the reviewed studies reported several settings in which there was public apathy towards participation, coupled with mistrust of public participation [24, 122, 126, 130, 131]. Such features of context often undermined the extent to which the public shared feedback with the health system generally, and with HFCs specifically. In these studies, public apathy and mistrust were linked to histories of centralized government with little popular participation in governance, recent democracies and histories of dictatorship and civil unrest [24, 122, 126, 130, 131]. For example, in Zimbabwe, policy and legislative documents had provisions for community participation but local decision-making was dominated by the central government with little involvement of communities[131]. As such local priorities shared through HFCs were reportedly hardly considered during district planning. In the Philippines, mayors were positive about the LHB and decentralization because it gave them control over health services, but little attention was paid to democratic

selection of community representatives and building community capacity for participation as power was concentrated among the local elites [122]. In Nepal, the distribution of facility committee membership along party lines led to exclusion of marginalized community members despite government guidelines requirements for inclusivity [134].

Several articles described the importance of cultural and historical factors in influencing HFC functioning. For instance, Jacobs & Price [116] reported that a culture of volunteerism and trust in the Pagoda[2] institution seemed to enhance community participation in a district in Cambodia that used existing pagodas to select health committee members. In a subsequent study, the Pagoda volunteers were able to plan, target and manage an equity fund and enhance access to care among the poorest [117]. In Peru, in contrast with other settings where female participation was often inadequate, the CLAS had many female members who were actively involved, drawing on a history of grass-root self-help groups that had high female membership [121]. Elsewhere social hierarchies and power asymmetries tended to permeate into HFC structures undermining the functioning of health committees. For example, in India social norms hindered women's active participation in VHSNCs as they were not allowed to speak to men or to travel outside their villages where training and quarterly cluster meetings happened [133]. VHSNC members who were Muslim or lower caste members could not speak out against frontline health and nutrition workers who often were members of higher castes [133].

Facilitation by NGOs was a key strategy reported for coping with power asymmetries related to political interference and socio-cultural hierarchies [130, 133, 137]. For example, in Northern India, NGO facilitators were instrumental in enabling women to participate and identify local needs without creating conflict within the villages. They also enforced sharing across castes and were non-discriminatory in their interaction with VHSNC members [133]. This may have subtly challenged the existing social norms as members across castes and religious groups agreed on local priorities and needs [133]. From their Nigerian study, Abimbola et al suggest that power asymmetries between health committees and local governments could be reduced through NGOs facilitating meetings between HFCs and actors in local governments or coaching HFCs on how to approach decision-makers within local governments[130].

[2] Pagodas are a local institution based on Buddhist principles around which social, religious and welfare activities at village-level are organised. Pagodas are governed by a Pagoda committee which has between five to seven members, comprising Buddhist monks and laypersons within the village. Pagodas are recommended by the local government as key partners in community development 116. Jacobs, B. and N. Price, *Community participation in externally funded health projects: lessons from Cambodia.* Health policy and planning, 2003. **18**(4): p. 399-410.

Summary of the Literature gap

The reviewed literature highlights several gaps concerning how HFCs mediate health system responsiveness and the influences on HFC responsiveness practices. First, few studies examined whether and how HFCs received public feedback. Second, few studies reported on how the feedback received was analysed or processed, and whether responses were generated for this feedback. Third, few studies provided evidence about the experiences of marginalized groups as members of HFCs or as members of the public sharing feedback with HFC members.

Considering the reported influences on HFC practices of responsiveness, it appears that how HFCs balance the interests of the public and their relations with health managers and health providers is critical to whether they can contribute to a more responsive health system. Yet these interactions, including the associated power dynamics inherent in them, have not been explored in an in-depth manner in the existing literature.

2.3 Review 2: How does power shape District Health Management Teams' responsiveness to public feedback in Low and Middle-Income Countries

2.3.1 Review methodology

I conducted the search for papers on Pubmed, Google Scholar, and Scopus between December 2020 and March 2021 using the search criteria presented in Table 2.2 below.

Table 2.2: Search Strategy for DHMT review articles

Term A[1]: Responsiveness Variants combined by OR	**Sub-national Health Management Team** Variants combined by OR
Responsive*, Social accountability, accountability, community participation, community feedback, community participation, Community voice, community engagement public feedback, public participation, stakeholder participation	District health management team*, Sub-county health management team*, district health manager*, regional health management team*, regional health manager*, provincial health management team, provincial health manager*

1: The two groups were combined with AND

I chose these databases because they were free to access, comprehensive, and known to cover health-related matters. 694 papers were identified through database searches. I made all the searches in consultation with a librarian. All the citations from the different databases were exported to Excel and duplicates were removed. This was followed by screening of the title and abstracts for relevant papers. I hand-searched the reference lists of articles identified to find additional articles judged relevant to the review questions. 703 papers were identified in total. Articles were included in this review if they met the following criteria 1) they contained substantial content on DHMTs receiving, processing, and/or responding to public input 2) they focused on LMICs 3) were in English, and 4) were published between 2000 and 2021. The latter criterion was adopted because responsiveness was introduced as a health system goal by the

WHO in 2000 [4]. Twenty-one articles were retained after screening. Figure 2.3 below summarises the screening process.

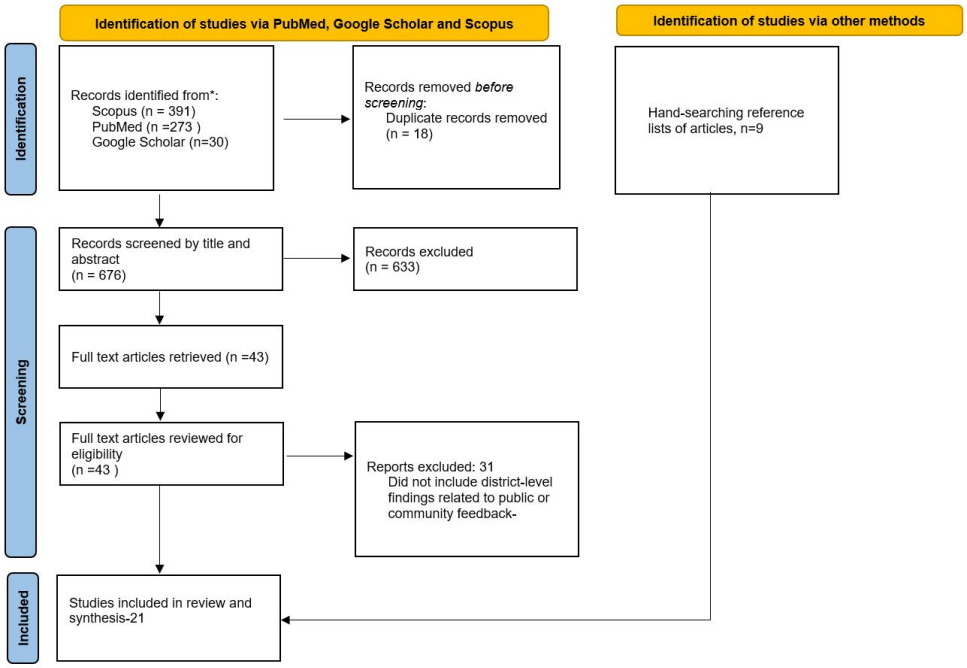

Figure 2.3: PRISMA flow diagram for article screening processes

Data Extraction and derivation of themes

I first read and re-read the studies to identify raw data for synthesis. I devised a data-extraction Excel sheet to systematically identify article characteristics, study objectives, and actors described in the papers. I also included columns for feedback channel, the content of feedback, processing of feedback, responses generated from feedback, and composition of the DHMT in the template for extracting content from the reviewed articles (see Appendix 2 for the full list of articles and sample of extracted content). This content was useful to answer the over-arching review question. I combined deductive and inductive approaches to derive themes. This included drawing on the conceptual framework (section 3.3.) to code all studies according to which element of the frameworks they addressed and coding content arising from the articles but not included in the framework. To support comparison across papers, I entered data extracted from various sections of the primary studies into charts. I analysed the evidence presented in the charts to present an overarching synthesis of the practice of responsiveness by DHMTs and influences on their functioning.

Characteristics of the articles

The 21 articles reported studies that mainly used qualitative data collection methods such as in-depth interviews, focus group discussions, observation, and document review. The studies formed two broad categories: those that examined health system functioning with some consideration of public feedback at the district-level [96, 98, 135, 144-154], and intervention studies that reported on efforts to enhance the inclusion of and response to public feedback in priority-setting [155-157],

including through social accountability approaches [158-161]. The reviewed studies reported on experiences from a range of geographical contexts spanning Sub-saharan Africa (18/21 papers), India (2/21), and Central Asia (Tajikstan) (1/21), and addressed a range of issues from general health governance to specific service delivery areas (Figure 2.4).

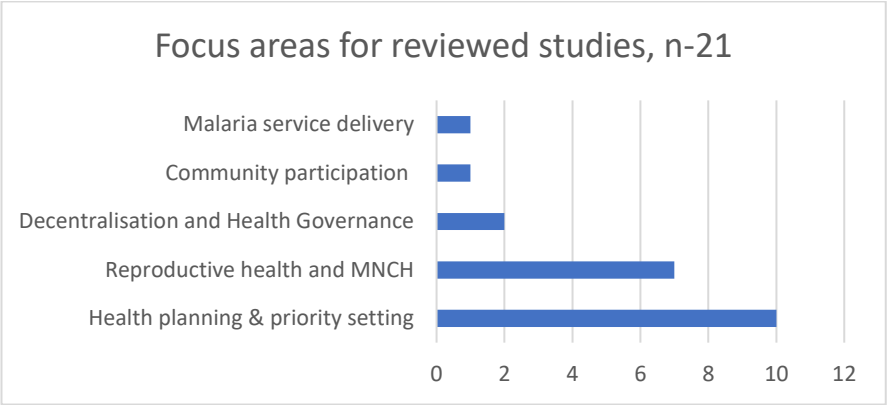

Figure 2.4: Focus areas reported on within reviewed articles

Regarding the governance contexts in which the DHMTs operated, 15 out of 21 of the articles mentioned a decentralised context. However, in the majority of these 15 studies, there was inadequate detail to judge the form of decentralisation, with only four studies, three in Kenya [96, 98, 144], and one in Uganda [148], providing details of a devolved context.

2.3.2 Results

This sub-section is presented in two broad parts. The first part describes the processes of receiving, processing, and responding to public feedback at the DHMT level, including specific feedback channels utilised by the public and the content of public feedback. The second part focuses on the influences on the DHMTs in the practice of responsiveness.

How DHMTs Received Feedback from the Public

From the studies, I identified five broad categories of channels through which DHMTs received feedback from the public (Box 2.3). Four of these categories were formal mechanisms established in country policy and guidelines. The last category, informal feedback channels, was more commonly reported in contexts where challenges were faced in the functioning of the formal mechanisms.

Formal feedback mechanisms

District-level participatory channels

- District stakeholder forums [145, 148, 149]
- District health councils [151]
- Council Health Boards[156]

Ward or village-level participatory channels

- Neighbourhood Committees[155]
- Health Unit Management Committees
- Public Health Committees[148]
- Community Oriented Resource Persons (CORPs)[3] [135]
- Village health teams[161], public participation meetings [144, 148, 149]
- Local Action Groups (LAGs)[4] [162]
- Community-based Health Planning Services (CHPS)[145]

Peripheral facility-level channels

- Facility/Clinic committees and complaint management systems [135, 146]
- Suggestion [151] and complaint boxes (Van Belle and Mayhew, 2016)

Social accountability interventions supported by Non-Governmental Organisations (NGOs)

- Community score-cards [160]
- Facility report cards [158]
- Community dialogue meetings[159]
- Community-based organisations/Village organizations [147]

Informal feedback mechanisms

- Direct calls to DHMT members [145]
- Public airing of service delivery concerns on the radio [145]

Box 2.3: Mechanisms through which DHMTs received public feedback

Several studies reported variations in the extent to which public feedback successfully reached DHMTs [96, 98, 144, 148, 149, 152]. For example, poor attendance at budgeting and planning meetings by community members was cited as a challenge to including public feedback in priority-setting [144, 148, 149, 152]. In Kenya, a lack of capacity and clarity about who was responsible for budgeting and planning within the department of health in the post-2013 newly devolved context constrained the inclusion of public priorities [96, 98]. In Ghana an absence of *functioning* mechanisms within the district bureaucracy combined with a focus on vertical (to regional managers) and horizontal (to NGOs) accountability, limited public accountability [145]. Similarly, in South Africa, there was a predominance of internal bureaucratic accountability initiatives focused on the performance of healthcare providers at the expense of accountability to the public [146]. Finally, in Tajikstan, NGO-supported Community Based Organisations at the village-level had little leverage to demand feedback from the DHMT as they were directly linked to NGOs rather than the state mechanisms [147].

[3] CORPs is another term for Community Health Workers (CHWs) used in the policy documents at the time. One CORP was expected to support 50 households in a community unit. CORPs were overseen by Community Health Extension Workers (CHEWs) who are health professionals linked to primary care facilities (dispensaries and health centres) (O'Meara et al, 2011)

[4] LAGs are a mechanism comprising multiple stakeholders operating within sub-districts and districts to complement the work of other health-related governance structures such as HFCs, Multi-Sectoral Action Teams (MSATs) and the Community Policy Forum, and to undertake local-level action for identified needs and priorities. The LAG roles were viewed as going beyond specific health facilities and/or a specific set of health issues to include broader social determinants of health (Cleary et al, 2014)

Who provided feedback and what was the content of the feedback?

The equity element of responsiveness requires consideration of which groups provide feedback and whether marginalised groups gave feedback [4, 72]. In most of the papers reviewed, feedback was commonly reported as though voiced by a homogenous public, and it was difficult to identify specific feedback from vulnerable groups. Several studies noted that vulnerable groups were often left out of priority-setting processes for the health sector [144, 148, 149], lacked representation in decision-making committees [145], or experienced barriers to voicing concerns about specific services such as reproductive health [161]. The vulnerable groups mentioned in these studies were women, youth, people with disability, and adolescents [144, 145, 148, 161]. Four studies explored in some detail the factors that contributed to the exclusion of vulnerable groups in terms of priority-setting [144, 145, 148, 161]. This is discussed in more detail in the section on factors influencing DHMTs' practices of responsiveness.

Of the 21 articles reviewed, only six included details about the content of public feedback. Drawing on these papers I identified four broad categories of public feedback: provider-client interactions; quality of service issues; infrastructure issues; requests for the introduction of new services; and challenges in accessing services. These are illustrated in Box 2.4.

Provider-client relations

- uncaring and harsh attitudes by health providers [151]
- unwelcoming reception approaches (such as neglecting the principle of first-come-first-serve and emergencies first)[151]
- politicians being prioritised for services at facilities[151]
- lack of responses to complaints made by the community members
- health worker absenteeism[151]
- Suspicions that HCWs divert drugs[159]

Infrastructure, staffing and commodity-related issues

- inadequate malaria medicines at health facilities; inadequacy of subsidized ITNs, (including being required to pay more than the subsidized amounts by healthcare workers)[151]
- poor referral systems and lack of emergency transport equipment and systems[158, 159]
- lack of clinics for children under five, and functional maternity wards[159] (Butler et al, 2020)
- shortages of drugs and supplies[158, 159]
- inadequate FP/RH* supplies and commodities[161]
- poor accessibility of some facilities (due to bad roads)[158]
- inadequate staffing of maternity and FP areas[158, 159, 161]

Requests for the introduction of new services & challenges in accessing services

- lack of 'youth friendly' health services[161]
- Inadequate staffing for Family Planning [161]
- Requests for inclusion of filariasis, skin infections, bilharzia, and chronic conditions such as hypertension, diabetes and arthritis, health issues affecting adults and the elderly, and substance abuse among the local youth in district priorities [135]

Other issues not directly related to health service delivery that impacted the uptake of health services

- poor water and sanitation in health facilities[158, 159]
- issues related to traditional customs and beliefs (e.g. child marriage, home deliveries)[159]
- gender-based violence and lack of male involvement in RMNCH[159]
- lack of health budget experience and training for newly appointed councillors[159]
- socio-cultural norms that prevented access to FP/RH commodities[161]

Box 2.4: Content of feedback received by DHMTs extracted from reviewed articles

Abbreviations: FP-Family Planning, RH-Reproductive Health, RMNCH-Reproductive Maternal Newborn and Child Health, HCW-Healthcare workers, ITNs-Insecticide Treated Nets

Processing of public feedback

A third (7/21) of the studies reported some form of analysis or consolidation of feedback at the district-level [135, 155-157] [158-160]. The details of how public feedback was processed as provided in the reviewed studies are summarised in Table 2.3 below. In the cluster of health sector priority-setting studies [135, 152, 155-157], I identified consolidation of community input at the facility-level, then upward submission to the district-level. Table 2.3 also highlights that in this group of studies practice deviated from recommendations about processing arrangements for public feedback. For example, review by a multi-stakeholder board was uncommon in Tanzania [152], and public appeal of disseminated priorities hardly occurred across several countries [155-157]. These deviations from recommended practice commonly resulted in little meaningful inclusion of public input for priority-setting.

Table 2.3: Processing of public feedback at DHMT-level in reviewed articles

Studies	**Details of proposed (on paper) processing of feedback received from the public**	**How processing played out in practice as reported in reviewed articles**
Priority-setting studies		
O'meara et al, 2011; Maluka, 2011; Maluka et al, 2011, Zulu et al, 2011, Byskov et al, 2013,	Consolidation of community priorities shared from community level, upwards to facility and district levels	Community priorities were consolidated and shared up-wards to Primary Health Care (PHC) facility level, then to the district level.
Maluka, 2011	*Review by a multi-stakeholder board* comprising community representatives to check for inclusion of community priorities	This board was often bypassed because they did not meet frequently. The board could not also scrutinize budgets and plans for the inclusion of community priorities
O'meara et al, 2011	*Community priorities were considered concerning district targets* (which were shared in a top-down process informed by national indicators).	The community priorities were excluded if they did not align with the national indicators and district targets. District targets were developed in a separate process that was linked to national indicators
Zulu et al, 2014, Maluka et al, 2011, Byksov et al, 2014	*Information provision to the public to give room for appeal* before formally adopting the district plans	The public did not appeal any of the proposed priorities shared
Social accountability studies		
Blake et al, 2016; George et al, 2018;	Quantitative analyses of facility and community scorecards results	
Butler et al, 2020; Blake et al, 2016	Combination of quantitative and qualitative summaries of findings from multiple feedback mechanisms	

Table 2.3 also illustrates the processing of public feedback in a cluster of studies reporting on social accountability interventions. This processing was supported by NGOs and mainly entailed *quantitative analyses* of facility score-card results [158] and village-level report cards [160] to develop summaries of data collected from service users. In two studies, conducted in Malawi [159] and Uganda [161], feedback from multiple mechanisms were integrated, combining both qualitative and quantitative analyses. Across all four studies describing social accountability interventions, public feedback was shared with district health managers [158-161], who responded

as described in the sub-section below on responses. Notably, the processing of feedback was not done within the DHMTs in these studies. Instead, NGOs did the analysis (Table 2.3) and shared the findings with the DHMT.

Responses to public feedback

Seven studies discussed some detail on responses to public feedback. One study conducted in Zambia highlighted district managers 'selection' of issues to respond to, based on their perception of what they could influence. For example, in the study by Tuba et al (2010) DHMTs reportedly 'took no action' about public complaints related to waiting times and health provider behaviour such as rudeness to the public [151]. However, the same district managers responded to complaints about over-priced nets at the facility-level by collaborating with an NGO to set up a monitoring system for tracking the sale of insecticide-treated nets [151]. In Ghana, the DHMT also 'took no action' in response to public feedback despite the public's efforts to express their service delivery concerns through radio and calls to DHMT members [145]. In the O'Meara et al study response to public feedback was in the form of community priorities being adopted only if they aligned with national targets [135]. All other priority-setting studies [155-157, 163] simply did not discuss whether community priorities eventually informed district plans.

Four other studies highlighted specific responses generated at the facility, community, or district levels. In these studies, the reported responses appeared to have had system-level effects. They included; providing a vehicle to improve the referral system within the district [158]; increasing budget allocations for family planning and reproductive health services [161]; including identified service needs in the financial plan for the subsequent year [159], and improvements in facility infrastructure and initiation of service delivery in defunct facilities [160]. These four studies [158-161] also reported escalating some feedback to the regional and national level, but responses from these higher levels were not discussed.

Factors influencing DHMT practices of responsiveness

Factors influencing DHMT practices of responsiveness ranged from issues related to structural and cultural factors that contributed to low participation of members of the public in feedback mechanisms, health system characteristics, and broader political processes and interactions with political actors. These are discussed in turn in the sub-sections below.

Structural, and cultural factors hindered the public from sharing feedback

Despite the multiple channels identified for DHMTs to learn about public views and concerns in Box 2.1 above, DHMTs appeared to receive little feedback from the public. This appeared to be linked to the lack of flow of information from the public upwards into the health system which constrained the process of receiving public feedback. This lack of information from the public was commonly

reported in terms of poor attendance at public participation meetings [144, 148, 149, 152], and low functionality of other local-level feedback mechanisms [151, 155]. An exploration of the reasons for low public attendance revealed varied constraints to participation by the public. These included structural factors such as economic concerns and cultural norms and low awareness among the public about the value and process of providing feedback [148, 149, 156].

Regarding economic concerns and cultural norms, Kapiriri et al (2003) in their Ugandan study, unpacked the commonly cited low attendance of public participation meetings. They found that while politicians perceived that the public had no interest to attend public participation, the youth reported that they failed to attend because they '*felt exploited, being mobilized only for activities without monetary benefits [yet they were unemployed], they felt individual tangible benefits should be part and parcel of participation' (pg 210)*[148]. Coupled with this was a perception among the youth that politicians were paid to do priority-setting and so should do all the work. Women interviewed in the study reportedly '*felt they needed to be presentable and dress 'properly' to attend the local council meetings, which they could not afford*' (pg 210)[148]. Consequently, for both women and youth, attendance was low.

McCollum et al also reported low attendance at public participation meetings in their Kenyan study, citing the influence of patriarchal norms in contributing to women staying away from public participation forums because they had too many household chores to attend to [144]. Even when women attended these meetings, they often had little confidence to speak. More broadly community members felt that they did not have a role to play in priority setting, a view that contributed to low attendance of public participation meetings and therefore little inclusion of public views in priority-setting. Political actors who might have imparted information on the value of participation, and how communities could share their views were reportedly reluctant to empower community members for fear of losing their power [144]. In both Zambia and Tanzania, despite efforts by DHMTs to involve the public during priority-setting, illiteracy, a lack of awareness on the possibilities of participation and a culture of not questioning those authority hindered more inclusive priority-setting processes [155, 156].

Other factors influencing low attendance were problems with communication about public participation meetings. Two Ugandan studies reported poor communication illustrated by low mobilization of community members to participate in public fora where health priorities were being discussed [148, 149]. In Tanzania and Kenya, priority-setting in the district often started late leading to a rushed process that made it difficult to truly incorporate public priorities [135, 152, 156]. In the Tanzanian study by Maluka (2011), though district health plans were presented to the Full Council (comprising elected public representatives), the time allocated for reading the plans was insufficient to enable councillors to read and understand all the items in the district health plans

before approval [156]. Further, other members of the district planning team, such as the private sector and NGOs (who might have presented public views) had no time to review the planning guidelines and information before the planning meetings, resulting in minimal participation and inclusion of their views [156]. In the same study access to planning guidelines was confined to the District Medical Officer-who kept the planning guidelines in his office, and a few Council Health Management Team members (the District Planning Officer, District Treasurer). Thus, even within the CHMT itself, there was unequal access to planning guidelines and information which limited the inclusiveness of views.

Health system characteristics

Other constraints that influenced the extent to which public feedback was received and responded to by DHMTs were health system features such as funding, governance, and organisational culture. These are discussed in turn.

In several of the studies reviewed, feedback mechanisms were not allocated funding to support their functioning [155, 157, 162]. This undermined the extent to which they could be a conduit for public feedback. For example, in Tanzania, members of the Council Health Management Team identified women, youth and Persons Living with the Human Immunodeficiency Virus (PLWHIV) representatives to participate in district planning as part of an intervention to improve district priority setting and planning [157]. However, these representatives could not attend the planning meetings due to a lack of funding for their transport and accommodation [157]. In Zambia, during the processing of public feedback, owing to a shortage of funds, district managers were often unable to address all agreed priorities leading to a re-priority setting that resulted in more ad hoc decision-making at the district-level. Community members and other stakeholders were often not reached during this re-prioritisation due to the additional costs of including them when changing priorities [155].

Across the reviewed studies, the majority of which included decentralised contexts [145, 148, 150-152, 155], the influence of the central MoH and/or national government tended to constrain DHMT responsiveness to public input. Reasons for this included an organisational culture of endorsing national MoH priorities [155], and requirements to adhere to national priority-setting guidelines and national indicators [135, 150, 152]. For example, in the Kenyan study by O'meara et al (2011), the identification of local priorities happened as a separate process from target setting and activity planning and budgeting. Due to the parallel nature of the two processes, only local priorities that were consistent with national indicators were included in district plans and budgets [135]. This resulted in service delivery activities that matched national-level priorities and not local priorities. In Tanzania, Maluka (2011) reported that it was not uncommon for changes to be made to district plans at the regional level so that they could align with the regional and national guidelines [152].

As a result, local priorities that were incorporated into the plans were excluded. In South Africa, Mukinda et al, reported that the local district health system in which they conducted their study had multiple initiatives that were focused on reporting performance targets for Maternal Newborn and Child Health, but few were focused outwards to the public [146]. Overall, across the reviewed studies, a hierarchical organisational structure and dependence on the national level for resources for their activities appeared to contribute to higher level actors having significant influence over DHMTs.

From the reviewed papers, I identified perspectives that further illustrated the organisational culture of not valuing public feedback. For example, in Van Belle and Mayhew, community participation appeared to be valued for its usefulness in supporting the health system rather than as an avenue through which DHMTs and health system actors could be held accountable [145]. As a result, even though the public evolved new ways of providing feedback to health system actors, such as calling DHMT members and airing complaints on the radio, much of this feedback remained unacknowledged and was not responded to [145]. In Tuba et al, district managers reportedly did not recognize the public as legitimate stakeholders during decision-making for health care delivery because they lacked medical or technical training [151].

Broader governance processes and interactions with political actors

In some of the reviewed studies, relationships with political actors and histories of governance appeared to shape DHMTs' practices and responses to public input. For example, in several studies, politicians had direct budget control and responsibility for resource allocation and approval of district health plans [145, 151, 152, 155], and for convening public participation for health priority setting [148, 149]. In these studies, district health managers' ability to receive and respond to public feedback was undermined when there was little mobilisation by political leaders [148, 149]. Responsiveness was also undermined when DHMT members chose not to respond to public complaints that involved political actors due to concerns that political power might be used against them to, for example, transfer them to other workstations [151].

More broadly, political processes that were external to the health system also influenced the inclusion of and responsiveness to public input. For example in the study by O'meara et al, the priority-setting process was rushed and limited in the extent of public inclusivity owing to government re-organization due to a contested national election process in 2007 [135]. Another study reported that turbulence resulting from post-election social unrest in 2007 and the post-election split of the MoH (into the Ministry of Medical Services and Ministry of Public Health and Sanitation) undermined routine meetings in the Kenyan districts. Consequently, the DHMT was denied the opportunity for continued implementation of the intervention that was aimed at improving the inclusion of public priorities in district planning [157]. In a more recent Kenyan study,

inclusion of community views into the County annual workplan and budget was undermined by a lack of participation at the County Department level owing to little capacity in the newly decentralised health system [96]. Following rushed decentralisation from the national government, staff at the county level who could support the planning and budgeting process had not yet been recruited. In their absence, all other levels of the health system including the sub-county (district level equivalent) and community levels did not forward their priorities for budgeting and planning [96]. Finally, in the study by Jacobs and Camargo (2020), the public did not share feedback with the DHMT because of a legacy of autocratic rule that had led to low expectations of answerability from government and government actors [147].

Summary of literature gap

In this review I have identified limited existing literature on DHMT practices related to responsiveness to public feedback. I also identified weaknesses in DHMTs' responsiveness practices including, constraints to receiving feedback from the public (particularly vulnerable populations), little analysis (processing) at the DHMT level, inconsistent generation of responses, and little communication to the public on generated responses. In the review, I have identified factors that influenced DHMT practices of responsiveness, which include structural and cultural factors, health system characteristics and broader political processes. In the reviewed studies I have identified little attention to the internal functioning of DHMTs and how these relate to the practice of responsiveness, and little exploration of how DHMTs link with other governance structures within the broader context of the health systems of which they are part. This is important because DHMTs are middle-level managers who work between frontline providers and senior health managers and interact with the public and external stakeholders [164, 165]. Their interactions with multiple actors suggest that there is value in exploring how these multiple interactions and any related power dynamics might impact responsiveness. Such an exploration may generate ideas for how to strengthen the practice of responsiveness at the DHMT level.

2.4 Chapter Summary

In this chapter, I have presented two reviews. The reviews described the practice of responsiveness by HFCs and DHMTs and explored influences on health system responsiveness. I found challenges in the inclusion of vulnerable groups in participatory feedback mechanisms, and generation of responses to their feedback. None of the reviewed studies set out to consider responsiveness practices of HFCs and DHMTs together or examine their interactions in an in-depth manner. Yet HFCs and DHMTs are an important part of district health systems, with critical governance roles that could contribute to more responsive health systems.

From the reviews, HFCs and DHMT members interacted with multiple actors who had varied interests and levels of power. There was however little exploration of actor interactions power

dynamics within HFCs and DHMTs in the reviewed studies. Among the studies reviewed, three studies on HFC practices reported on experiences from Kenya. Two studies focused on the management roles of HFCs, with one focusing on financial management roles following introduction of the Health Sector Services Fund (HSSF) [139], while the other explored management roles including HFC contribution to community accountability [136]. The study by O'Meara et al mentioned HFC roles in facilitating incorporation of community priorities into health sector planning [135], but provides little detail about how HFC form and functioning influenced this process. Across all three studies, there was little explicit focus on management of public feedback at HFC level. Further, data from all three studies were collected prior to devolution of health services to the county, a significant contextual factor within the Kenyan health system. Hence this study by focusing on HFCs ten years after devolution fills a gap in the literature about HFC management of public feedback in Kenya.

Among the studies reviewed, four mentioned DHMT functioning in Kenya. Two of these studies [98, 157] described in detail DHMT membership and/or functioning and how this was influenced by the recent devolved context in Kenya. In the Byskov et al study [157] , the changes within the DHMT made it difficult to implement the study's priority setting intervention, thus there was little evidence generated about DHMT engagement with public feedback related to priority setting. Similarly, the Nyikuri et al, Tsofa et al and McCollum et al studies [78, 98, 144] while useful for understanding the context within which DHMTs functioned, did not conduct an in-depth exploration of processes of receiving and responding to public feedback.

Across all the studies reporting HFC and DHMT experiences in Kenya, interactions across system levels in relation to public feedback were infrequently explored, and when mentioned there was little detail. This finding is consistent with the literature review findings from other LMICs. This thesis therefore attempts to fill some of these identified gaps. I aim to contribute to the literature on responsiveness by exploring HFC and DHMT practices of receiving and responding to public feedback, considering the experiences of vulnerable groups, and by examining power dynamics as influences over HFC and DHMT practices as well as interactions between these governance structures across health system levels.

Chapter 3 Study Setting and Methodology

3.1 Introduction

In this chapter, I begin by presenting the study setting, starting with the Kenyan context and how the health system is organised in the country. I also provide details about Kilifi County, where study primary data were collected, and describe the methods I adopted to examine the policy and practice of responsiveness. This chapter also provides a description of the study's conceptual framework and the theoretical underpinnings that influenced data collection and analysis. This is followed by a sequential presentation of the study design, a detailed description of case selection, data collection and data management procedures, and the analytical approach I adopted. I also present the measures taken to enhance research rigour, the philosophical underpinning for the study, my positionality in the research process, and ethical considerations. I conclude with a summary of the chapter.

3.2 Study Setting

3.2.1 Background: Kenya

Kenya is a lower-middle-income country [166] with an estimated population of 47.6 million, a per capita GDP of 2006, and a life expectancy of 66 years [167, 168]. Table 3.1 below presents a summary of key demographic, socio-economic and health indicators for Kenya.

Table 3.1: Demographic, socio-economic and health indicators for Kenya

Indicator	Value
Demographic [168]	
Population size	47.6 million
Annual population growth rate	2.2%
Life expectancy at birth	66 years
Social and economic indices [166, 167]	
Gross Domestic Product (GDP) (in 2021)	USD 110.35Billion
GDP growth rate	5.1%
Health indices [169]	
Maternal mortality ratio	342 per 100, 000 live births
Under-five mortality rate	39.2 per 1,000 live births
Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease	356.5

Sources World Bank, Kenya data, 2022; World Bank Classification, 2022; Kenya Housing and Population Census, 2019; MoH report on health-related Sustainable Development Goals, 2018

Governance structures under devolution

Following the adoption of a new constitution in 2010, Kenya adopted a devolved system of government that came into place after the March 2013 general election. In this system, the country has two governance levels: the national government, and 47 semi-autonomous devolved county governments. There are two arms of Government at the County level that include; the County Executive, including the civil service, and the County Assembly (CA) and the legislature [170, 171].

The County Executive is comprised of a Governor directly elected by the people, his/her Deputy, County Executive Committee members (CECs) appointed by the Governor with the approval of the County Assembly. The County Government Act 2012 provides for up to 10 CEC members within the County Executive [171]. Reporting to the CEC members are Chief Officers who provide administrative support and are the accounting officers of the respective county government departments. The Legislative arm; the County Assembly is comprised of Members of County Assembly (MCAs) elected directly by the people representing each electoral ward; and some nominated members representing various interest groups including women, youth and PLWD nominated by political parties in a proportion based on each party's numerical strength from the elected positions. MCAs have representation, legislative and oversight roles; and pass bills, county plans and budgets every fiscal year [170, 171]. A semi-autonomous County Public Service Board (CPSB) is established in every county to oversee public service and staffing matters for the county.

At the national level, the President, his/her Deputy and the Cabinet Secretaries form the Executive; legislative authority is vested in the Parliament which consists of the Senate and National Assembly [171]. The National Assembly represents constituencies and special interest groups (women, youth, PLWD, ethnic minorities and marginalised groups) while the Senate represents the counties and serves to protect the interests of the counties and their governments. The third arm of government is the Judiciary which is headed by the Chief Justice.

The Health System in Kenya

Kenya has a pluralistic healthcare system. Following independence, the government provided grants to mission hospitals to complement government provision of health services and encouraged NGO and community participation through grants for capital development [76]. Local governments (municipal and city council governments) also undertook public health activities supported by public finance; the private for-profit sector provided mainly curative services and the private not-for-profit sector (such as Faith-based hospitals) provided curative services but at a much lower price than the private for-profit sector[76]. This approach to health service provision influenced how the healthcare system evolved over the years resulting in a healthcare system that is divided into three sub-systems: the public sector, the private for-profit sector, and the private not-for-profit sector which includes faith-based organizations. Overall, the private sector owns 59% of all health facilities with private sector ownership concentrated in the lower levels of care [172]. However, the majority of the Kenyan population is served by public health care facilities owned by government [173].

Public Health System

At independence, the public health system was highly centralised around the MoH which had responsibility for policy direction, coordination of government and NGO activities, implementation of service delivery, and monitoring and evaluation of policy changes [77]. The public sector has

since then undergone various forms of decentralization. Before devolution in 2013, the public health system was decentralized with the district as the focal point [76, 77]. The district health system was managed by DHMTs who oversaw all health sector activities within the districts [174]. DHMT roles included the management and supervision of district hospitals and rural health facilities (sub-district hospitals, health centres, and dispensaries), planning and coordinating health activities, ensuring quality standards were upheld and performance monitoring of staff at the sub-district hospitals and rural health facilities [174].

Following devolution, the (national) MoH has responsibility for health policy direction, training and regulation of health services while county governments have responsibility for policy implementation and service delivery[171]. Before devolution, Provincial Health Management Teams and DHMTs had responsibility for the coordination of health services at the province and district levels respectively [175]. County Health Management Teams (CHMTs) and SCHMTs now have responsibility for oversight, managing and planning service delivery at county and sub-county levels respectively[176]. Provinces and districts no longer exist.

Currently, service delivery in the public sector is structured around the Kenya Essential Package for Health (KEPH) which requires inputs at the community level (Level 1) for health promotion and demand creation for services at higher levels (Figure 3.1). The first point of contact when disease arises is expected to be the primary care facilities (Figure 3.1). The primary care facility includes the dispensary (level 2) which would then refer to a health centre (Level 3). Thereafter referrals may be made to county referral facilities (levels 4 and 5) and national referral health services (level 6).

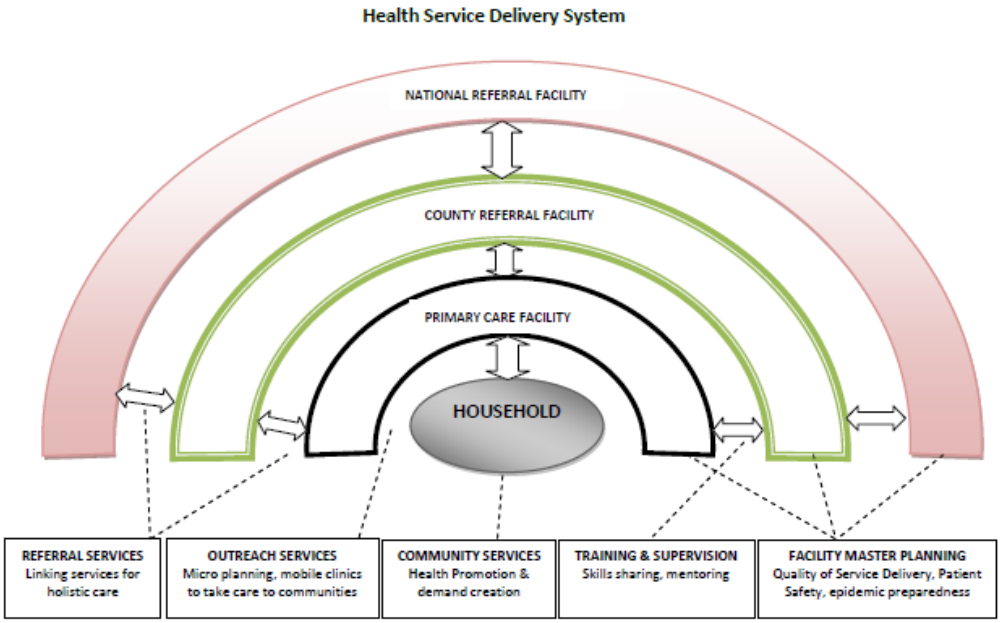

Figure 3.1: Relationship between different tiers of the Kenyan health system
Source: KHSSP (2013-2017)

At the different levels of the health system, various mechanisms were introduced over time to promote public participation in health system activities. These include HFCs at dispensary and health centre levels, and hospital management boards Hospital Management Boards at sub-county and county facility levels [175, 177]. This thesis focuses on HFCs and SCHMTs in Kilifi County to understand the practice of health system responsiveness.

3.2.2 Kilifi County

Kilifi County was purposefully selected for this study to leverage on the existing collaboration between researchers and health managers. These are described in more detail below under the section on the Kilifi learning site. I deemed the existing relationships between the researchers and health managers to be valuable for gaining access to study participants, to documents for review, and for building the rapport required to conduct this qualitative study. This was important given that some forms of public feedback could be perceived as sensitive and/or have reputational implications for health facilities and healthcare workers. Further, these existing relationships help to support direct feedback to health managers which can enhance the potential that findings are used in health system decision-making. I focused on one county to allow for in-depth exploration of the issues under focus within the study timelines and resources.

Kilifi county has an estimated population of 1.5 million people [168], has a high poverty rate (48.6%), and is one of five most unequal counties in Kenya (Gini coefficient of 0.57)[178]. Table 3.2 below presents the key demographic and health indicators of the county.

Table 3.2: Kilifi County Health and Demographic Indicators

Indicator	**Kilifi county 2018**
Population	
Total	1, 498, 647
Male	723, 204
Female	775, 443
Under 5	54, 518
Under 1	259,538
Healthcare workers	
Nurses (per 10,000 people)	4
Doctors (per 10,000 people)	1
Health Facilities	
Public	143
Faith-based	13
Private	135

Source: Kilifi County Integrated Development Plan (2018-2022)

At the start of data collection in June 2020, the Kilifi County Department of Health (CDoH) was headed by a County Executive Committee Member (CEC-M) who had responsibility for policy within the health sector. The department also had two chief officers, one for Medical Services and one for Public Health who reported to the CEC. Table 3.3 below summarises the organisational structure of the department. During the period of data collection, changes occurred in the organisational structure of the department in which the separate offices of Medical Services and Public Health

were merged into one, and five heads of division were instituted to replace the 35-member CHMT. These changes are described in more detail in Chapter 7 (section 7.2.1, Figure 7.1)

Table 3.3: Organisational structure of the Kilifi County Department of Health

OFFICE	ROLES
Office of the County Executive Committee Member Health Services	Overall policy leadership of the County Department of Health and Reports to the Governor
Office of the Chief Officer Medical Services	Accounting officer Medical Services reports to the CEC
Office of the Chief Officer Public Health Services	Accounting officer Public Health Services reports to the CEC
Office of the County Director Medical Services	Technical leadership
Office of the County Director Public Health Services	Technical leadership
County Health Management Team	Heads of Cadres and Program Managers (Report to County Director of Medical services) Public Health Program Managers report to the Director of Public Health Services
Sub-County Health Management Teams	Heads of Cadres and Program officers at the Sub-County, have supervision and oversight roles over PHC facility service delivery
Health facilities (Public, Private & Faith-based)	Service delivery
Community units	The linkage between Community and the health system

Source: Author developed from document review and interview data

Kilifi County Learning Site

Within Kilifi County, there exists a 'health system learning site' where a wide range of work on health governance has been done in recent years [95, 96, 98, 99]. A 'learning site' is an approach to research where researchers and health managers in a given setting, over a long-term relationship of continuous interactions and reflections, develop specific research questions and work towards answering them together [179, 180]. The learning site approach is useful for ensuring locally relevant learning and is responsive to calls to have more embedded research approaches for complex health systems issues [181-183].

Much of the work on health governance was possible because of a long-term research collaborative that conducted health system research in Kilifi County [101]. A longer existing collaboration also exists between the County Department of Health and KEMRI-Wellcome Trust Research Programme, which has conducted health research in the County for over 25 years and is embedded in the main county referral hospital, Kilifi County Hospital [184].

At the time of preparation for data collection, the COVID-19 pandemic became a significant part of the health system context nationally and at the sub-national level. Kilifi County was the second county after Nairobi where COVID-19 cases were identified, therefore it was necessary to include how the COVID-19 pandemic impacted health system responsiveness in Kilifi. This is considered in

Chapter 7, but the section below presents a summary of the COVID-19 response in the early days of the pandemic in Kenya and Kilifi County.

3.3 The COVID-19 response in Kenya and Kilifi County

When COVID-19 was announced as a global health threat, there were quick reactions to the pandemic at the national level (Figure 3.2). On 15th March the President of Kenya announced preventive measures which included restriction of travel from any countries with cases of COVID-19, closure of schools and higher learning institutions, recommendations to work from home and to conduct cash-less transactions, avoidance of crowded places and introduction of a toll-free number for reporting suspected COVID-19 cases [185]. These initial measures seemingly did not interrupt transmission of the virus, as the first cases were observed in different parts of the country, often linked to people (foreigners or nationals) coming into the country. In response to these first cases, measures were tightened to include suspending international flights, restricting public gatherings to no more than 15 people and requiring social distancing in public transportation [186]. As cases continued to rise, stricter measures were put in place which included a lockdown of counties reporting cases and a nationwide curfew [187]. Kilifi County was among the first counties to be put on lockdown. Fig 3.2 below summarises some of the global and national events in the early days of the COVID-19 response.

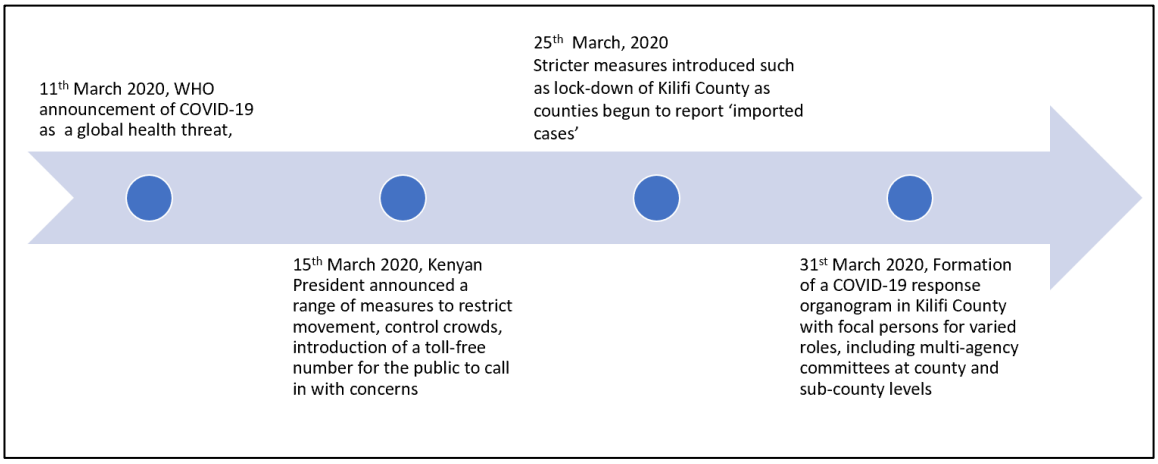

Figure 3.2: Summary of global, national and county-level events in the early days of the COVID-19 response
Source: Author from review of documents and interview data

In Kilifi County, measures instituted for crowd control at the health facility level included reducing the number of visitors for hospital in-patient clients, closing special clinics (for chronic diseases) and halting immunisation services, and elective surgeries. These services, for example, immunisation services were re-opened shortly after (two weeks after they had been closed) but the impact of their closure reduced the number of patients attending the hospital as the public feared that they would contract coronavirus at the hospitals. PHC facilities also experienced low numbers of visits by members of the public who were afraid that they would contract COVID-19.

3.4 Conceptual Framework

This study was guided, overall, by a conceptualisation of health system responsiveness (Fig. 3.3 & 3.4), derived from a literature review on the concept of responsiveness [72], and from policy analysis theory about the factors influencing the translation of policy ideas into practice. Fig. 3.3 presents a conceptualisation of responsiveness as comprising three interrelated processes: receiving, processing, and responding to public feedback. Fig 3.3 highlights that feedback may come from various public groupings, including marginalized groups. Considering who feedback comes from allows for the examination of inequities in responsiveness [4, 188]. The process of receiving feedback can occur through varied mechanisms (both formal and informal) and engagements between the public and health system actors. As distinguished in section 1.2, formal mechanisms are those proposed in policy documents, while informal mechanisms may arise due to absent or weak functioning of the formal feedback mechanisms [53, 54]. In other cases, informal mechanisms could also be the product of norms driven by personal or professional ethics [22, 147]. For example, Jacobs & Camargo highlight how in-kind payments made by the public to frontline providers created a 'social debt' with an obligation for some answerability among frontline providers; representing a form of informal governance [147].

At the centre of the framework (Fig. 3.3, Black box A]) are 'processing spaces'– these are places where feedback from the public should be received, processed, and responded to by health system actors. These spaces are important because what happens to the feedback received here can help to understand the responsiveness of the health system. In some instances, a processing space could also be a feedback mechanism or channel. For example, a HFC is both a processing space and a feedback mechanism because the public can share feedback directly with HFC members, and it is also possible for responses to this feedback to be generated at HFC level.

Health system responses to public feedback may be in the form of information to the public and/or changes to the system, or non-action. As figure 3.3 shows, such changes may include changes in the mechanisms of processing feedback, in turn impacting on future health system responses. To 'count' as h*ealth system* responsiveness, there should be a response at the system level and not just at the individual level (e.g. between individual provider and patient) [13, 18]. Linked to this idea of a-whole-of-system response, diverse responses may, therefore, be enacted by policymakers, system managers and/or service providers.

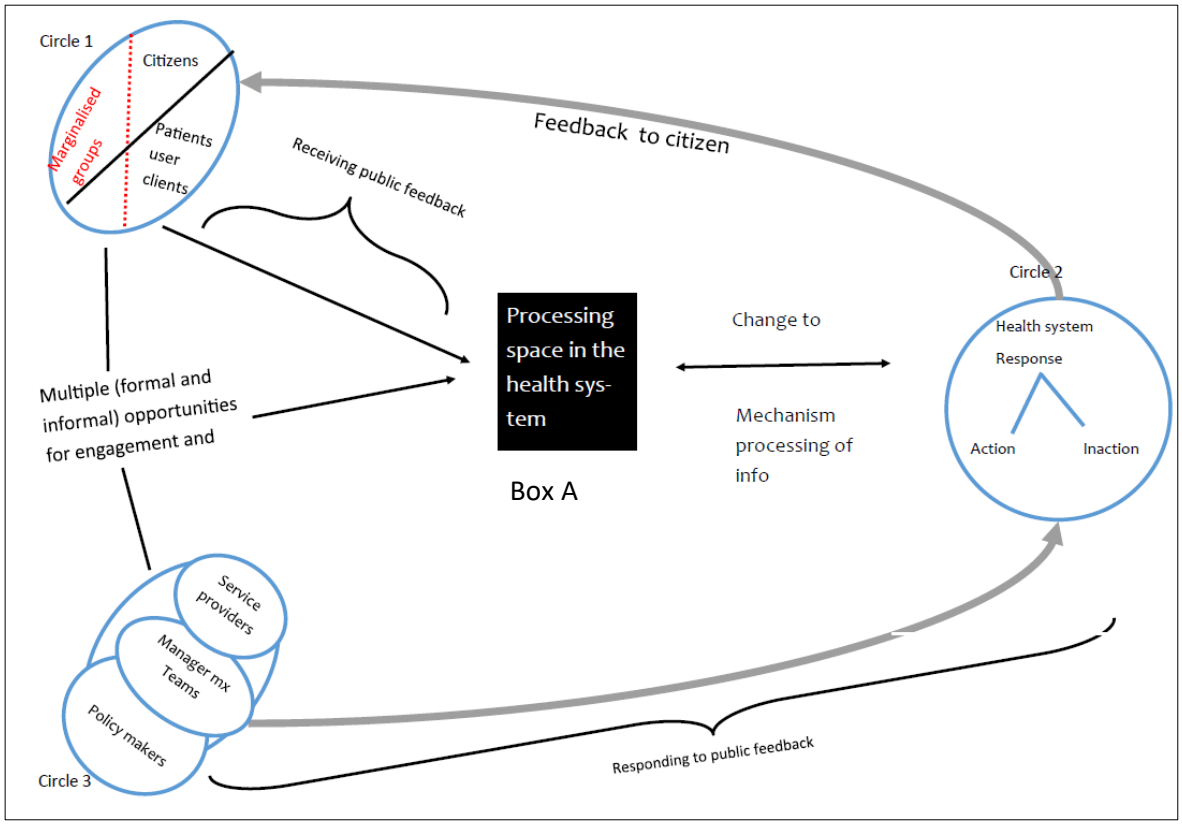

Figure 3.3 Conceptual framework describing processes of receiving and responding to public feedback

Figure 3.3 above draws attention to the processing spaces (Box A) as mediators of responsiveness. Figure 3.4 below is an expansion of the 'processing space' shown in Figure 3.3 and highlights the issues that I considered when examining responsiveness in practice. These issues were identified using a policy analysis lens, as this work set out to inform the policy and practice of responsiveness. As discussed further below, the figure thus reflects the widely used policy analysis framework of Walt and Gilson [189]. Finally, as noted in the outer circle of Figure 3.4, my broad interest was in both 'what was supposed to happen' and 'what happened in practice' in the processing spaces.

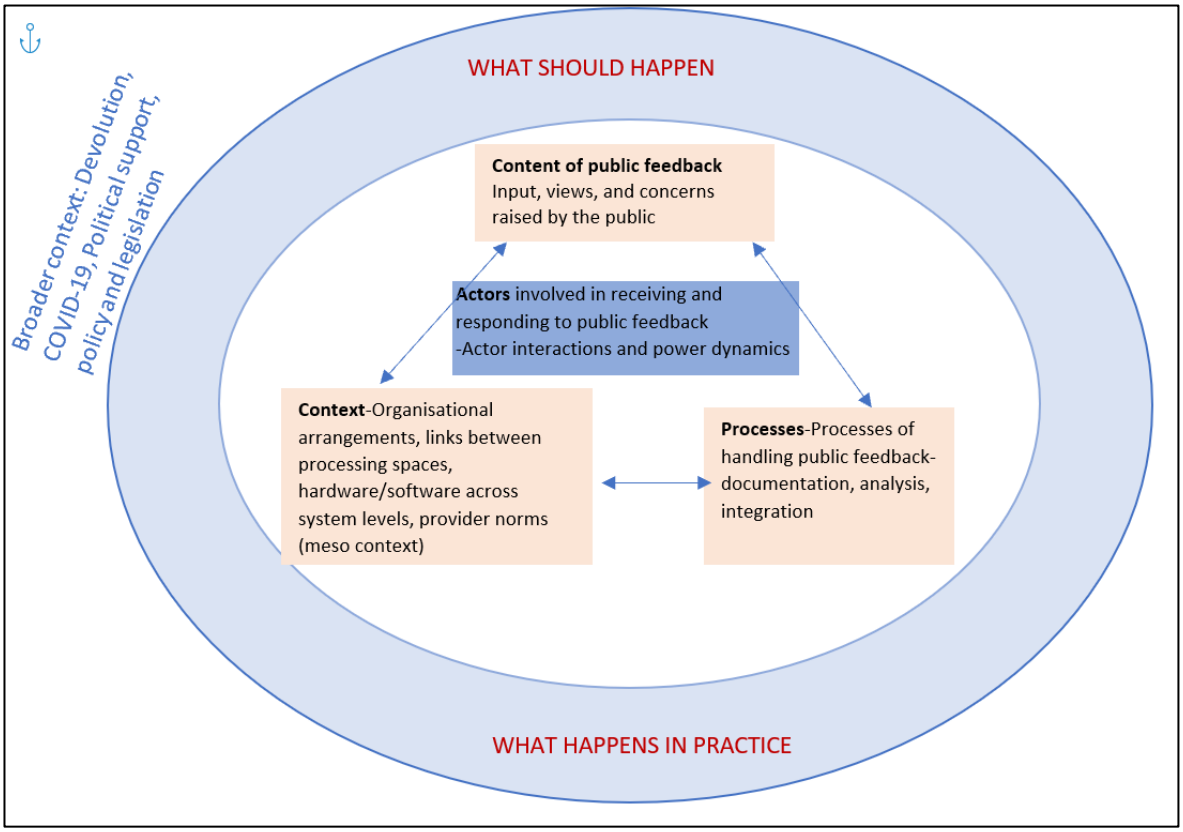

Figure 3.4: Explaining relationships

In my investigation of responsiveness, I have drawn on several frameworks to explain how and what influences the translation of policy goals and intentions into practice. Studies focusing on LMICs have emphasised the important role of a range of influences including the context and institutions in which actors operate [58, 189, 190], and actor roles and power over implementation [191-193] [194-196]. In this work, I have drawn on the policy triangle [197] to understand what happens in a processing space (see Figure 3.4). The policy triangle proposes that understanding health policy change needs to focus on analysing actors involved, context, process and policy content and the interaction across these elements [197]. In this study this included examining the content of public feedback, the processes through which responses to public feedback were generated, the actors involved in these processes, and the context in which actors interacted. Context as depicted in Figure 3.4 included the meso-context of health system and organizational features, as well as the broader context such as national-level policy and legislative context (referred to as macro-context in Chapter 4 and 8), and the COVID-19 pandemic response.

To unpack the organizational factors (meso-context) that interacted with and influenced receiving, processing and responding to public feedback, I utilised concepts from Ellokor et al (2013) which draw on Aragon's organizational capacity framework [198, 199]. This framework presents three interacting dimensions of the meso (organisational) context (see Figure 3.5): the system's hardware of funding levels, infrastructure, and technology; the *tangible software* of decision-

making and management processes, skills, and knowledge, and the *intangible software* of values and norms, relationships, and power. Intangible software are especially important as they are argued to, *'guide actions and underpin the relationships between system actors and elements'* [200].

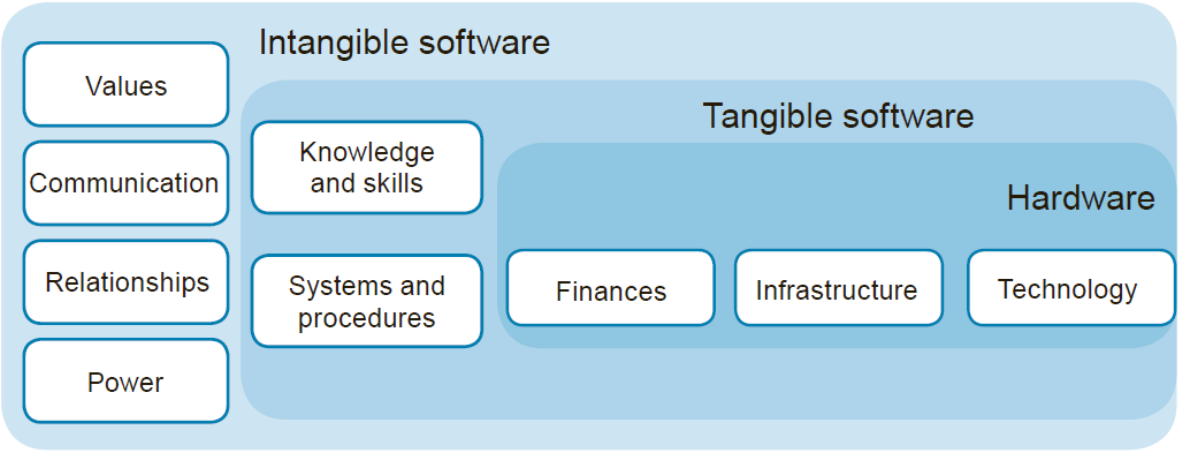

Figure 3.5: Organisational capacity framework
Source: Ellokor, 2013; Aragon, 2010 [198, 199]

Power dynamics are inherent in the interactions between elements described in the policy triangle [189], and a central element of intangible software. Therefore, to understand better how the processing space worked and impacted on HS responsiveness, I considered questions such as: How do power dynamics among actors influence decision-making about issues to address or responses to those issues? How does the meso context influence the power dynamics among actors or the effectiveness of the micro-processes?

I also expected that the broader context might influence how the processing space worked and so I considered issues such as how the health system is resourced, organised, and governed, including health provider beliefs around responsiveness and how they impacted the dynamics within the processing space as illustrated in the outer circle (Figure 3.4).

To examine power dynamics within the processing spaces, I applied Gaventa's power cube (Table 3.4) [195] and Long's actor interface analysis [201]. Gaventa's power cube was a good fit for systems analyses of responsiveness because it recognises levels of the system as influencing each other. Further, it adopts widely used participation action theory and allows for various exercise of power around spaces. This was relevant to the notion of processing spaces adopted in this work. Gaventa's power cube also has relevance for researchers with applied interests, and I hoped through this power analysis to generate ideas about how HS responsiveness might be deepened. Long's actor-oriented perspective on power illustrates how the lived experiences of actors, their interactions and power struggles shape policy implementation [202]. Long's actor interface analysis allowed deeper analysis of actors' power practices and what shapes them. The combination of

these two power frameworks supported analyses that a) identified structural and organisational power (Gaventa's power cube), and b) considered power at the micro-level to understand power differentials and struggles between actors (Long's actor-interface analysis), and so supported analysis of how both impacted on the practice of responsiveness. I focused on actors in line with the wider recognition of the importance of actors in health systems, and in Health Policy and Systems Research (HPSR) [203, 204].

Table 3.4: Gaventa's dimensions of power

Spaces for power	**Details**
Closed spaces	Decisions are made by a set of actors behind closed doors. This could be in elites, bureaucrats or elected representatives making decisions without the involvement of the public
Invited spaces	Spaces are created into which people (users, citizens or beneficiaries) are invited to participate by authorities such as governments, non-governmental organisations
Claimed spaces	Spaces formed by less powerful actors from or against the power holders. These may form due to popular mobilisation, around identity or issue-based concerns, or like-minded people coming together to debate issues
Forms of power	
Visible	Definable and observable decision-making. Includes formal structures of authority, institutions, and procedures of decision-making
Hidden	Certain powerful people and institutions maintain their influence by controlling who gets to the decision-making table and what gets on the agenda. Mainly operates by excluding certain people and devaluing the concerns of less powerful groups
Invisible	Shapes the psychological and ideological boundaries of participation. Significant problems and issues are kept from the decision-making table, and from the minds and consciousness of the different players involved, even those directly affected by the problem. May be perpetuated by socialisation and cultural processes that define what is acceptable.
Levels of power	
Global	Decision-making based on agreements and treaties by global and international bodies such as WHO, World Bank
National	Decision-making at the macro level, to include national governments and development partners
Local	Decision-making at the sub-national level might include counties, districts, and provinces down to the community level

Source: Gaventa, 2005 [205]

Gaventa argues that there is a tendency to focus on who participated, who benefitted and who lost to see who had power (visible power), yet power in relationship to space also works to put boundaries on who can participate and to exclude certain actors or views (hidden power); or power may be so deeply internalised in socialization that actors unwittingly follow the dictates of power even against their best interests (invisible power) [195]. The spaces dimension refers to the platforms and opportunities for participation and action, including closed, invited and claimed spaces [195]. This study considered how power manifested in the spaces where public feedback was received by examining the opportunity for members of the public to be invited, involved or to contribute their views and concerns. The levels dimension of the cube includes global, national and local where authority and decision-making might occur [195, 206]. This study focused mainly on the local level (sub-national level), but with the recognition that the national level influences the possibilities available in local spaces, given the policy-making role at the national level in the Kenyan context.

According to Long, the points of interaction between actors in relation to a policy can be understood as actor interfaces. These interfaces are shaped by intersecting *actor lifeworlds*, a term that refers to the lived experiences of actors. The formation of these lifeworlds is dynamic and linked to the contexts of actors' lives [202, 207]. These contexts include knowledge and power relationships in society and organisations, personal characteristics and worldviews influenced by social-cultural-ideological standpoints (Table 3.5).

Table 3.5: Actor Lifeworlds

	Broad Dimensions of Actor Lifeworlds		
	Relationships of Power	Personal Life Concerns or Characteristics	Social/Cultural/Ideological world views
Elements	Social positions or status, authority, organisational hierarchy, professional expertise, resourcefulness, gender, caste, class relations	Individual interests, motivation, identity, image, recognition, previous experiences, cognitive and behavioural traits, situations in personal lives, understanding	Values, norms, beliefs, moral standing, religious views, organisational norms, and culture

Source: Long, 1999; Long, 2003; Parashar et al, 2020 [201, 202, 208]

Power practices ranging from domination, collaboration, negotiation, and resistance to contestation may be observed within the actor interfaces [202, 209]. In relation to Gaventa's power cube, I anticipated that these power practices may be observable across the forms and within the spaces and levels of power. Table 3.6 below elaborates more on these power practices.

Table 3.6: Power practices

Power practice	**Definition and illustration of where observed**
Domination	Certain actors holding positional power (managerial, professional) over other actors
Negotiation	Occurs when actors are partially aligned to another actor's decisions or actions
Collaboration	Actors work together to support an action or decision
Contestation	Opposition between two actors interacting at an interface
Resistance	Actors object to or oppose a decision or action of another actor

Source: Long, 2003; Parashar et al, 2020 [202, 208, 210]

In summary, this study adopts a health policy analysis analytic lens and draws on relevant power and organizational frameworks to investigate how the health system responds to feedback from the public. Drawing from the conceptual framework specific forms of analysis were conducted to support the achievement of different study objectives. Table 3.7 below shows a summary of theories or frameworks that were drawn upon in relation to the study objectives.

Table 3.7: Summary of research question, objective and frameworks guiding data collection and analysis

Research objective	**Research question**	**Summary theory or framework that informed data collection and analysis**
1. To analyse the policy and legislative context for responsiveness in Kenya	-Is responsiveness prioritised within national level policy and legislative documents? -What mechanisms and processes are proposed within policy documents for receiving and responding to citizen feedback? -How is responsiveness framed within Kenyan policy documents?	
2.To analyse the practice of responsiveness in Kilifi County	-What mechanisms are available for receiving and responding to citizen feedback in Kilifi County -How is public feedback received, processed, and responded to across case study SCHMTs and HFCs	Policy triangle, Aragon's organisational capacity framework
3. To critically examine the influence of actor and power relations impact responsiveness in Kilifi County	-How do actors' relations and practices of power influence the process of receiving, processing, and responding to citizen feedback?	Policy triangle; Gaventas power cube; Long's actor interface analysis Framework analysis
4.To examine the influence of contextual factors, including the implications of health system shocks for responsiveness in Kilifi County	-How does Kilifi County context influence the process of receiving, processing, and responding to citizen feedback -How was citizen feedback received and responded to during the COVID-19 pandemic response?	Policy triangle
5.To identify and propose strategies for strengthening health system responsiveness to public feedback	How can receiving, processing, and responding to citizen feedback be improved in counties within Kenya?	Policy triangle; Aragon's organizational capacity framework, Gaventas power cube; Long's actor interface analysis;

3.5 Study design

I adopted a qualitative research approach for this work because of its appropriateness for exploring the processes and experiences of participants in their natural setting, and about which little is known [211]. I conducted this work in two phases, so that I could first gather preliminary information (phase one) that would then guide the effective investigation of the practice of, and influences on responsiveness (phase 2). This was important given the dearth of information on the practice of HS responsiveness. In the first phase, I adopted an exploratory descriptive research strategy to achieve a better understanding of the policy and legislative context for HS responsiveness, and to identify case studies for in-depth exploration to understand the practice of responsiveness. In this first phase, I also collected data relevant to the context at the time which included response to the COVID-19 pandemic.

For the second phase, I adopted a multiple-case study approach. I considered a qualitative case study design approach to be appropriate for this work because of the focus on the 'how' and 'why' questions regarding the practice of responsiveness, and the importance of context in answering these questions [212]. A qualitative case study research approach is adopted to support the holistic and in-depth investigation of a complex issue, and when the context is important to the phenomenon to be studied [212] [213].

3.6 Study phases and Data Collection Methods

3.6.1 Phase one: Exploratory Research

This phase aimed to enable familiarity with the study context and identification of case studies for in-depth study. In relation to figure 3.4 context refers to the organisational arrangement and culture of the health system processing spaces where public feedback is received (meso-context), and the legislative and policy frameworks national and the broader environment in which the health system is situated (macro-context). At the time of conducting this work, this broader environment included the emergence of COVID-19 as a global health emergency. This context is also considered in this work, which includes an exploration of the implications of the COVID-19 pandemic on health system responsiveness.

The data collection methods employed in this phase were document review, in-depth interviews, and observations. These are discussed below.

Document review

The purpose of this component was to understand the national legislative and policy environment of relevance to public feedback and responsiveness. The document review supported content and framing analysis of HS responsiveness within policy documents, as presented in Chapter 4.

The document retrieval process was conducted iteratively, over a period of three months, assessing national-level policy, legislative documents, and health system assessment reports from 1994 to 2020. Following independence, Kenya operated until the mid-90s without a substantive health policy, or strategic plan [83, 214]. The first Kenya Health Policy Framework KHPF (1994-2010) was published in 1994. To accelerate the realization of the policy vision, the Ministry of Health (MoH) published two five-year strategic health sector plans; the National Health Sector Strategic Plan I NHSSP (1999-2004) and the NHSSP II 2005-2010. A second national health policy, Kenya Health Policy (KHP) II (2012-2030) was developed, which has several five-year plans linked to it. All of these were included in the document analysis. As the implementation process of policies involves monitoring and periodic evaluation [215], I considered it important to explore policy document

proposals for measuring responsiveness, and included reports of national health system assessments among the documents for review.

I searched the websites of the National ministry of health of Kenya for health sector-specific policies, plans and assessment reports. Where documents were not available online, I reviewed hard-copy documents. I also searched for broader national-level public sector documents and legislative instruments. I found it necessary to include public sector policy documents because public health systems exist as part of the broader public sector, and often, governance principles adopted for the wider public sector will apply in some ways to the public health sector. The legislative instruments were included as they are frequently drawn upon as justification for policy direction. A summary of the documents extracted and reviewed can be found in section 4.2. (Table 4.1).

Observations and In-depth Interviews

I conducted non-participant observation of Kilifi CHMT meetings between June and July 2020. These observations aimed to build rapport and trust between myself and potential study participants. As noted above, during the period of data collection, the COVID-19 pandemic response was a significant part of the health system context. The CHMT in June 2020 held daily COVID-19 briefings. I attended these briefings as a non-participant observer to learn whether and how public feedback was discussed in these meetings and/or incorporated into the pandemic response, to identify potential participants for in-depth interviews and to learn about experiences at the sub-county and facility levels that could inform selection of case study SCHMTs and HFCs.

I also conducted 20 in-depth interviews with purposively selected health system county and sub-county managers. These interviews were conducted to identify available feedback mechanisms within the county, to track how citizen feedback was received and responded to during the early days of the COVID-19 pandemic and to consider the implications of COVID-19 on responsiveness. Each participant provided written informed consent (Appendix 3) after the study details and the interview process had been explained to them. All interviews were conducted face-to-face but followed provisions for infection control such as wearing masks and social distancing. All the interviews were conducted in English. Three respondents declined to be recorded, so for these interviews I took notes during and after the interviews. I employed interview guides tailored for each type of health manager (Appendix 4). Given the current attention to COVID-19 at the time, the interview guides included questions to understand how the CDoH had organised itself to respond to the COVID-19 pandemic, what provisions had been made to receive and respond to public feedback, what forms of public feedback were received and how they were responded to.

The interview guides thus drew on the study conceptual framework and the literature review, while being sensitive to the context at the time.

The interviews in this phase lasted on average 40 minutes. I developed an interview summary after each interview, which I shared with my supervisory team. The interview summaries presented the key emerging data, and I drew on them to discuss with my supervisors' insights that fed back into the data collection process.

3.6.2 Phase Two: In-depth case studies: HFCs & SCHMTs

Case selection

Merriam [216] describes a case as "an intensive, holistic description and analysis of a bounded phenomenon such as a program, an institution, a person, a process, or a social unit" (p. xiii). The "processing spaces" illustrated in Fig. 3.3 (Box A) served as the "case" of focus in this study. These spaces represent points or places where the processing of input (feedback) from the public happens. The exploratory process in Phase 1 coupled with knowledge from previous learning site work, contributed to the identification of two types of 'processing spaces' (cases) where health system decision-making regarding public feedback happens at the sub-national level. These cases are Health Facility Committees (HFCs) and Sub-County health management teams (SCHMTs).

The HFC and SCHMT are two different types of processing spaces: HFCs are comprised of community members, health managers, and political and administrative representatives, while SCHMTs are composed of health managers. Both spaces are governance structures, but operate at different levels of the health system, HFCs work at PHC facility-level while SCHMTs co-ordinate service delivery across multiple PHC facilities in one sub-county. The choice of governance structures across different health system levels was aimed at examining system-level interactions. In the study context, there are linkages between HFCs and SCHMTs, as SCHMTs have oversight responsibilities for HFCs, an organisational arrangement carried over from pre-devolution days [136, 139]. In essence therefore, this was a nested case study design, where the selected SCHMTs were cases, while the two HFCs in each SCHMT were sub-cases, nested within the case study SCHMTs. In selecting specific examples of each case to study I first selected two out of 7 SCHMTs, then within each SCHMTs, I selected two HFCs (Figure 3.6). I expected that the cases (SCHMTs and HFCs) would interact because as noted above within the Kenyan health system structure, the SCHMT co-ordinates service delivery and health system issues at PHC facility-level (including HFCs). Further, while members of HFCs work mainly at PHC facility-level, as members of the public their interactions when receiving and responding to public feedback can span more than one level of the health system including facility, sub-county, and county levels.

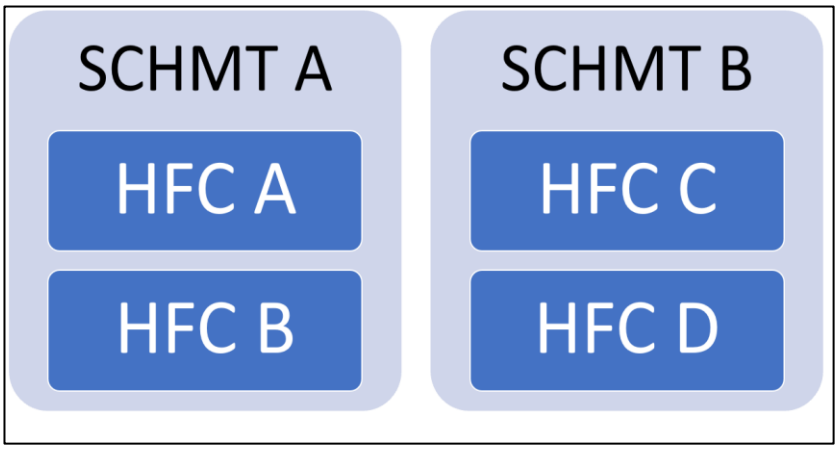

Figure 3.6: Cases for in-depth exploration

The selection of specific SCHMTs and HFCs was purposive, and I sought to identify specific cases that were rich in information rather than representation [217, 218]. For example, in selecting the SCHMTs I considered the two SCHMTs out of the seven in Kilifi County which had dealt with a high number of COVID-19 cases because I wanted to continue to learn more about the implications of the unfolding COVID-19 pandemic on processes of receiving and responding to public feedback. One of these SCHMTs, SCHMT-A supported service delivery in facility A which was converted into a COVID-19 isolation centre. This provided an opportunity to learn more about what public feedback if any had been considered in making this decision and others related to the COVID-19 pandemic response. The other SCHMT, SCHMT-B, had handled the second highest number (after SCHMT-A) of COVID-19 cases during the first nine months of the COVID-19 pandemic response, and therefore also provided an opportunity to learn more about their experiences with management of public feedback during a pandemic response.

Anecdotal evidence suggested that the two SCHMTs had varying team dynamics where SCHMT-A was perceived by the CHMT to be a more cohesive team than SCHMT-B. Another consideration in selecting the two SCHMTs, was that one SCHMT was stationed near the county headquarters where multiple county decision-makers were located, while the other was further away. This latter consideration was relevant because physical proximity could provide more opportunity for health managers and decision-makers to formally (or informally) engage over public feedback.

In selecting the specific HFCs to conduct my investigation I considered that Level 3 facilities (health centres) served a larger population than level 2 facilities (dispensaries). Previous experiences with collecting data at PHC facility level suggested that Level 3 Health Committees elected more community members in their HFCs than Level 2 facilities. To achieve diversity in the characteristics of the HFC members, I, therefore, opted to include HFCs of Level 3 facilities in the sub-counties managed by the two case study SCHMTs.

Data collection

To capture the complexity and entirety of cases under study, case study design requires multiple forms of data [212, 216, 218]. I therefore collected and drew from multiple forms of data as described below.

a) Document reviews

Document reviews were useful as a means of triangulation for information collected from other sources [218, 219]. Documents reviewed included HFCs and SCHMT minutes, facility and SCHMT annual work plans, and county-level documents such as annual development plans, budgets, and health sector reports. A summary of these documents is provided in Table 3.8 below.

b) In-depth Interviews and Focus Group Discussions

I conducted 35 in-depth interviews and four focus group discussions (FGDs) with a range of respondents (sub-county health managers, facility in-charges and frontline providers, MCAs and HFC members) (Table 3.8). The respondents interviewed were purposively selected for their involvement in receiving, processing, and responding to citizen feedback across all the case study SCHMTs and HFCs. I accessed many of the respondents that I had planned to interview, however among the MCAs I was only able to interview four of the intended six and eight. At the time of data collection, many MCAs were involved in political campaigns, in anticipation of national elections that would be held in August 2022. Despite these challenges in accessing some respondents, I felt I was able to reach a point of saturation where I was not hearing any new or additional data relevant to the study objectives [220]. Further literature suggests that these numbers for in-depth interviews and focus group discussions (FGDs) are adequate to yield rich data without compromising the quality of data and analysis [211].

The purposive selection of health managers was informed by the nature of the subject under investigation; a mix of health managers from different levels of the health system was deemed necessary to examine interaction across system levels. Again, every participant provided written informed consent after being explained to the study objectives and the interview process. Most of the interviews were recorded. Five participants declined to be recorded. I, therefore, wrote notes during and immediately after those interviews. The interviews lasted on average one hour. I conducted the in-depth interviews using an interview guide (Appendix 5) that drew on the study's conceptual framework. I also used in-depth interviews to dig deeper into some Phase 1 findings. For example, some of the Phase 1 findings were related to feedback mechanisms that were introduced during the COVID-19 pandemic, and others that had been in the health system but were not utilised by the public to provide feedback. During this second phase of data collection, I used

the interviews to explore further the functioning of these mechanisms and influences that supported or hindered their functioning.

I also conducted four Focus Group Discussions (FGDs) with HFC community members. These FGDs were conducted at the facility where the HFC members were elected to serve and lasted between one and a half to two hours. Communication about the FGDs was made through the facility-in-charges of the respective facilities where the HFCs worked. The facility-in-charges were not included in the FGDs. Before starting the FGDs, participants were informed about the nature of the study by a field worker in the local language (Giriama) and were asked for written consent (Appendix 6). Every FGD member signed a consent form written in the local language. The FGDs were audio-recorded. A topic guide was used to introduce themes during the discussions (Appendix 7). Basic demographic information- age, education, occupation, or another role in the community was also collected from participants.

c) Observations

I conducted non-participatory observation of meetings and support supervision activities of SCHMTs to gain first-hand experience of decision-making processes. The observations aimed to identify potential respondents and provide a means of triangulating information captured from documents and interviews. The observations also provided an opportunity to observe relational behaviour among different actors and other subtle procedures and dynamics. An observation guide (Appendix 8) was used to ensure that pertinent information was gathered and documented for each case.

I conducted observations of SCHMT-A meetings, between July and August 2021. The SCHMTs held meetings every Monday morning where they shared feedback about what activities they had been involved in. However, several SCHMT meetings did not occur as planned due to a lack of quorum in the last weeks of August and September 2021. Both SCHMT-A and SCHMT-B members were attending other meetings and training sessions. In SCHMT-B, I, therefore, went into conducting interviews directly without doing observations of their meetings. I was only able to attend one support supervision session held by SCHMT-A (but these included visits to two facilities), as many of the other scheduled supervision sessions during the planned data collection period were frequently re-scheduled due to challenges with accessing a utility vehicle to transport the SCHMT members. Table 3.8 below summarises the data collection activities described above.

Table 3.8: Summary of data collection activities across study phases

Form of Data	Quantity/Duration	Respondents	Details in relation to study objective
Phase 1			
Document review	National-level health sector Policy documents, public sector documents, legislative instruments, and health system assessment reports (n=29)		Exploratory phase: To learn about the policy on paper for responsiveness and identify cases for in-depth exploration
Observations of meetings	Observation of CHMT meetings between June and July 2020		To support identification of case study sites; to build rapport for phase 1 interviews, to understand
In-depth interviews	20	CHMT members (15) Medical superintendent (1) SCHMT members (4)	Exploratory phase: To identify cases; COVID-19 focused data;
Phase 2			
In-depth interviews	18	SCHMT members (16)- CHMT members (2)	SCHMT as a processing space for public feedback
	13	HFC managers (5) and frontline workers (8)	HFC as a processing space for public feedback
	4	MCAs (4)-3 linked to HF A, B, & C 1 member of the Health Services County Assembly Committee	-Aimed at understanding MCA's role (as part of HFC, and also in the Health Services Committee role in strengthening responsiveness)
Focus Group Discussions	4	HFC community members	HFC as a processing space for public feedback
Observations of meetings	Observation of SCHMT meetings & support supervision (SCHMT-A) between July and August 2021 (6 meetings)		
Document review	-County-level documents (CBOP; CIDP, Health Sector Mid-term Review, County Budgets)		To understand the context in which the SCHMTs and HFCs functioned
	Satisfaction survey findings -SCHMT & HFC minutes -SCHMT & HF Annual Work Plans		To identify whether and how received public feedback was documented, and any identification of responses

Abbreviations: CHMT-County Health Management Team, CBOP-County Budget Outlook Paper, CIDP-County Integrated Development Plan, HFC-Health Facility Committee, HF-Health Facility, MCA-Members of County Assembly, SCHMT-Sub-County Health Management Team

3.7 Data Management and analysis

Data cleaning and transcription

Recorded interviews were transcribed by my organisation's (KEMRI) in-house data processing team with experience in transcribing qualitative data. All FGDs were translated verbatim into English. For data cleaning, I listened to all the transcripts against the audio recordings to check on missing data and make corrections. This process also enhanced my familiarity with the data. I removed identifiers

(names of respondents, places that could easily identify facilities) during this data-cleaning phase and replaced with codes (Table 3.9). I used this cleaned data for analysis. I also made summary notes from document reviews and maintained observation notes and diary entries. I later imported data into NVivo 12 software to support analysis.

Table 3.9: Description codes used for transcription and in quotes

Descriptor Code	Details
CHMT-001	County Health Manager
SCHMTA-001	A respondent from Sub- County Health Management Team A
SCHMTB-002	A respondent from Sub- County Health Management Team B
HFA001; HFB002	Health Facility A respondent (Health Care Worker); Health Facility B respondent
HFC-A (FGD)	FGD quote from community members of HFC A
HFC-B	FGD quote from community members of HFC B
HFC-C	FGD quote from community members of HFC C
HFC-D	FGD quote from community members of HFC D
MCA-001	Member of County Assembly

Abbreviations: FGD-Focus Group Discussion; HFC-Health Facility Committee

Data analysis

I used content and framing analysis for the policy and legislative documents retrieved in Phase 1, and a modified framework analysis approach for all the other forms of data across both study phases. The modified framework approach allowed for an inductive step for data collected through observations, in-depth interviews, and focus group discussions. These are explained in more detail in the sections below.

Content and Framing analysis of policy documents and legislative instruments

Analysis of documentary sources is recognised as a valuable qualitative analysis method and has been used in other studies, for example, to examine how inter-sectoral collaboration is framed, and how equity is considered within public health policy documents [221] [222, 223]. I analysed policy and legislative documents in two phases: 1) data extraction and coding and 2) framing analysis.

Once the selection process was complete, I read and re-read documents to establish their main content. I then developed a content coding sheet in Microsoft Excel for each document and coded the following items:

- The purpose of the document and influences in the development of the document
- Specific reference to the term responsiveness
- Use of other terms linked to responsiveness (see Table 3.10)
- To whom responsiveness is directed (public, patients/clients, community)
- Mention of vulnerable groups and which vulnerable groups are mentioned
- Feedback mechanisms mentioned or established within the legislative or policy documents
- Actors identified as responsible for responsiveness or functioning of feedback mechanisms
- Measurement of responsiveness (indicators for tracking responsiveness)

The terms linked to responsiveness summarized in Table 3.10 were informed by an earlier review of the health system responsiveness literature [72]. The review aimed to map research findings related to health system responsiveness, and to identify evidence gaps that could support further research work in LMICs [72]. I sought to extend some of the review findings including drawing from the three broad categorizations of responsiveness framing identified by the review: responsiveness as unidirectional service user interface, responsiveness as feedback between users and the system, and responsiveness as accountability [72]. These three framings did not map neatly on to the study's reviewed documents, making it necessary to adopt additional frames. These are highlighted in more detail in chapter four.

Table 3.10: Summary of words and phrases related to responsiveness searched for in policy documents

Words and phrases searched for in the policy and legislative document	
Responsiveness	Patient's rights
Health system responsiveness	Needs of minority groups
Public service responsiveness	Needs of marginalized groups
Accountability	Citizen views
Social accountability	Community views
Public participation	Population views
Community participation	Citizen's voice
Community involvement	Community voice
Community engagement	Population voice
Citizen participation	(Legitimate) Expectations of users
Citizen involvement	Expectations of clients
Citizen engagement	Expectations of the population
Social Good	User satisfaction
Social rights	patient satisfaction
Citizen Rights	Citizen satisfaction

To understand how responsiveness policy is constructed in Kenya, I employed framing analysis which is a form of interpretive policy analysis [224]. Framing analysis is concerned with how problem definition is linked to policy solutions. Frames highlight certain aspects of a problem, diagnose causes, make moral judgements and propose solutions [225]. The term frame is used in different ways in relation to health policy processes as identified by Koon et al [224]. In this study, I used the term framing to refer to the construction of social problems which includes *'contestation over diverging interpretations or portrayals of both the causes and solutions to specific policy dilemmas'* [224]. By asking how responsiveness is 'framed as a policy issue' I sought to understand how policy documents articulate or describe responsiveness and what arguments are used to support varied views of responsiveness. To elicit frames from the policy documents, I considered to whom responsiveness is targeted, which methods are proposed to enhance responsiveness, and with what objectives.

Modified Framework analysis

I adopted a framework analysis approach to analyse all other data because of its appropriateness for analysis oriented to policy and practice [226]. Other reasons included that it supports the

systematic treatment of similar units, and enables comparison between and within cases [227]. I followed the five steps of framework analysis; first, I familiarised myself with the data by listening to audio recordings of interviews, reading through interview transcripts, observation notes, meeting minutes and documents reviewed. During this stage, I listed key ideas, recurring issues, and patterns. I then developed a thematic framework (Appendix 9). This framework was informed by the research objectives, questions from the topic guide, the study's conceptual framework and issues emerging from the collected data. Thus, I adopted both deductive and inductive approaches in developing the thematic framework. Next, I coded the individual transcripts using the thematic framework in NVIVO 12 software. In this stage, I labelled different sections of text within the transcripts into corresponding nodes (different themes or sub-themes). I then created charts for each subject area and made entries for several respondents. After sifting and charting the data in this way, I examined the themes and categories more closely to support abstractive interpretation and find associations within the data. This process was guided by the research questions and involved finding linkages between the emerging findings and existing literature. I then developed individual case summaries for each of the cases which I used to conduct cross-case analysis.

For phase 1 data, I pooled all interview data during the analysis process. However, in phase 2, I adopted a case-by-case approach in which I considered each SCHMT and HFC separately, then compared and contrasted HFCs, SCHMTs, and HFCs and SCHMTs. Even though described in a step-by-step approach, the analysis of data was an iterative process in which data collection, coding and analysis overlapped.

3.8 Enhancing research rigour

Ensuring rigour is important to establish the trustworthiness of a study. There are four criteria posited by Lincoln and Guba (1985) for enhancing trustworthiness. These include credibility, dependability, conformability, and transferability [228]. I employed multiple strategies to meet these criteria and enhance the rigour of this research work.

Credibility refers to whether the study findings are 'congruent with reality' [229]. Some of the strategies I adopted to enhance the credibility of this work included triangulation, which involves the use of multiple data collection methods to enhance the exploration of the richness of social behaviour and patterns by studying it from more than one standpoint [230]. I also included a wide range of participants to obtain a range of perspectives on the same phenomenon, and used a multiple case study design which allowed for cross-case analysis and exploration of replication of findings [231]. Further, I involved study participants in verifying the interpretations of my research findings by presenting analyses of my work to CHMT members during their weekly meetings, and by sharing a policy brief (Appendix 10) developed from the first phase of the work. This policy brief,

which described how public feedback was incorporated into the COVID-19 response in the early days of the pandemic, was circulated to and discussed with sub-county and county health managers. This process of member checking helped to obtain systematic feedback from study participants on the collected data, interpretations, and conclusions of the study [232]. Some of the feedback from the respondents helped to identify potential participants and interview questions for the second phase of data collection. I also consistently engaged with my supervisory team who reviewed interview summaries and provided feedback that shaped subsequent interviews. During data collection and analysis processes, the supervisory team provided input that shaped and refined the thematic framework and development of case summary reports. In this way, they acted as peer debriefers. Another form of peer debriefing was by sharing research plans and preliminary findings with other researchers during departmental seminars and at a conference where they asked questions about the procedures, meanings, interpretations, and conclusions of the investigation [232].

To achieve dependability (showing that the findings are consistent and could be repeated)[229], I endeavoured to maintain a clear audit trail of the research process by adopting a systematic research approach using data collection and study methods that meet widely accepted standards for qualitative research. In this work, I have provided the rationale for methodological choices, a philosophical understanding (section 3.8) and conceptual and theoretical frameworks to show how study findings were arrived at to contribute to this audit trail. This was further enhanced using NVIVO 12, which provided a link for the trail across the steps in the analysis of the raw data.

The audit trail and peer debriefing processes also contributed to confirmability (grounding of the study findings in data) [228, 229]. Finally, to enhance transferability (showing that the results could be applicable in other contexts) of the findings, I have endeavoured to provide a thick description of the fieldwork site, including methods and time frames of the data collection [228, 229].

3.9 Philosophical underpinning for the study

Researchers bring their beliefs and philosophical assumptions to research, and these shape how the inquiry is conducted [233]. These philosophical assumptions are varied and include positivism, post-positivism, critical theory, pragmatism and interpretivism [234]. These assumptions represent researcher's perspective on what is to be known (ontology) and how that knowledge can be gained (epistemology) [233]. In selecting the philosophical stance from which to approach this study, I considered the type of research questions I sought to answer and the potential means of generating the knowledge that would answer these questions [233]. The purpose of this study is to identify the gaps in policy and practice of responsiveness and formulate proposals relevant to policy and practice. Thus, a pragmatic framework appeared fitting for this study. Pragmatism concerns itself

with what works—and solutions to problems, by emphasising the research problem, and then using multiple approaches to understand the problem [233]. Pragmatic inquiry draws from a range of methods to produce knowledge that helps to improve situations [235]. Kaushik and Walsh (2019, pg 4) argue:

> *"Pragmatism is situated somewhere in the center of the paradigm continuum in terms of mode of inquiry. Postpositivism typically supports quantitative methods and deductive reasoning, whereas constructivism emphasizes qualitative approaches and inductive reasoning; however, pragmatism embraces the two extremes and offers a flexible and more reflexive approach to research design (Feilzer 2010; Morgan 2007; Pansiri 2005). In adopting this stance, the pragmatist researcher can select the research design and the methodology that are most appropriate to address the research question. Pragmatism is typically associated with abductive reasoning that moves back and forth between deduction and induction." (pg 4)[235]*

The philosophy of pragmatism is evident in several ways from this study. First, the study objectives seek to analyse, and critically examine responsiveness policy and practice, and make recommendations to strengthen responsiveness. These objectives are in line with the pragmatic approach that is concerned with problem-solving [233, 235]. Second the choice of study approach, a qualitative case study was informed by the suitability of this approach to answer the study questions [236]. Third, the study utilises various data collection methods (interviews, focus group discussions, observations, and document reviews), which is characteristic of a pragmatic framework [233, 235]. Finally, I adopted a modified framework approach to the analysis of study data. The framework approach is deductive and is recommended for inquiries that set out to produce recommendations that are relevant to policy [227]. However, I employed a modified approach by including an inductive step in the analysis process to allow for the emergence of themes from the data.

In this study therefore, I take the ontological position that no single reality exists [234] and, this realities are determined (epistemological position) by the use of multiple tools of research [234, 235]. These positions orient themselves to qualitative research, which was a good fit to meet my study objectives. A distinctive feature of qualitative inquiry is the researcher as an instrument of data collection and analysis [237]. My experiences are therefore likely to influence the research process. In the next section, I reflect on my role in shaping the research process.

3.10 Positionality and Reflexivity

In qualitative research, the researcher's characteristics (such as values, beliefs, personal experiences and professional characteristics) may impact the research process [238]. Thus

reflexivity is a crucial strategy that increases the rigour of qualitative research work [239]. By being reflexive, the researcher provides the reader with an opportunity to understand the biases and assumptions that could affect the study [238].

In reflecting on the likely influence of my social and professional experiences, it is likely that my academic training, professional experience, formed opinions and views influenced the research process in some ways. I trained as a nurse and have worked with healthcare workers in the health system on and off for five years. Of these five years, one year was spent working as a nurse in a public hospital, another year working in a private hospital, and two years working with an NGO that supported HIV care and treatment and service delivery in public health facilities. These experiences influenced my interest in focusing on research in public health facilities, because of the differences in patient experiences, availability of supplies and commodities I witnessed in the public health facilities compared to the private health facilities, and when NGO support was available to public health facilities. Therefore, my implementation of this study was not purely as a 'disinterested observer' but as someone interested in seeing a responsive public health system through better policy and practice, and eventually outcomes.

My experience working in the health system, and later researching the health system affected data collection and analysis because it allowed me to approach the study with some knowledge about public health system processes and to know to address certain topics. My professional identity as a nurse may have had an impact on my interactions with study participants. For example, it appeared to affect interviewees' expression, who in a few instances left sentences unfinished with the assumption that, '*you know how this health system is...*' Because of this 'insider' position, I endeavoured to be alert, reflect on how I shaped interviews and explained that while I may have worked in the health system, experiences differ, and I wanted to learn from theirs.

I was a member of a large research collaboration, RESYST [180], that in the period preceding this work]investigated health governance in Kilifi County. Several health managers in the county participated in this work, and this too affected the process of data collection. Previous shared experiences with these managers (of interviewing and attending meetings with them) appeared to diminish the distance between myself and these study participants. For example, the health managers I had worked with in RESYST were more open to requests for me to observe their activities, for documents to review, and during interviews were less guarded than health managers who had recently joined the SCHMTs and CHMT. In one of the sub-county teams and one facility where I collected data for this study, I was denied access to minutes and the facility's Annual Work Plan despite explaining the study objectives and the confidentiality provisions. In both instances,

the custodians of these documents at SCHMT and facility level had been recently appointed to their positions.

Finally, I have three supervisors, all of whom were involved in the cross-country responsiveness project within which this work was nested. One of my supervisors had worked in the Kilifi County health system as a health manager, has existing relationships with health system actors in the county and therefore has a good understanding of the history and nuances of the Kilifi County health system. My association with him improved access to potential respondents, including their willingness to be interviewed and speak openly about their views. However, some respondents might have been concerned about their relationship with this supervisor and therefore provided socially desirable information. This risk was offset by the presence of other supervisors, one who had lived in Kilifi and conducted health system and qualitative work for a long time and is knowledgeable about the Kilifi context and could therefore challenge interpretations of data collected. My other supervisor conducted work in a learning site in South Africa and is familiar with the Kenyan learning site from previous collaborative work. Together, they played 'the devil's advocate' by challenging assumptions and interpretations to improve the overall quality of the study.

3.11 Ethical Considerations

This study was approved in December 2019 by the KEMRI Scientific and Ethics Review Unit (Appendix 11). However, when the COVID-19 pandemic was declared a global health threat in March 2020, I sought approval for an amendment to include a new specific objective line with the realities of the COVID-19 pandemic (Appendix 11). This amendment was aimed at achieving a better understanding of context. Health system functions were affected by the COVID-19 crisis. It therefore seemed necessary to investigate whether and how public feedback is valued and prioritized during a crisis, and to examine the implications of the COVID-19 pandemic on responsiveness.

Before beginning the study, I sought permission from the Kilifi County Department of Health Research Committee. I also explained the study purpose and procedures to the CHMT and SCHMTs at first contact with them. At the PHC facility level, I planned initial meetings with staff through the facility-in-charge. At these meetings, I explained the study objectives and procedures to all staff but clarified that I would be speaking with a few of them who were involved in receiving and responding to public feedback. With individual study participants and during FGDs, I explained the objectives of the study and sought consent before proceeding with any data collection activities. This information was contained in an informed consent form (Appendix 3), which participants signed before the start of an interview or an FGD. Verbal consent to undertake document reviews was

taken from the head of the CHMT and SCHMTs and the individuals who were custodians of the documents.

3.12 Chapter Summary

In this chapter, I have presented the study design and approach adopted for this study. I adopted a case study approach as it lends itself well to the examination of complex processes. Two cases of processing spaces -HFCs and SCHMTs- were selected for in-depth exploration. The chapter also presents my experiences during fieldwork and the procedures I adopted for collecting data which include document review, in-depth interviews, observations, and FGDs. I have also presented in this chapter the study's conceptual framework (Fig 3.3 and 3.4) which I drew on to collect and analyse data, and in subsequent chapters to structure study findings. I have also highlighted the philosophical framework that guided the conduct of this work and included the steps taken to ensure research rigour as well as the ethical conduct of the study. In the next chapter, I describe the policy and legislative context for health system responsiveness in Kenya.

Chapter 4 The policy and legislative context for health system responsiveness in Kenya

4.1 Introduction

I present the findings of this study in four results chapters. In this first results chapter, I present findings from a content and framing analysis of national policy documents and legislative instruments. Analysis of policy documents can help to gain insights when exploring the what, the how and why concerning a health policy issue [219]. Therefore, I began my examination of health system responsiveness by exploring policy and legislative documents. The analysis of policy documents was guided by three questions that link back to the first study objective as described in section 3.3. These questions are:

i) What is the content on health system responsiveness in policy documents and to whom is responsiveness targeted?

ii) How is responsiveness framed within Kenyan policy documents and legislative instruments?

iii) What are the mechanisms and who are the actors responsible for enhancing health system responsiveness including where (local, sub-national, national) mechanisms/processes could be enacted

I have organised this chapter in line with the three questions above. To answer these questions, I extracted the term 'responsiveness', its variations and other terms relating to responsiveness and public feedback from the policy documents and legislative instruments. The terms are summarised in Table 3.10 and were informed by an earlier review of the literature to identify the various frames used in health system responsiveness literature [72].

4.2 Description of the content of policy and legislative documents relevant to responsiveness

I reviewed 24 legal and policy documents and five related health system assessment reports in total, as summarised in Table 4.1 below.

Table 4.1: Table showing categories of documents reviewed

Document Type	Document
Legal instruments	Constitution of Kenya-2010
	County Governments Act 2012
	Public Finance Management Act 2012
	Health Act 2017
	Urban Areas and Cities Act 2012
	Legislative supplement No 67 Kenya Gazette Supplement No 123, 2007
	Legislative supplement No 25, Kenya Gazette Supplement No 67, 2009
	Public Service Act 2017
Public sector policy	Human Resource and Procedure Manual for the Public Service, 2017
	Kenya Vision 2030
	Public Participation Guidelines, 2016
Health sector-specific policy	The Kenya Health Policy 1 1994-2010
	Kenya Health Strategic Plan 1 1999-2004
	The Kenya Health Sector Strategic Plan II (KHSSP) 2005-2010
	Taking Kenya Essential Package for Health to the Community (2006)
	The Kenya Health Policy 2014-2030
	The Kenya Health Sector Strategic Plan (KHSSP) 2013-2017
	Patient rights Charter-2013
	Community Strategy 2014-2019
	Kenya Primary Health Care Strategic Framework 2019-2024
	Kenya Community Health Policy 2020-2030
	Community strategy implementation guidelines 2006-2010
	Kenya Health Sector Strategic Plan 2018-2023
	Kenya Community Strategy for Health 2020-2025
Health system assessment reports	KIPPRA Health Assessment Survey, 2017
	Service Availability and Responsiveness Mapping (SARAM), 2013
	Public Expenditure Tracking Survey (PETS), 2012
	Evaluation of the Community Strategy, 2010
	Service Delivery Indicator (SDI), 2018

The term responsiveness was explicitly mentioned in 13 (54%, N=24) of the documents reviewed. Of these texts with specific mention of responsiveness, Figure 4.1 below highlights that health system documents referred to responsiveness as a health system goal, while legislative instruments and public sector documents referred to responsiveness as a value and principle of public service.

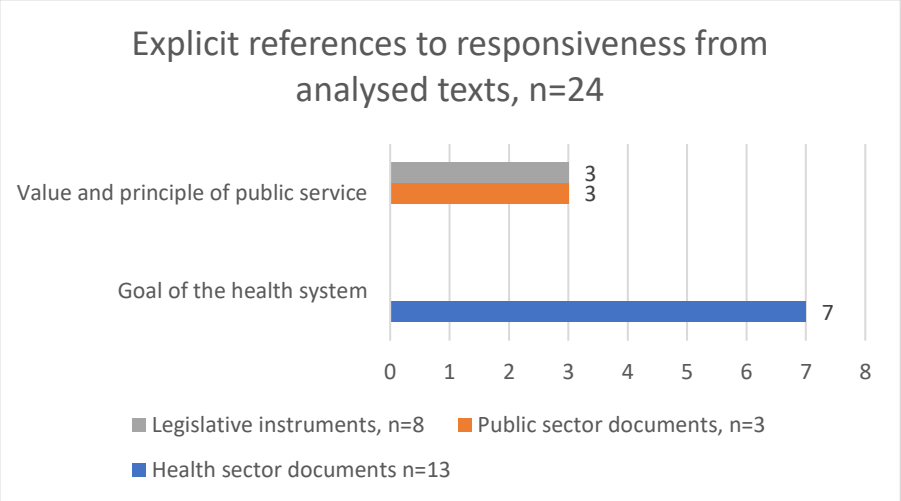

Figure 4.1: Policy documents and legislative instruments with explicit mention of responsiveness

Despite these broad references to responsiveness, closer inspection of the content in the policy documents revealed little specific direction that could guide action on building a responsive health system. This appeared to be the case even when other terms related to responsiveness were considered. More details on these findings are presented in the sub-sections below, which are in three parts. The first section highlights the different ways in which responsiveness was referred to; the second section describes the populations mentioned in policy documents to whom responsiveness should be directed, and the third section presents policy content about the measurement of responsiveness.

4.2.1 Frequent but disjointed and undetailed reference to responsiveness

Responsiveness was a frequently mentioned term in the reviewed documents as illustrated by Figure 4.1 and Table 4.2. Table 4.2 below also highlights that there was little detail related to the achievement of this goal, and lack of continuity across health sector policies and plans, as each document introduced some variation in the description of responsiveness.

Table 4.2: Varying description of responsiveness in health sector policy documents

Health sector policy document	**Reference to responsiveness**
Kenya Health Policy I 1994-2010	Reference in the foreword of the policy document, as an **aim of health sector reform**, '*To ensure that local health authorities become both more autonomous and more responsive to local needs' (pg ii)*
National Health Strategic Plan I 1999-2004	No reference to responsiveness
National Health Sector Strategic Plan II 2005-2010	As an **output measure of improved performance** in health-related parastatals & at the district level (*improving information & responsiveness to claims*), *pg 7* As an **output measure of equitable access**: '*The resource gap to reach the (very) poor is defined on the basis of an agreed set of criteria, together with a package of care that is responsive to the needs of this group [the very poor]'; pg 10* As a **health system objective**: *to improve the quality & responsiveness of services in the [health] sector, pg 12*
Taking the Kenya Essential Package for Health (KEPH) to the community, 2006	In reference to the **health system objective** mentioned in KHSSP II: '*to improve the quality & responsiveness of services in the sector' (pg 1)*
Community Strategy Implementation Guidelines 2006-2010	In reference to the **health system objective** mentioned in KHSSP II: '*to improve the quality & responsiveness of services in the sector' (pg 1)*
Kenya Health Policy (KHP) 2014-2030	**Responsiveness of health services** is presented as a **goal of the health system**
Kenya Health Sector Strategic Plan KHSSP 2013-2017	Responsiveness is presented as a health system goal: *'attaining the highest possible health standards in a manner responsive to the population needs.*
Strategy for Community Health 2014-2019	In reference to the KHSSP (2013-2017) as a broad **goal of the health system** (pg 1)
Patient Rights Charter, 2013	No reference to responsiveness
Kenya Community Health Policy 2020-2030	Reference to responsiveness in the foreword, as a **feature of the Community Health Information System** (pg viii)
Kenya Primary Healthcare Strategy 2019-2024	As a **mission of the public health system**: '*To ensure progressive, accessible, affordable, resilient, responsive, and sustainable primary health care services of the highest standard for all Kenyans' (pg 35)*
Kenya Health Sector Strategic Plan 2018-2023	Responsiveness as an **HS goal** is implied by inclusion in the logical framework of the document
Kenya Community Strategy for Health 2020-2025	References the KHP II 2012-2030 wording, that responsiveness is an **HS goal**: '*attaining the highest possible health standards in a manner responsive to the population need*'

Abbreviations: HS-Health System

In the health sector policy documents developed before the adoption of the 2010 constitution, responsiveness was referred to in connection with health sector decentralisation to the district level where it was expected that district-level decentralisation would lead to greater responsiveness to the public. For example, in the foreword of the Kenya Health Policy (KHP) [1994-2010], the then Minister for Health states:

> *'Throughout [the implementation of health sector reforms proposed in the KHP (1994-2010), the locus for the executive control of resources will undergo further, functional decentralisation. This will ensure that local health authorities become both more autonomous and more responsive to local needs' (pg 4).*

Despite this introduction, responsiveness was not referred to again in the KHP (1994-2010). The KHP (1994-2010) did have a key strategic imperative: the creation of '*an enabling environment for increased private sector and community involvement in health sector provision and finance'* [175]. However, the strategy focused on strengthening NGO, private and faith-based health service providers, without reference to the inclusion of public feedback in shaping service delivery. Even though District Health Management Boards (DHMBs) comprising health sector actors, broader public sector actors, NGOs and members of the public were mentioned, their role appeared to be restricted to oversight of user fees in the KHP (1994-2010) and the National Health Sector Strategic Plan (NHSSP) I (1999-2004).

Responsiveness was mentioned as a health system objective in the NHSSP II (2005-2010). In this document, responsiveness was talked about in three different ways: first, as an output measure of improved performance in health-related parastatals and at the district level ('*improving information & responsiveness to claims*', *pg 7*), second, as an output measure for equitable access (*'the resource gap to reach the (very) poor is defined on the basis of an agreed set of criteria, together with a package of care that is responsive to the needs of this group' pg 12)*; and third, as a health system objective: (*to improve the quality & responsiveness of services in the sector', pg 10)*. However, when the evaluation for the NHSSP II (2005-2010) implementation period was conducted, responsiveness was measured in terms of quality-of-care improvements in Maternal Child Health (MCH), HIV, TB and malaria programs, and in the development of facility norms and standards [93]. This appeared to be a disconnect between the broad description of responsiveness included in the documents, and what was eventually measured, as only a few specific vertical program areas were evaluated.

There was slightly more consistency across the Kenya Health Policy (KHP) 2014-2030 and the KHSSP (2013-2017) which both refer to responsiveness as a health system goal. In the KHSSP (2018-2022) responsiveness as a health system goal is less explicitly stated, but it is included alongside improvement in health outcomes and financial protection and equity in the impact section of the KHSSP (2018-2022) logical framework. Across all three-health sector strategic plans, the proposed measure for the achievement of responsiveness is a satisfaction index.

More recently, the adoption of the 2010 constitution created a new governance landscape with explicit processes, mechanisms and actors that could potentially enhance responsiveness within the public (including health) sector. These include for example processes for public participation, mechanisms such as the County Budget Executive Forum, and actors such as MCAs. Some of these mechanisms are highlighted in Figure 4.2 below which presents the policy documents and associated mechanisms intended to support public participation as well as serve as channels through which the public can provide feedback to the health system.

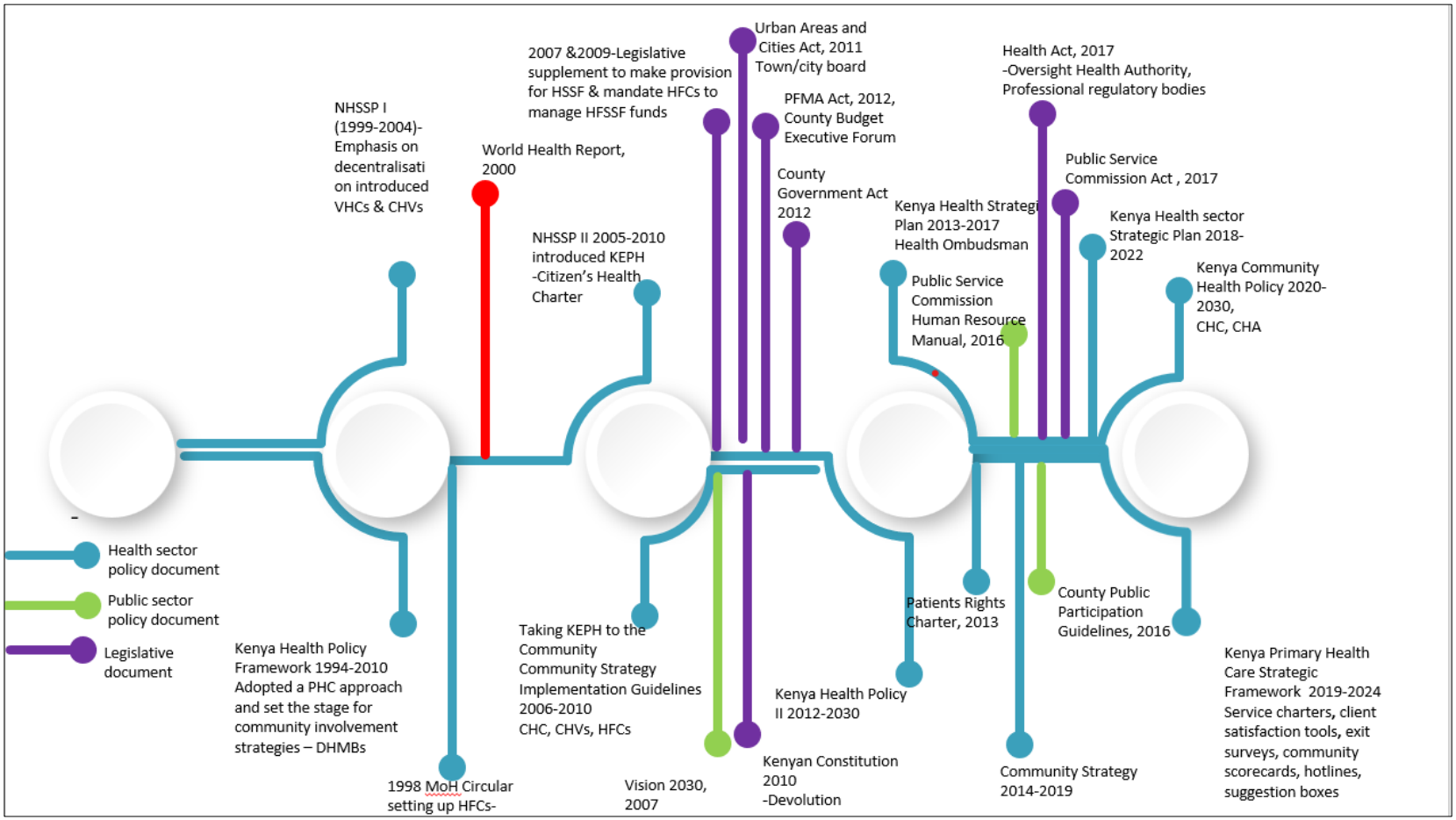

Figure 4.2: Timeline of Kenyan policy and legislative instruments relevant to responsiveness (1994-2022)

Key: PHC-Primary Health Care, DHMB-District Health Management Board, MoH-Ministry of Health, KEPH-Kenya Essential Package for Health, NHSSP-National Health Sector Strategic Plan, CHC-Community Health Committee, CHV-Community Health Volunteers, HFCs-Health Facility Committees, PFMA-Public Finance Management Act, CHA-Community Health Assistant

Notably, since responsiveness was first referred to in the KHP (1994-2010), and later highlighted as a broad goal of the health system by the KHP (2014-2030), there has not been a single overarching strategy for enhancing health system responsiveness. Notable also from the timeline (Fig 4.2) is how few guidelines there are to support the functioning of the various feedback mechanisms introduced in legislation, public sector and health-sector policies and strategic plans. Guidelines for feedback mechanisms could have expanded on responsiveness by providing more detail and supported continuity across the health sector policies and plans.

4.2.2 Varying breadth of responsiveness across the policy and legislative documents

There was also variation in the breadth of responsiveness across the documents reviewed. Breadth here refers to 'to whom' policy documents propose responsiveness should be directed. Figure 4.3 below highlights this variation that includes responsiveness to patients, to both patients and communities, and finally (also) to the public (including patients and the community). Half of all the documents reviewed referred to responsiveness to the public (12/24). Notably, only one health sector, the KHSSP 2018-2022 expressly referred to responsiveness directed to the public.

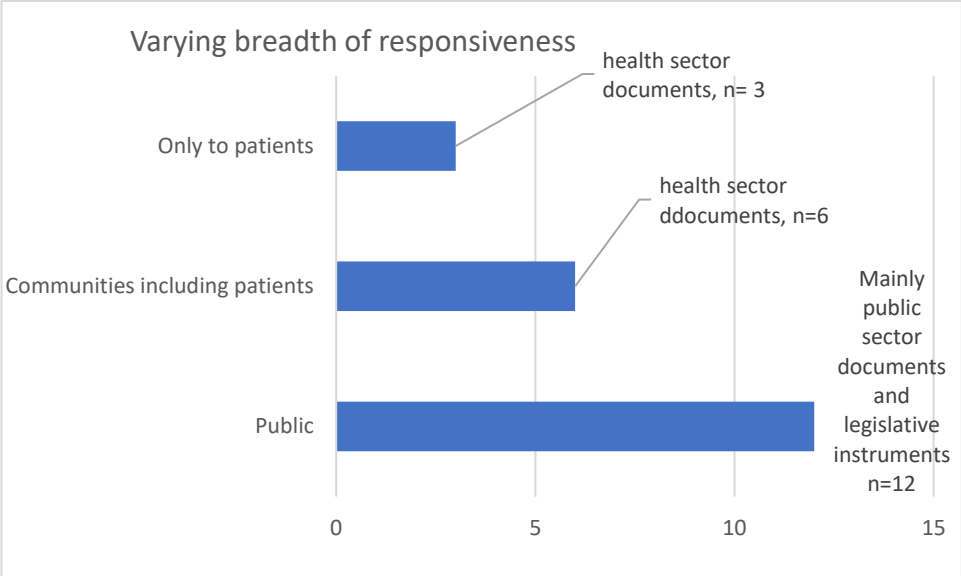

Figure 4.3: Description of 'to whom' responsiveness should be directed

Patients and the community are a sub-group of the public, but it was important to make the distinction between responsiveness to the public and to patients given that the interests of patients are often narrower. Literature suggests that patients mainly focus on treatment of specific conditions or on a particular service, while the perspective of a member of the public includes broader concerns such as affordable treatment, universal coverage, equity, access, and accountability [42].

Across twelve of the reviewed documents, there was an explicit recognition of the need for responsiveness to vulnerable groups (12/24, 50%). Figure 4.4 below highlights that the most frequently mentioned vulnerable populations in these documents included People Living With

Disability (PLWD), youth, women and the elderly. The chart in Figure 4.4 represents how many times a vulnerable group was mentioned in any of the 12 documents that referred to responsiveness to vulnerable groups. The frequencies illustrated below were identified from different documents.

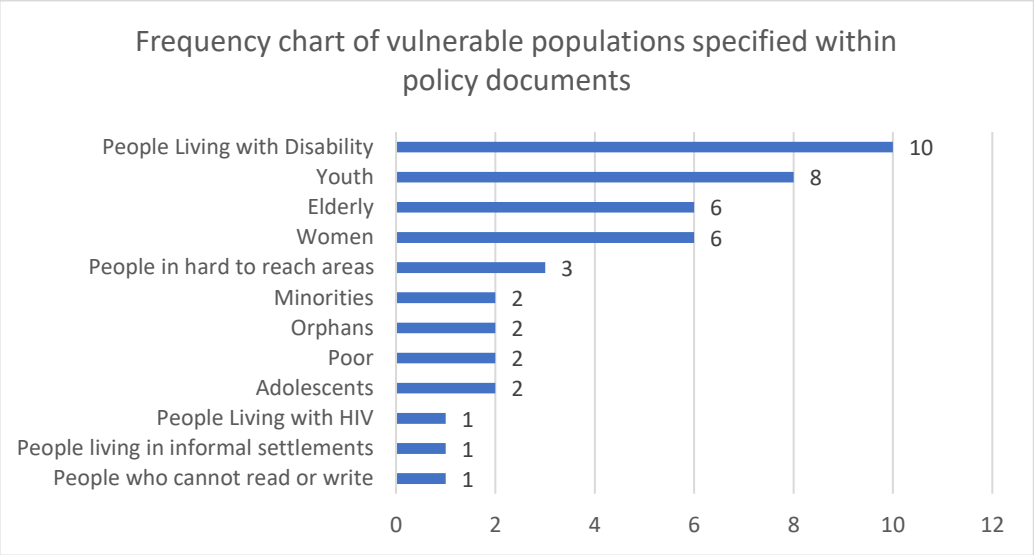

Figure 4.4: Commonly mentioned vulnerable populations within reviewed documents

Despite the mention of the need for responsiveness to vulnerable groups, few of the analysed texts explicitly proposed actions that could enhance the presence of vulnerable groups in participatory feedback mechanisms or how their voices would be included in shaping health system views or functions. These findings are summarised in table 4.3 which highlights how the vulnerable groups were mentioned in relation to participation in feedback mechanisms. Documents that had specific directives included, the legislative supplements for health facility committees (HFCs) which recommended the presence of women as HFC members and the Urban Areas and Cities Act (UACA, 2012) and County Government Act (CGA, 2012) which required inclusion of the vulnerable groups in making city plans (UACA, 2012) and in all areas of county economic, political, and cultural life (CGA, 2012).

Table 4.3: Policy attention to vulnerable groups and their inclusion in feedback mechanisms

Policy Documents	**Proposed policy action towards responsiveness to vulnerable groups**
Kenyan Constitution, 2010	• Article 53-57 identifies vulnerable groups as children, youth, PLWD, ethnic minority groups): • Article 21:3 -Requires state and public officers to meet the needs of vulnerable groups (includes minority ethnic or cultural groups)
County Governments Act, 2012	• Section 97 requires inclusion and integration of minorities and marginalized groups in all areas of economic, educational, social, religious, political, and cultural life.
Urban Areas and Cities Act, 2011	• Requires that *'the city development plan reflect the community needs and its determination on the affirmative action in relation to the marginalised groups access to services;* (Section 40d) • Includes youth, people who cannot read or write, people with disabilities as groups of people whose special needs to be considered *in setting up governance systems in which residents participate* (Schedule two section 2:1)
Health Act, 2010	Highlights government's responsibility to *ensure the realization of health-related rights and interests of vulnerable groups (women, older members of society, persons with disabilities, children, youth, members of minority or marginalized communities and members of ethnic, religious, or cultural communitie*s)-Section 4 (c)
Legislative supplement No 67 Kenya Gazette Supplement No 123, for Health Facility Committees	Recommends that HFC committee membership should comprise at least three women members
Legislative supplement No 25, Kenya Gazette Supplement No 67, for Health Facility Committees	
Kenya Health Strategic Plan 1 1999-2004	Includes a specific objective: '*to promote and participate in the implementation of operational research with a focus on vulnerable groups & priority health problems' (pg 4)* but does not identify who the vulnerable groups are
Kenya Health Sector Strategic Plan II 2005-2010	• Identifies vulnerable groups such as the elderly, street children and orphans, single mothers, and patients with chronic diseases like TB, HIV/AIDS and diabetes • Highlights that access to health services for these groups can be improved through improving financial, geographical, and cultural access
County Public Participation Guidelines	• Identifies vulnerable groups such as women and youth, persons with disability & the elderly; ethnic minorities (pg 42). • Proposes ways to include vulnerable and marginalised groups public participation processes: o *integrate minorities and marginalised individuals into mainstream public participation process.* o *specifically targeting mapped-out minorities and marginalised groups* o *use of translators, visual aids, indigenous languages, and translations of official county documents.' (pg 42)*
Kenya Community Health Policy 2020-2030	• Identifies, women, orphans, ethnic minorities, and PLWD as vulnerable groups. • Identifies services that Community Health Assistants and Volunteers can provide for orphaned children, and PLWD ranging from information awareness, referral, and linkage to relevant services (pg 17-22)
Kenya Health Sector Strategic Plan 2018-2022	Focuses on actions to be taken to improve access, and responsiveness to various vulnerable groups e.g. • for the poor stipulates the strengthening of a safety net mechanism and insurance subsidies. • implementation of the National Adolescent and Sexual Reproductive Health Policy to meet adolescents' needs. • improvements in facility environments to facilitate access for PLWD

Abbreviations: FP-Family Planning, HIV-Human Immunodeficiency Virus, IDP-Internally Displaced Persons, KEPH-Kenya Essential Package for Health, KIPPRA-Kenya Institute of Public Policy Research and Analysis, PLWD-People Living With Disability, PLWHIV-People Living with HIV, TB-Tuberculosis

4.2.3 Underdeveloped assessment of responsiveness

Though identified as a broad goal of the health system (Figure 4.1), the assessment of HS responsiveness was rarely discussed in the reviewed policy documents. Part of the implementation process of policies involves monitoring and periodic evaluation [215]. I, therefore, considered it important not only to explore documents for proposals on how responsiveness could be measured but also to compare this with what is measured in national health system assessments (that is to review the content of those assessment tools as well). In the national-level health system assessment reports (Table 4.1), HS responsiveness, and related elements as conceptualised in the study's framework (receiving, processing, and responding to public feedback in section 3.3) were often not evaluated.

A satisfaction index (tracked annually) was adopted as a measure for HS responsiveness in three documents, the KHP (2014-2030) and its subsequent strategic five-year plans KHSSP (2013-2017) and KHSSP (2018-2022). In the KHSPP (2013-2017), the satisfaction index was reported at 65% in 2012, 78% in 2015 and a target for 2017 set at 85%[240]. The KHP (2014-2030) set the client satisfaction target at 95% in 2030.

The adoption of a satisfaction index as a measure of responsiveness raised several questions. First, it was unclear from the documents reviewed whether the reported satisfaction rates in the policy documents were a measure of satisfaction with the health facility, the services provided by the HCW, the health system in general or a combination of all three. Second, there was no description of the populations that these statistics represented, nor comment on variations across population segments.

Among the HS assessment reports, a healthcare service delivery assessment survey conducted by KIPPRA in 2017 also assessed citizen satisfaction with the national and county healthcare systems. The connection between health system responsiveness and citizen satisfaction in this document was implied by the report's reference to the fourth objective in the KHP 2014-2030 which relates to the '*provision of medical services that are affordable, equitable, accessible and responsive' (pg 7)* [241]. From the findings, citizen satisfaction assessed at the household level (n=1437) and in facility surveys (n=217) of both the national and county healthcare systems fell short of citizen expectations; only 28.6 per cent of individuals surveyed felt that their county health system had met their expectations and only 2.9 per cent felt that the national health system met their expectations [241]. It was not stated in the healthcare service delivery assessment survey what these expectations were. Notably, the overall sense of satisfaction levels in the KIPPRA healthcare service delivery assessment survey differed from those reported in the KHSSP (2013-2017). In the KIPPRA report, there was also no disaggregation of the statistics generated as satisfaction levels. Given that a public health system should balance responsiveness to different public groupings to

ensure equitable responsiveness, there would be value in disaggregating the statistics further by different population groups to show the satisfaction rates of vulnerable groups as identified in legal and policy documents. Further, it was not clear from the survey report whether for a question as broad as 'satisfaction with the national or county healthcare system' the respondents were alerted to the various segments of the health system.

In summary, the measurement of responsiveness appeared to be underdeveloped, characterised by infrequent assessment, ambiguous questions, and overall different impressions depending on the measure adopted. All of this resulted in a lack of clarity on the measured aspects and how they link to responsiveness.

4.3 The framing of health system responsiveness across policy documents and legislative instruments

The term *frame* in this work is used as described by Koon et al *'as a label to describe a variety of ideas, packaged as values, social problems, metaphors or arguments'* [224]. By asking how responsiveness is 'framed as a policy issue' I sought to understand how policy documents articulate or describe responsiveness and what arguments are used to support varied views of responsiveness. To elicit frames from the policy documents, I considered to whom responsiveness was targeted, which methods were proposed to enhance responsiveness, and with what objectives.

In this section, I present five framings of responsiveness identified within the policy documents. Although presented separately there were overlapping elements across the framings. I included all the documents that I found to be relevant to a particular framing, resulting in some documents appearing more than once in the various framings (Figure 4.5). Figure 4.5 below illustrates that the most dominant framing was responsiveness as feedback on clinical service, identified in ten Kenyan health sector policy documents.

Document/Framing	Participation	Rights-based	Accountability	Health Service Feedback	WHO non-clinical framing
Constitution of Kenya	X	X			
County Government Act, 2012	X	X			
Public Finance Management Act, 2012	X				
Urban Areas and Cities Act, 2011	X	X			
Health Act, 2017		X	X		
Public Participation Guidelines, 2016	X	X			
Kenya Health Policy I (1994-2010)				X	
Kenya Health Sector Strategic Plan I (1999-2004)				X	
Kenya Health Sector Strategic Plan II (2005-2010)		X	X	X	X
Taking KEPH to the community, 2006		X	X	X	
Community Strategy Implementation Guidelines (2006-2010)		X	X	X	
The Kenya Health Policy (2012-2030)				X	X
The Kenya Health Sector Strategic Plan (2013-2017)				X	
Patient Rights Charter 2013		X	X		
Community Strategy (2014-2019)			X		
Kenya Health Sector Strategic Plan (2018-2023)			X	X	
Kenya Primary Healthcare Strategy (2019-2024)				X	
Kenya Community Health Policy(2020-2030)				X	
Kenya Community Strategy for Health (2020-2025)			X		

Figure 4.5: Summary of responsiveness frames identified in analysed legislative instruments and policy documents

Responsiveness as feedback on clinical service

Within several health sector policies, n=10 (Figure 4.5) responsiveness was predominantly framed as feedback on clinical service. In these documents, most of the feedback mechanisms identified were targeted at patients or service users. All these ten documents had a focus on gauging client or patient satisfaction to improve services in response to findings from satisfaction ratings or reported patient experiences. For example, the KHP (1994-2010) and NHSSP I (1999-2004) noted

the need to establish a multi-professional inspectorate to ensure professional conduct and institution of proper regulatory mechanisms in the interests of the public in order '*to better respond to the needs of patients,'*(pg 15) [175]. The NHSSP II (2005-2010) included responsiveness to *client needs and quality of care* as one of its objectives. Among the actions intended to enhance responsiveness were: '*ensuring complaint procedures are in place*, and *'training health workers on client handling and patient-centred accountability'* (pg 26) [92]. Within the KHSSP (2013-2017) strategic objectives, health services were expected to be '*responsive' to client needs (pg 39).* Specific actions to achieve these objectives were mainly health service related and the ways to track them included mainly collecting information from service users or clients. For example, the KHSSP (2013-2017) proposed that quality of care and responsiveness of health services could be strengthened by, *'conducting regular client satisfaction surveys to continually ensure clients expectations are informing intervention provision and ensuring patient safety is ensured in the provision of services' (pg 33)* [93].

Responsiveness as non-clinical dimensions of care (WHO framing)

There were few explicit references to the WHO framing of responsiveness with its seven dimensions (presented in section 1.1). I only found two terms related to the WHO framing of responsiveness. These were 'legitimate expectations of the population' and 'dignified care' identified in two health sector policy documents. The KHP 2014-2030 in its description of a people-centred approach to health and health interventions stated that health interventions should be *'premised on people's legitimate needs and expectations'* (pg 25) [91]. However, the document did not elaborate further on what these legitimate expectations were. Dignified, human and compassionate care was mentioned in the NHSSP II (2005-2010) in the context of service provision to vulnerable groups (women, children, and people with mental and physical disabilities) who experienced socio-cultural barriers when accessing care [92]. However, there were no additional details regarding dignified care, for example, how it might be measured or what interventions might contribute to dignified care beyond providing privacy for women during service delivery.

Responsiveness as public participation

I identified this frame of responsiveness within legal instruments, public sector documents and one health sector document (n=5). The texts described public participation as being required for policy formulation and implementation including service delivery. For example, the Urban Areas and Cities Act required that '*community needs are reflected in Urban Areas and Cities*' *plans, especially for access to services'* (section 40(d)); and identified that residents had '*a right to participate in decision-making, and a right to prompt responses* '(pg 28-29) [242]. The documents required not just the collection of public views, but also that government plans reflect community needs and

input. Besides inviting public views, state actors were required to facilitate the participation of local communities in governance and build the capacities of communities to participate (Constitution of Kenya, Section 196; 201) [171]. Public Participation Guidelines developed in 2016 identified various ways that county governments could receive feedback from the public. The methods proposed to get public input were varied representing a mix of quantitative and qualitative approaches to gathering public views. In the public participation guidelines, responsiveness was described as '*when the implemented process shall envisage a response from a decision maker or institutional representative, to ensure that participants' inputs are taken seriously and properly considered' (pg 38)* [88].

Responsiveness as accountability between the public and the health system

Documents that commonly adopted this frame of accountability between the public and health system referred to responsiveness as answerability between the public and health system actors across various levels. The documents where I identified this framing included NHSSP II (2005-2010), KHSSP (2018-2022) and the Community Strategy policy documents [92, 243-246]. For example, within the Kenyan Community Strategy (CS) policy and implementation guidelines, CS was described as a way for communities to '*seek accountability from the formal system for the efficiency and effectiveness of health and other services' (pg 2)* through '*participation in meetings to discuss trends in coverage, morbidity, resources and client satisfaction, and giving feedback to the service system' (pg 4).* The CS implementation guidelines presented participatory mechanisms such as CHCs and HFCs as channels where feedback from the community could be shared with health system actors. These mechanisms were described as linked across system levels, with a suggestion that where there was a failure to address issues, then members of the public could go to the higher health system level to seek redress or a response. The responsiveness-related roles for CHCs were '*providing a channel of communication with levels 2 and 3 management committees (HFCs), divisional health forum and the district health stakeholder forum (pg 6)*[243]. Responsiveness-related roles for HFCs included '*providing feedback on services at level one [the community]…advocacy for community issues to be taken up to higher levels of the system…and review of client satisfaction records' (pg10-11)*[243].

Responsiveness as the realisation of the right to health

Responsiveness was also framed as the realisation of the provisions and entitlements to uphold and promote fundamental rights such as access to health for the public. I identified this framing in several legal instruments [170, 171, 242, 247] and health sector policy documents [92, 243, 244, 248], which considered the state and service providers as duty bearers in providing the right to health, with the public as rights claimants. To facilitate access to other rights (including the right to

health) the Constitution included a right to '*information held by the state and state* actors' (Article 35)][171]. The County Government Act reiterated this right to information by requiring governments to establish mechanisms to '*facilitate public communication and access to information in form of media that has the widest public outreach' (section, 95:2)*[170]. The Health Act 2017 reiterated the constitutionally guaranteed right to health, the duty of the state for the provision and the responsibility of the county governments to facilitate participatory governance. Within the health sector-specific policy documents, the NHSSP II 2005-2010 included a human rights approach to service delivery, where the health sector was expected to *'respond to the aspirations and expectations of communities'*(pg 41)[92]. This is referred to again in the CS policy document and implementation guidelines which sought to empower communities to '*claim their right to accessible and quality care and seek accountability from the formal system*' [243, 244].

From among the five frames of responsiveness identified, some frames were more dominant in certain clusters of documents than others. For example, the responsiveness as participation frame and rights-based frames were more commonly found in the public sector and legislation instruments, while the accountability and clinical service feedback frames were more dominant in the health sector-specific documents.

Some of the gaps identified in the analysis related to the functioning of feedback mechanisms (see section 4.4) appear to be a product of the various frames identified above. This is highlighted in Figure 4.6 below which draws attention to how the focus of responsiveness narrows as one moves across the legislative instruments, through public sector documents, to health sector policy documents. For example, the narrow focus on patients and patient-provider interactions appears to be a product of the framing of responsiveness in terms of feedback on services rendered in health sector-specific documents. The legislative instruments and broader public sector documents 'talk about' responsiveness in all stages of the policy process and focus on the public and are inclusive of vulnerable groups as a target of responsive systems, while the health sector policy documents, despite mentioning the public or communities, often reverted to a focus on patients. Indeed, as noted in earlier sections of this chapter, key health sector policy documents such as the current KHP 2014-2030, the KHSSP 2013-2017 and KHSSP 2018-2022 refer to '*health service* responsiveness' as a *health system* goal and propose to measure responsiveness using satisfaction surveys. Figure 4.6 below illustrates this narrowing of responsiveness concerning whom responsiveness is targeted at, and in proposals for implementation as illustrated in Figure 4.6 below.

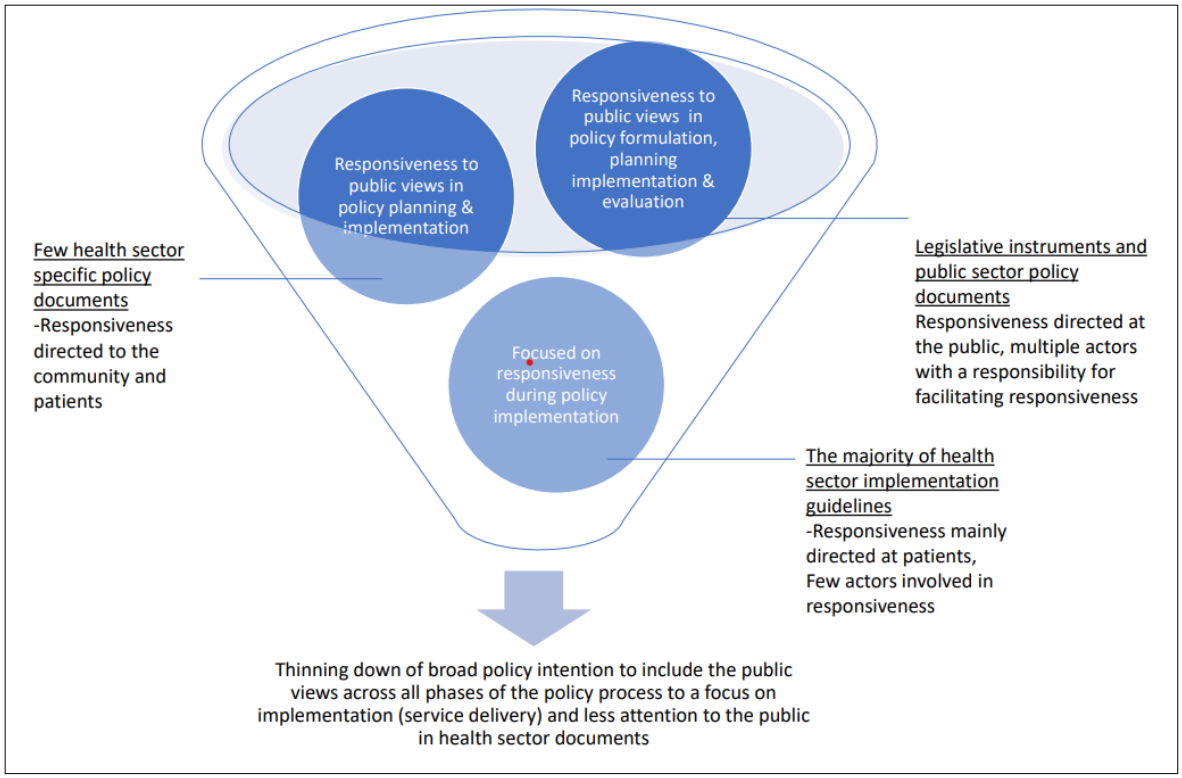

Figure 4.6: Narrowing of the focus of responsiveness as a system goal across different clusters of documents

4.4 Feedback Mechanisms supporting Health System responsiveness

In this section, I describe the various feedback mechanisms that could support HS responsiveness in five parts. This includes an overview of the varied feedback mechanisms, the range of actors with responsibility for receiving and responding to public feedback, and details about the functioning of feedback mechanisms including monitoring and evaluation of their functioning.

4.4.1 Multiple Channels through which the public could provide feedback to the health system

Most of the mechanisms I identified had broad functions related to public engagement. Receiving feedback from the public was therefore one among other functions carried out by the mechanisms. Within the health sector, feedback mechanisms could be broadly classified into i) those that mainly supported feedback on service after a provider-client interaction for example client satisfaction surveys, suggestion boxes, patient rights charters, and complaint management systems, and ii) participatory mechanisms with a broader remit beyond collecting feedback. These included participatory mechanisms with public representation such as HFCs and county health boards (Table 4.4). All these mechanisms were proposed to function at various levels of the health system from the community, through PHC, facility and sub-county, and upwards to county and national levels. Overall, I identified 20 different mechanisms that the public could use to share feedback with the public health system from the analysed policy documents.

Table 4.4: Mechanisms with functions supporting responsiveness across the public sector broadly and the health sector specifically in Kenya

Health sector-specific mechanisms	
Those immediately supporting service feedback	**Those supporting broader participation and responsiveness processes**
Facility/community level • Community scorecard • Patient charters • Suggestion boxes • Patient satisfaction/client exit surveys • Complaint handling committee National level • Health Oversight Authority • Health Professional Regulatory bodies Health Ombudsman Hotlines	Facility/community level • Community Health Workers & Community Health Committees • Health Facility Committees • Public participation meetings at ward levels (sub)County-level • District/County Health Management Board • County Health Stakeholders Forum • Sub-county Health Stakeholders Forum • Public participation meetings at sub-county levels • County Budget Economic Forum
Broad public sector mechanisms that could address health sector issues	
Mechanism	**Details on functioning**
Kenya National Human Rights and Equality Commission (Constitution Chapter 4:Part 5; Section 59) at the national level[171]	Has a responsibility to investigate *'unresponsive'* official conduct and human rights violations including within the health sector [171]
County Budget and Economic Forum (CBEF) at the county level administrator and vetted by County Assembly (Section 53 (1)) [170]	Provides an avenue for consultation between the county government and the public on matters relating to budgeting, economy & financial management, (Section 137 (3)[170]
Boards of cities and municipalities (at the county level)	Responsibility to ensure that residents participate in decision-making processes and that feedback mechanisms allow all persons (including those who cannot read and/or write) to participate in planning and to lodge complaints and petitions [242] Have responsibility for ensuring and coordinating the participation of the village unit in governance (Section 53(1) [170]

4.4.2 Varied range of actors with responsibility for supporting health system responsiveness

Actors ranging from health managers, public administrators, elected politicians (Governors, Members of Parliament, and MCAs) and community representatives had responsibility for enhancing responsiveness to the public in varied ways (Table 4.5). These included national and county politicians receiving petitions from the public [170, 171], politicians and public sector administrators ensuring public views were considered in strategic policy, budgeting, planning activities and evaluation of county performance [170, 249] and hospital heads, health facility in-charges receiving complaints and compliments from service users [243, 247, 248]. The roles of county and sub-county health managers in enhancing responsiveness were more implicit given their participation in various participatory mechanisms such as County Health Stakeholder Forums, and County and Sub-county Primary Health Committees as secretaries to these participatory mechanisms that comprised health managers and community members [93, 250].

Table 4.5: Actors with a role or responsibility for enhancing responsiveness

Actor	Responsibility/Role in enhancing responsiveness	Level of the health system
Parliament (National Assembly & Senate-elected representatives at the national level)	• National Assembly-Deliberates on and resolves issues of concern to the people (Article 95 (2)[171] • Senate- Serves to protect the interests of counties and their governments (Article 96 (1)[171] • The National Assembly and Senate can receive petitions from the public as individuals or as organisations and may pass legislation, and invite health system actors to respond in response to public petitions (Section 119)	National
County Governor (elected heads of counties) County Executive Committee members- appointed by the Governor to head various departments within the County Public Service (including Health) and vetted by County Assembly Members (Section 35 (1) (2)[170] Chief officers-accounting officers for the various county departments appointed by the Governor and vetted by Members of the County Assembly (CGA Section 45)	• CEC Finance is responsible for ensuring public participation occurred in every annual budget and planning cycle (Section 125 (2)[249] • The Governor and CEC are required to consider responsiveness to community needs when organising county departments (Section 2a) & promote citizen participation in the evaluation of the performance of county public service (Section 47(d) [170] • Chief officers have responsibility for participatory budget-making (CGA section 50 (4))	County
Members of the County Assembly (elected local leaders) at the ward level	• Responsible for ensuring public participation during annual budget and planning cycles [170, 249] • Sit in HFC meetings as Ex-officio members • Receive petitions from the public and may invite the HS actors to respond, or pass legislation in response to public petitions [170]	
Ward & sub-county administrators - These are employees of county governments appointed to co-ordinate, manage and supervise administrative functions in Wards & Sub-counties respectively (Section 50 (3) and Section 51 (3)[170]	• Facilitate public participation processes in each ward and sub-county for upward submission of community priorities [249]	Sub-county and ward
County and Sub-county health management team	• Receive feedback from the public raised through HFCs at the facility level or from the health facility-in-charge [243, 250]	
Health facility in-charge	• Expected to respond to complaints raised by community members, and/or escalate to higher system levels [243, 247, 248]	Peripheral health facility
Community Health Assistant/Community Health Extension Worker	• Responsible for follow-up and monitoring actions emerging from community dialogue and planning sessions to ensure implementation in collaboration with other sectors, and at the health facility level [243, 251]	Community

Table 4.5 above presents a wide range of actors across different levels of the health system, and within the broader governance architecture. But the roles presented are broad, and it was difficult to deduce more specific roles about supporting aspects of feedback mechanisms. These included which actor (s) had overall responsibility for aspects such as implementing and managing feedback mechanisms at various health system levels, who had responsibility for evaluating the mechanisms, and for ensuring a response was generated when feedback was received, including communicating the response back to the public.

4.4.3 Wide range of feedback mechanisms

In this section, I present a detailed description of the wide range of feedback mechanisms identified in section 4.4.1 (Table 4.4 and featured in Figure 4.2). These mechanisms have been grouped into five clusters for ease of description. These clusters include stakeholder fora, facility management committees and boards; Community Strategy structures (CHVs and CHCs); unidirectional feedback mechanisms (service charters, patient rights charters, suggestion boxes and patient satisfaction surveys); County level participatory mechanisms (such as public participation meetings) and indirect participatory mechanisms such as the County Assembly (MCAs have representation and oversight roles through which they can learn about public feedback). These mechanisms are discussed in more detail in turn below.

Health Stakeholders Fora, Facility Management Committees and Boards

In Kenya, facility management committees and boards pre-dated devolution in 2013 and are a significant feature in the country's health system reform history. DHMBs were set up in May 1992, with the main role of promoting community representation to oversee user fees management in the district, while HFCs were officially established in 1998 through a circular by the MoH [252]. HFCs were established to increase community involvement, a key strategy of the PHC approach adopted in the KHP (1994-2010). HFCs were to be set up at health centres and dispensaries; their members would be elected from the catchment area of every facility [252]. Roles and responsibilities of these committees included oversight of facility operations and management, advising the community on health service promotion, representing and articulating community interests on health matters in local development fora and mobilising community resources towards health service development in their area [252]. HFCs were also given authority to employ support staff for the health facility and have oversight over the development, expansion, and maintenance of physical facilities within the health facility. The introduction of the Health Sector Services Fund (HSSF) in 2010 expanded HFC roles to include financial management of HSSF funds [253, 254]. The HSSF was a direct facility financing initiative aimed at strengthening community accountability and improving the financing of the lower levels of the health system [253].

From the document review, HFC and DHMB roles related to giving or processing feedback to the health system included, review of client satisfaction records, identification of and dialogue on areas needing improvement and planning action to do so, and advocacy on issues to be taken up to higher system levels [243]. HFCs were also expected to link to CHCs (the governance structure for the Community Strategy) to increase the breadth of feedback available from community members.

Following devolution of the health sector to the counties in 2013, HFCs were retained in the re-organised structure for partnership and governance of the health system (Figure 4.7). Figure 4.7 presents an illustration of the various committees and boards proposed to operate at various levels of the health system, their linkages to health system management units, and stakeholder fora. These linkages aimed at supporting public participation could also support the flow of public feedback to the health system.

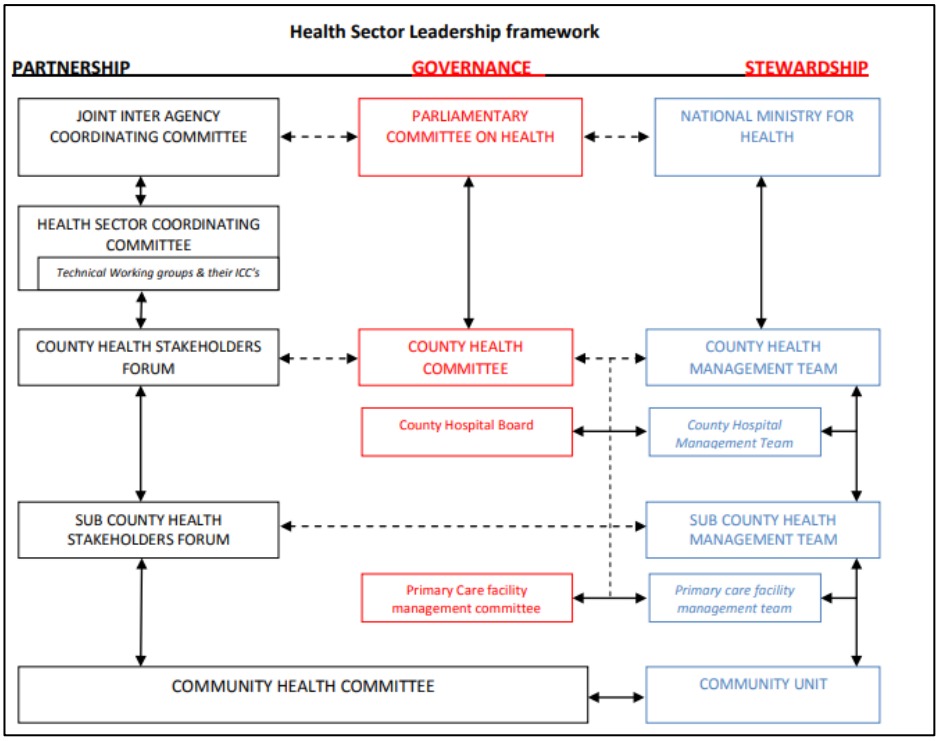

Figure 4.7: Formal committees and boards linking to health management units and stakeholder fora
Source: Kenya Health Sector Strategic Plan (2013-2017)

Another mechanism included in this cluster that dates to pre-devolution times is the County Health Stakeholder Forum (CHSF) (Figure 4.7) which was referred to as the District Health Stakeholder Forum. From the policy documents, the CHSF was described as a partnership arrangement that brought together non-state actors (for example NGOs and the private sector) involved in or contributing to health service delivery [91]. In this work, I, therefore, considered the CHSF a potential channel through which public feedback could be received by HS actors.

The County Budget and Economic Forum (CBEF) is another potential 'processing space' on paper. It should comprise the Governor, CEC Members, persons representing professionals, business, labour issues, women, persons with disabilities, the elderly and faith-based groups at the county level [249]. The main function of the forum as proposed in policy documents is to facilitate public engagement with the broader budgeting and planning process, therefore supporting not just the process of receiving public feedback about county budgets and plans but also supporting communication of responses about this feedback.

Community Strategy (CS)

A key innovation of the National Health Sector Strategic Plan in Kenya (NHSSP II – 2005–2010) was the introduction of a new approach to the delivery of health care services to Kenyans –the Kenya Essential Package for Health (KEPH)- which included six lifecycle cohorts and six service delivery levels. The introduction of the KEPH included the formal acknowledgement of the community as a service level (service level 1). This was aimed at empowering Kenyan households and communities to take charge of improving their health and heralded the introduction of the Community Strategy (CS) in 2006 [92, 243, 244]. The CS aimed at attaining greater coverage, community involvement and empowerment by strengthening the community to progressively realize their rights for accessible and quality care, and seek accountability from facility-based health services [243, 244].

Within the CS structure, policy documents proposed that a community unit should cover approximately 1,000 households or 5,000 people living in the same geographical area; one CHW serves approximately 20 households [243, 251]. The community units are organized in villages and are responsible for identifying and supporting the CHW. CHWs are supervised by the Community Health Extension Worker (CHEW)[5] or Community Health Assistant, (CHA), who is a trained healthcare worker attached to a health facility to provide support and supervision to 25 CHWs (2 CHEWs per unit of 50 CHWs and 5000 people) [243, 251]**.** The policy documents recommend that a Community Health Committee (CHC) should govern the community unit (see Figure 4.8). CHC members should be elected at the Assistant Chief's *baraza* ensuring that there is representation of all the villages in the community unit, with a CHW elected as treasurer and CHEW as secretary of the CHC [243, 246, 251]

[5] In the most recent Community Health Policy document, CHEWs are now referred to as Community Health Assistants (CHA). CHAs have the same responsibilities of supporting CHWs and are healthcare workers employed by the health system

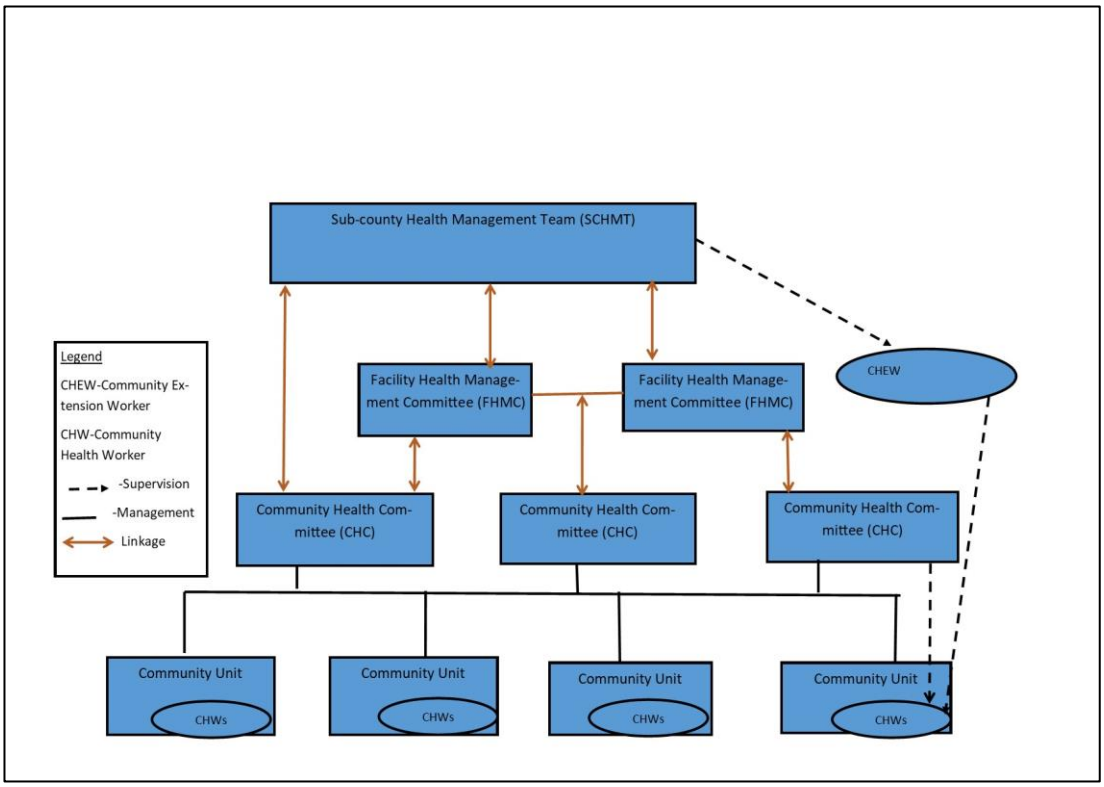

Figure 4.8: Community Strategy Management and Supervision Structure
Source: Author (from document review)

Across the various CS and Community Health Policy documents, CHW roles related to receiving and responding to public feedback included: attending and taking an active part in community meetings to discuss trends in coverage, morbidity, resources and client satisfaction; giving feedback to the health system either directly or through representation; ensuring that health providers in the community are accountable for effective health service delivery and resource use and are functioning in line with the Citizen's Health Charter; and participation in social accountability initiatives such as the community score card [92, 251].

Service Charters, Patient Rights Charters, Suggestion boxes and Patient Satisfaction surveys

These mechanisms are presented together because of their similarities in how they collect feedback from the public, which is commonly unidirectional (from the service user to the health system). These mechanisms were mentioned across various policy documents but introduced at varying times within the Kenyan health system (Figure 4.2). For example, the MoH introduced Service Charters in 2006 to enhance transparency, accountability and responsiveness to the clients and community health needs by enabling patients to easily understand the services offered, their costs and when and where such services can be accessed including where to get redress should they have complaints [92, 243]. The service charters were also intended to serve as a performance measure for health facilities. The Patient Rights Charter was launched in 2013, informing patients of their rights and responsibilities in health service delivery. They sought to empower service users to demand quality healthcare from health providers [248]. The Patient Rights charter also includes details for how the public can raise complaints at the facility level and options for seeking redress

including through litigation [248]. Patient satisfaction data was included in the KHP 2014-2030 as a measure of responsiveness. However as discussed in section 4.2.3, the use of this measure is fraught with challenges. Overall, across these unidirectional feedback mechanisms, there was little detail on their functioning that could be elicited from the health sector policy documents and guidelines. This is discussed in more detail in section 4.4.4.

Non-Governmental Organisations

NGOs were only mentioned briefly in the KHP 1994-2010 and KHP 2014-2030 as having an important role in contributing human and capital resources in the delivery and management of health services. This represents a gap regarding how NGOs can support responsiveness because, in addition to filling service delivery gaps, NGOs have played significant advocacy roles in shaping health policy to be more responsive, especially to vulnerable groups. For example, in the early days of the HIV/AIDS epidemic, Kenya AIDS Consortium (KANCO) members and its secretariat were involved in policy development and lobbying activities that culminated in the adoption of the Sessional Paper No. 4 of 1997 [255]. The sessional paper was adopted by the cabinet and parliament and was essentially Kenya's national policy on HIV and AIDS. In 2019, the National AIDS Control Council (NACC) estimated that 14,000 civil society entities were engaged in HIV and AIDS activities in Kenya ranging from advocacy to service delivery [256].

County Assembly

Several legislative instruments and one policy document described how the County Assembly had an oversight role to ensure public participation in budgeting and planning [170, 249]. Through the County Assembly health committee, MCAs could conduct visits at the health facility and community level to follow up on service delivery issues. Other MCA roles related to receiving public feedback included receiving petitions from citizens and providing redress [170].

4.4.4 Scant detail on functioning of feedback mechanisms for system response

In this sub-section, I present policy content analysis findings related to whether policy documents drew any connections between mechanisms, feedback, and responses. To do this, I draw on my literature-based conceptual framework of the responsiveness pathway, comprising the three elements of receiving, processing, and generating responses to public feedback (section 3.3).

In the policy documents analysed, there was inadequate detail regarding the functioning of feedback mechanisms. For both the health sector-specific service feedback mechanisms and the participatory mechanisms (Table 4.4), the functionality of the mechanisms was unclear concerning i) how they received feedback ii) what happened to that feedback and iii) if and how a response was provided to the public. For example, within the health sector-specific service feedback mechanisms such as hotlines, suggestion boxes, health ombudsmen, community scorecards and patient satisfaction surveys there was little implementation detail such as who would be assigned

to run hotlines and conduct satisfaction surveys and community scorecards, and how that information would be used to generate a response. Details about how responses could be communicated to the public were also not discussed for these feedback mechanisms. Further, there was little information on how feedback from vulnerable groups would be picked up by these service-focused feedback mechanisms.

For the mechanisms with a broader participatory remit (Table 4.4), there was some detail on how members of these mechanisms could receive public feedback. For example, CHVs could conduct community dialogue meetings where feedback from the public could be discussed, and HFCs could learn about satisfaction levels by reviewing satisfaction survey records [243]. Further, most of the participatory mechanisms such as CHCs, HFCs, public participation meetings and the CBEF had requirements for the inclusion of vulnerable groups in their membership suggesting that it was possible to learn about the experiences of marginalised communities through these mechanisms. However, a major gap across both the Community Strategy structures (CHVs, CHCs and the community unit) and HFCs, was the lack of clarity in *how* the feedback collected could be utilised to generate a response, and *how* this response could be relayed to the public. For example, the Community Strategy documents, and the Kenya Community Health Policy 2020-2030 described the escalation of concerns and feedback raised from the community level through participatory structures upwards through to higher health system levels. However, these documents rarely mentioned responses back down or out to communities or the public.

Despite the gaps mentioned above, there were two processes for which there was some detail on the functioning of feedback mechanisms including actions taken after receiving feedback from service users or the public. These processes were complaint management mechanisms and public participation as summarised in Box 4.1, which highlights procedures for raising complaints and public participation including the actors responsible for receiving the information. Box 4.1 includes an illustration of the flow of information across multiple levels.

Complaint handling process	Public participation process
1) Creating an enabling environment to lay complaints by displaying the procedure for raising complaints at the facility level and regularly communicating it to users 2) Response to complaints at the facility level primarily by the facility-in-charge or another person (or committee) designated by facility-in-charge 3) Escalation of complaint to higher health system level or regulatory authorities or Courts for litigation if not resolved at the health facility level 4) Feedback to the complainant within the stipulated time-frame[6] Source: Health Act, Patients Charter, CS Implementation guidelines 2006-2010)	1) Setting up enabling conditions for meaningful public participation through timely communication with the public about the content for discussion (these could be a proposed county policy, legislation, budget or development plan) and venue -Public participation guidelines suggest the availability of the drafts of the documents 14 days before discussion & notification of venue for public participation at least 7 days before participation day 2) Collection of public views on proposed plans across various administrative levels starting from the wards upwards to the sub-counties and eventually synthesis at the county level 3) Feedback to the public on the inclusion of their input -Public participation guidelines proposed communication of this feedback to the public seven days after the public participation forum 4) Receiving petitions and complaints and suggestions on ways of monitoring and evaluating public participation Note: The PFM Act below specifies the Chief Officer at the Department of Finance, MCAs as responsible for public participation in budgeting and planning Source: (*Public Finance Management Act* 2012, *County Governments Act* 2012; *County Public Participation Guidelines, Urban Areas and Cities Act, 2011*)

Box 4.1: Processes of handling patient and public feedback
Abbreviations: CS-Community Strategy; MCAs-Members of County Assembly; PFM-Public Finance Management

The connection between feedback received and response generated was explicitly considered in the public participation guidelines where proposed actions included communicating to the public which aspects of their feedback had been taken up. For the complaints management process, even though the flow of patient and/or public feedback across the health system could be teased out, these processes were focused on the individual. The connection between feedback and response at a broader system-wide level was not detailed, and it was not stated how feedback related to complaints could be used to introduce or support change beyond resolution at the individual level.

4.3.5 Weak Evaluation Strategy for Feedback Mechanisms

Across the analysed documents, there was little description of a monitoring and evaluation strategy for the different feedback mechanisms. One exception stood out: the public participation guidelines proposed a comprehensive evaluation of public participation that included performance indicators such as the extent to which civic education was conducted; the amount of resources allocated to the public participation initiatives; the extent of access to information by members of the public;

[6] The Health Act stipulates a time frame of 3 months for a response to be issued from the time of complaint. The other documents do not stipulate a time frame.

the extent of diversity of participants at public participation activities; timely communication; and the extent to which feedback from the public was taken up [88]. These among other indicators were proposed for inclusion in the Governor's Annual Report on Public Participation. Annual reporting on public participation was provided for in Section 92(2) of the County Government Act [170].

Perhaps linked to the absence of an overall evaluation strategy for feedback mechanisms, there were few national-level evaluations of how these feedback mechanisms functioned. I, therefore, pieced together findings related to the evaluation of feedback mechanisms from two nationwide health system assessments: the Kenya Institute of Public Policy Research and Analysis (KIPPRA) healthcare service delivery assessment survey and the Service Availability and Readiness Mapping (SARAM) conducted in 2017 and 2013 respectively. Participatory mechanisms (such as HFCs, Community Strategy Structures and more recently the public participation forum) were the more commonly evaluated feedback channels. For example, the KIPPRA report included findings on the extent of public participation in county resource allocation across sectors, and in healthcare-focused processes including planning, budgeting and service delivery [241]. A total of 1437 households and 217 facilities were surveyed across all the counties using a random and multilevel sampling approach. Of the 1437 households surveyed, urban households reported higher proportions for the public participation indicators (Table 4.6). This was attributed to higher literacy levels among urban dwellers, easier access to information than the rural dwellers, and greater use of social media to announce public participation meetings in urban than in rural areas[241].

Among the challenges observed with public participation were that few counties had civic education units, and where they existed there was little focus on health matters with more focus on general planning and budgeting issues [241]. There was also low attendance at planning and budgeting and health policy-making fora which were perceived to be linked to low invitation rates or poorly timed invitations [241, 257].

Table 4.6: Public participation indicators, n=1437

	RURAL	URBAN	ALL
The proportion of citizens with knowledge about the health rights In the constitution	76.4	83.1	77.1
The proportion of citizens who attended any public engagement Forum	29.9	54.5	38.6
The proportion of counties with established civic education units, n=47	11.2	12.7	12.5
The proportion of citizens that attended a health public policy Making forum	29.7	36.2	31.8

Source: KIPPRA Healthcare service delivery assessment survey, 2017

The SARAM conducted in 2013 to map out assets and skills that counties could leverage to provide health services to their citizens also included an evaluation of feedback mechanisms [258]. Table 4.7 below highlights that for the feedback channels assessed, there was reportedly low functionality, characterised by infrequent committee or board meetings, few active community

units, and low availability of suggestion boxes at the facility level. These findings suggest that there was probably little feedback received by health system actors from the public.

Table 4.7: Evaluation findings of feedback mechanisms

Indicator	Percentage availability	
	National (n=3707 health facilities)[7]	Kilifi County, n=226[8]
Number of functional board/health facility committees	54%	43%
The board/committee met at least 2 times in the last financial year	49%	41%
Suggestion box available at the facility level	26%	34%
Functional community units	28%	23%
Community units that carried out dialogue days at least once a quarter	26%	20%

Source: SARAM, 2013

Another way that feedback mechanisms were evaluated was at the expiry of a policy document. For example, following the release of the Community Strategy documents: the Kenya Essential Package for Health (KEPH) Level One Strategy (2006) and expiry of the implementation of Community Strategy Implementation guidelines (2007), an evaluation of the functioning of community units found high CHW attrition and conflict of workload for CHEWs [245, 259]. The most recent Community Health Policy document (2020-2030) and Community Strategy document (2020-2025) highlight challenges related to human resources for the Community Strategy which include low numbers of CHAs and low and inconsistent payments to CHVs [246, 251].

In summary, the findings in this section suggest that there were strong policy provisions for public feedback mechanisms. However, the policy provisions appear to focus on the collection of feedback from service users, and less on the generation of responses. In addition, there was inadequate detail on the functioning of feedback mechanisms towards contribution to system-wide responsiveness, and almost no proposals for monitoring and evaluation of the identified feedback mechanisms.

4.5 Chapter Summary

The findings presented in this chapter suggest that there are provisions for responsiveness across legislative instruments and policy documents. This is illustrated by the various mechanisms, processes and actors with roles and responsibilities with the potential to contribute to HS responsiveness. However, the findings presented here also draw attention to gaps in policy on

[7] The SARAM was conducted for both public and private facilities. For the data presented here is for public facilities and includes hospitals, health centres and dispensaries

[8] This is based on the number of public facilities in Kilifi County in 2013.

paper that have implications for the practice of responsiveness. First, even though responsiveness is frequently mentioned in policy documents and legislative instruments, there was significant variation in how responsiveness is referred to, including in its framing across legislative instruments, and public and health sector-specific policy documents. Second, despite the inclusion of responsiveness as a broad health system goal, I found the measurement of responsiveness to be underdeveloped, and there lacked a clear overarching strategy to support the achievement of HS responsiveness. There were gaps in the descriptions of the functioning of feedback mechanisms, little evidence of intention to integrate feedback from multiple channels, little provision for monitoring and evaluation of proposed feedback mechanisms and even less attention to how public feedback could be used to shape a responsive health system. These gaps in the written policy could contribute to weaknesses in the practice of health system responsiveness. In the next chapter, I explore the practice of responsiveness with a focus on two case studies as 'processing spaces' for public feedback in Kilifi County.

Chapter 5 The practice of responsiveness in Kilifi County

5.1 Introduction

In this chapter, I explore the second objective of this study to analyse responsiveness practices in Kilifi County. The findings in this chapter are drawn from in-depth interviews with CHMT members, SCHMTs, PHC facility-in-charges, focus group discussions with HFC members and document review of SCHMT and HFC minutes. In interpreting and analysing these study findings I draw on the study conceptual framework that draws attention to processing spaces within the health system where public feedback can be received, and describes the responsiveness pathway as composed of receiving, processing, and responding to public feedback (section 3.3). The findings are presented in line with these elements of the responsiveness pathway and focus on two processing spaces: HFCs and SCHMTs. I also draw on Aragon's organisational capacity framework (Figure 3.5) to explore the organizational factors (meso-context) that interacted with and influenced receiving, processing, and responding to public feedback.

I have presented the findings in this chapter in five sections. The first section presents a description of the membership, facility, and sub-county contexts of the case study HFCs and SCHMTs. In the second section, I present an overview of available feedback mechanisms in the study county and describe their functionality. The third section presents an exploration of factors that influenced feedback mechanism functionality. In the fourth section, I, present an overview of the content of feedback received by case study SCHMTs and HFCs. Finally, in section five, for the instances where responses were generated at HFC and SCHMT levels, I present findings on the nature and spread of responses, including communication of responses back to the public, and whether responses were generated for vulnerable groups.

5.1 Characteristics of case study SCHMTs and HFCs

5.1.1 The case study SCHMTs

Table 5.1 below summarises the demographic and facility type distribution in Sub-County A and B, where the two case study SCHMTs (SCHMT-A and SCHMT-B) had oversight for PHC facility service delivery.

Table 5.1: Summary of demographic and facility, and health workforce characteristics in Sub-county A and B

Sub-county A

Characteristic		
Catchment population	289, 407	
Type of Public Health Facilities in Sub-county	Level 4(county referral hospital)	1
	Level 3 (Health Centre)	2
	Level 2 (Dispensary)	16
Functional community units	45	
Health workforce distribution in Primary Health Care Facilities	Clinical Officers	9
	Nurses	45
	Community Health Extension Workers	7
	Community Health Volunteers	180
	Casual staff	80

Sub-county B

Characteristic		
Catchment Population	341,909	
Type of Public Health Facilities in Sub-county	Level 4 (Sub-County referral hospital)	1
	Level 3 (Health Centre)	2
	Level 2 (Dispensary)	12
Functional Community Units	8	
Health Workforce Distribution in Primary Health Care Facilities	Clinical Officers	14
	Nurses	28
	Community Health Extension workers	5
	Community Health Volunteers	27
	Casual staff	31

Source: Author (From document review and interview data)

As required by the guidelines, each of the case study SCHMTs was led by a Sub-County Medical Officer of Health (SCMoH) and comprised between 11-19 members. SCHMT roles reported by the SCHMT members included coordination and support supervision of service delivery in PHC facilities. Specifically, this included mentorship and training of frontline HCWs, planning and implementation of sub-county-wide public health activities such as immunisation campaigns, disease surveillance and bed net distribution and responding to issues of public concern. Achievement of these roles was reportedly tracked through an annual performance appraisal that was shared up-wards with county-level supervisors.

Both case study SCHMTs had core teams whose composition were slightly varied (see Figure 5.1). These core teams (highlighted in orange) comprised the SCMoH, Sub- County Public Health Nurse (SCPHN), Sub-County Public Health Officer (SCPHO), the Sub-County Health Administrator (SCHA), and the Sub-County Health Records and Information Officer (SCHRIO). SCHMT-A had an additional officer, the Sub-County Clinical Officer (SCCO) as a member of the core team. These core teams corresponded to the original District Health Management Teams (DHMTs) set up in the early 1980s when there were few vertical programs. Sub-county program officers co-ordinating various programs (for example School Health, Reproductive Health) reported to the core team members.

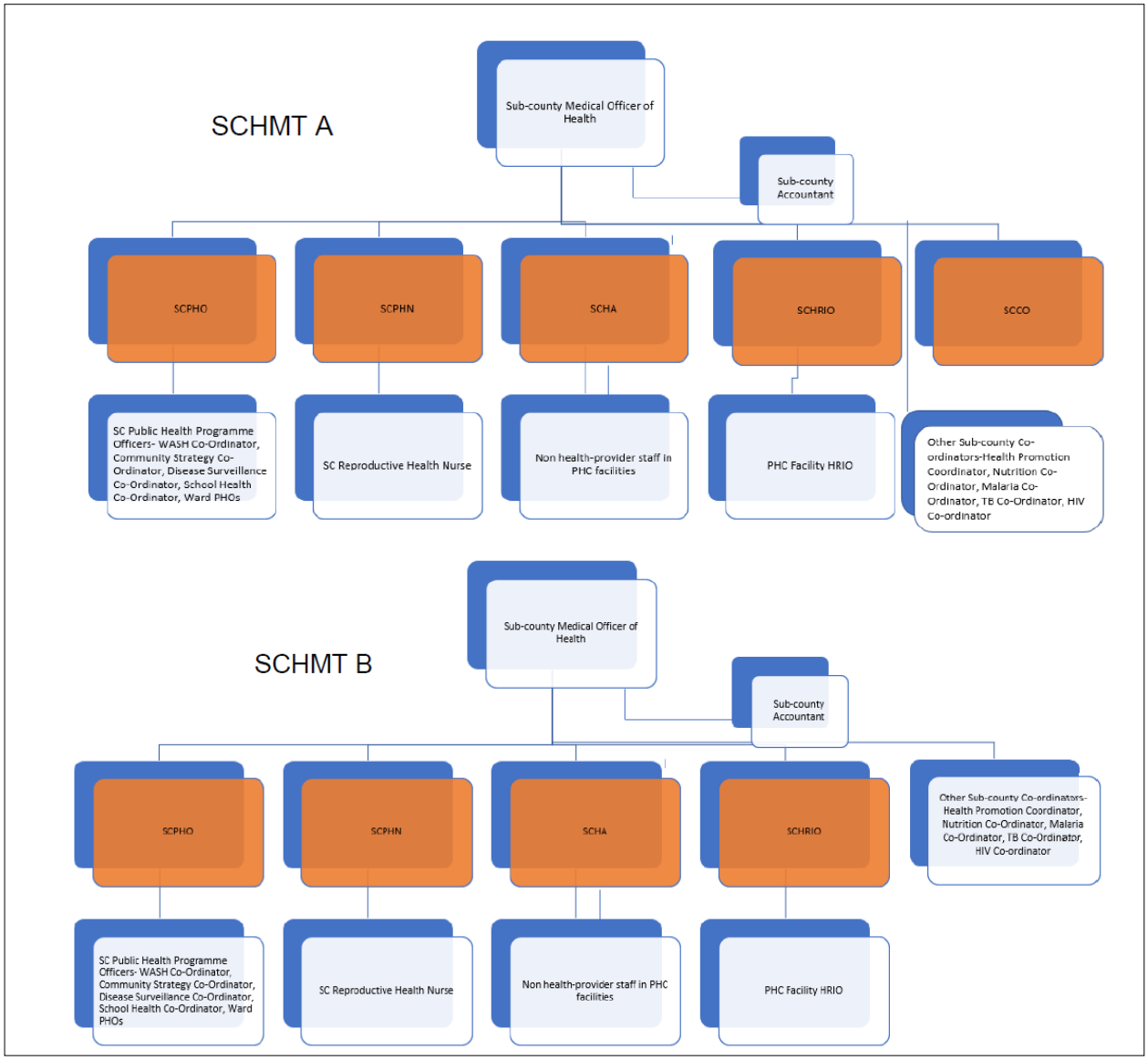

Figure 5.1: Structure of SCHMT A and B (source: interview data)

Abbreviations: EPI-Expanded Programme of Immunisation, HIV-Human Immunodeficiency Virus, HRIO-Health Records and Information Officer, PHO-Public Health Officer SCPHO-Sub-county Public Health Officer, SCPHN-Sub-county Public Health Nurse, SCHA-Sub-county Health Administrator, SCCO-Sub-county Clinical Officer, SCHRIO-Sub-county Health Records & Information Officer, SC-Sub-county, TB-Tuberculosis, WASH-Water Sanitation and Hygiene

5.1.2 Case study HFCs

Specific details about the facilities in which the four HFCs existed are summarised in Table 5.2 below. All four facilities had at least six departments: Outpatient Department (OPD), Nursing department (offering Maternity, Maternal Child Health and Family Planning services), Pharmacy, Laboratory and Comprehensive Care Clinic (Offering HIV Care and Treatment services) and the Public Health Department. In addition to these six departments, Facility A had a Dental Care and Radiography department, while Facility C had a maintenance department.

Table 5.2:Primary Health Care facility characteristics

Facility Characteristics	**HF_A**	**HF_B**	**HF_C**	**HF_D**
Type of PHC facility	Health Centre	Health Centre	Health Centre	Health Centre
Catchment population	22950	24383	48178	15134
Official opening hours	24 hours	24 hours	8:00-4:00p.m	24 hours
Departments/Range of services offered	OPD, MCH, Maternity, Lab, Dental, Radiography, Public Health, HIV Care and treatment	OPD, MCH, Maternity, Lab, Public Health, HIV Care and Treatment,	OPD, MCH, Maternity, Lab, Public Health, HIV Care and Treatment	OPD, MCH, Maternity, Lab, Public Health, HIV Care and Treatment
Emergency Referral Available	Ambulance available at facility but sometimes recalled to S/C headquarters	Ambulance available at facility but sometimes recalled to S/C headquarters	Rely on public transport	Ambulance available at facility
Health Workforce Distribution				
Clinical Officers	2	2	6	2
Nurses	7	8	10	5
Lab technologists	1	1	2	1
Pharmaceutical technologists	1	1	1	0
CHEW/CHA	1	1	1	1
Staff housing on site	Yes	Yes	No	Yes
Functional community units	Two	Three	Three	Two
Source of funding	DANIDA Funds Linda Mama funds User fees foregone-County Government of Kilifi			

Abbreviations: CHA-Community Health Assistant, CHEW-Community Health Extension Worker, DANIDA-Danish International Development Agency, FP-Family Planning, HIV-Human Immuno-deficiency Virus, MCH-Maternal Child Health, NHIF-National Hospital Insurance Fund, OPD-Outpatient Department, PHC-Primary Health Care
Source: Document review; in-depth interview and FGD data

As shown in Table 5.2 above, all the four facilities' sources of funding included transfer of funds from the National Hospital Insurance Fund (NHIF) for the *Linda Mama*[9] (Kiswahili for 'take care of the mother') initiative, user fees foregone[10] and operation and management funds provided by the Danish International Development Agency (DANIDA). Facility A stopped receiving *Linda Mama* funds when it was gazetted as a COVID-19 isolation centre since maternity and other MCH services stopped running. The casual staff in Facility A, therefore, continued working but had gone without salaries since the gazettement in April 2021 including up to the time of data collection in August 2021. When Facility A was gazetted as a COVID-19 isolation centre, staff from Facility B were also put on the COVID-19 isolation centre rota. Thus, some of the OPD staff would be away from the facility for up to one month (two weeks working at the isolation centre followed by two weeks in

[9] Policy intended to benefit the poor and vulnerable by removing user fees at facility-level for maternity services (from antenatal to post-natal period). The NHIF reimburses the costs of these services to the facilities.

[10] User fees foregone funds are costs reimbursed to facility for not charging user fees. These are received from county governments who in turn receive them as a conditional grant from national government

quarantine). There were no additional staff allocated to Facility B during the period when some of their staff would be away working at Facility A, the COVID-19 isolation centre.

HFC Membership

Across all four HFCs, committee members included the health worker in charge of the health facility as secretary and between five and nine elected community members (Table 5.3). In the absence of the health facility-in-charge the public health officer or the CHA sat in the HFC meetings. The chair and the treasurer were elected from among the community members, most of whom were farmers and businesspeople, though some were retired professionals such as teachers, and a few were CHVs. All the HFCs had area Chiefs, ward administrators and MCAs as ex-officio members. In HFC-C, all members also served either as village elders or as *Nyumba Kumi* representatives[11]. All committees had two female members, while two HFCs (both in Sub-County A) had youth representatives among the HFC members. PLWD were not represented in the case study HFCs which was different from what is expected from the HFC composition guidelines. In every one of the HFCs, except HFC-D, at least one of the members had served two terms as an HFC member.

Table 5.3: HFC characteristics

Characteristic	HFC A	HFC B	HFC C	HFC D
No. of elected members	5	7	9	9
No. of active community members				
Male	2	5	7	7
Female	1	2	2	2
Youth representative	1	1	0	0
PLWD representative	0	0	0	0
Ex-officio members:	-Members of County Assembly (MCAs) -Ward administrator -Chief and/or assistant chief			

Source: Author from Document review (HFC minutes), in-depth interview and FGD data
Abbreviations: PLWD-People Living With Disability

As per HFC regulations, the committees met quarterly and maintained minutes of their meetings. In all four facilities, the HFCs had met in the preceding quarter. HFC members reported that they sometimes met more frequently when there was an issue to address at the facility level. Across all HFCs, the elected community members were reimbursed transport costs for attendance of the quarterly HFC meetings, at a rate of Kshs 1000 in HFCs A, B and C, while in HFC D they were reimbursed Kshs 500. Additional visits to the facilities were not reimbursed across the HFCs except

[11] Nyumba kumi is a strategy of anchoring Community Policing at the household level or any other generic cluster. In the Kilifi context, this cluster is usually every ten households in a village

in HFC-C, where the previous HFC (2017-2019 tenure) had agreed and included in their minutes that all visits to the HFC would be reimbursed.

Selection, training, and support of HFC members

From the interviews, the facility staff (in-charge and public health office) upon expiry of the previous HFC's term (a term is 3 years) notified the chief, who invited the public to a chief's baraza to elect their community representatives for the HFC. All the four HFCs were in their third and final year of tenure as committee members. In HFC-A, at the time of data collection, only three of the elected five members had continued to carry out their roles among the five who were chosen. One elected member had not attended meetings for over a year. The other had recently (one month from the time of data collection) found work elsewhere outside the catchment area of the facility. Elections to replace the member who had been inactive for over a year had not occurred due to differences between the facility in charge and the HFC members on how long they should wait to replace the HFC member. Later, when COVID-19 was declared a global threat, it was difficult to schedule elections due to crowd-control regulations.

The majority of the HFC members interviewed had not had any formal training since they were elected. In HFC-A and B, only the executive members (chairperson, vice-chairperson, and treasurer) had been trained on their roles as HFC members. In HFC-C, only the chairperson had been trained on HFC roles and responsibilities, but this training had been conducted when he was an HFC member in a previous term. In HFC-D, a one-day orientation rather than a 5-day training had been conducted. Both SCHMT and HFC members reported that the county had not allocated resources to hold the HFC training.

HFC Roles and functioning

HFC members across the case study HFCs perceived that the function of receiving and responding to public feedback was a specific responsibility within the broader role of serving as a link between the facility and the public who accessed services in the facility's catchment area. From FGDs with HFCs, their mandate included oversight over facility finances, service delivery, and general maintenance of the health facility. HFCs were also expected to do resource mobilisation where they sought stakeholders who could fund development projects within the PHC facilities.

HFC meetings were scheduled to occur quarterly, but a review of HFC minutes showed more frequent meetings. For example, HFC-C members met almost monthly. In addition, one of two executive committee members (the treasurer or the chairperson) of the HFC also went to the facility to sign for consignments of drugs received at the facility. The main agenda in most of the HFCs' meetings included facility finances and their use. Findings from document review showed that the executive members were the most consistent attendees during these meetings, while the ex-officio members, particularly the MCAs were often not in attendance. In HFC-A and HFC-C, the chairperson

or facility-in-charge usually reached out to the MCA separately for issues they perceived required his assistance. In HFC-B, the elected community members perceived that the MCA had forgotten about them following the elections, because of his absence from the majority of the HFC meetings. However, interviews with the MCA and facility staff revealed that the public who accessed care at the facility sometimes shared feedback directly with the MCA, who in turn channelled it to the facility-in-charge. In a few cases, the issues arising were resolved without reaching the wider HFC. In HFC-D, there was a perceived 'cold' relationship between the local MCA and the HFC chairperson. The local MCA was unreachable for an interview.

In HFC-D, the HFC members had shared responsibilities for various health facility departments across the different members. For example, individual HFC members were assigned to the pharmacy, the maternity, maintenance and facility grounds and the facility kitchen (that prepared food for women in maternity) among others. The members then individually visited Facility D at least once a week to identify challenges in their allocated departments. They had reportedly shared responsibilities in this way to avoid overburdening the chairperson and the treasurer who together with the secretary formed the executive team of the HFC.

5.2 Functioning of feedback mechanisms to support receiving public feedback

The feedback mechanisms within Kilifi County mirrored those proposed in national-level policy documents. These mechanisms (Table 5.4) ranged from broad public sector mechanisms such as administrative local groups, participatory mechanisms within the health sector and uni-directional service feedback mechanisms.

Table 5.4: Feedback mechanisms available in Kilifi County

Meetings with administrative local leaders	**Participatory mechanisms within the health system**	**Service feedback mechanisms**
• Chiefs & Assistant chiefs • Village elders • Ward administrators • Sub-county administrators	• Public participation meetings held at the county level • County health board • Hospital boards • Health facility committees in PHC facilities • CSOs working within sub-counties • Community health committees at the community level • Community strategy-CHCs—CHVs-CHA-Ward PHO-SCHMT-CHMT	• Sub-county complaints committee • Annual client satisfaction surveys at the hospital level • Hospital complaints committee • Suggestion boxes/complaint boxes at the facility level • Hotlines at the facility level • Service charters at the facility level

Abbreviations: CHA-Community Health Assistant, CHC-Community Health Committee, CHV-Community Health Volunteer, CHMT-County Health Management Team, SCHMT-Sub-County Health Management Team, PHO-Public Health Officer

At each level of the health system there was a participatory structure that the public could use to share public feedback linked to health managers and/or decision-makers at that level (Figure 5.2).

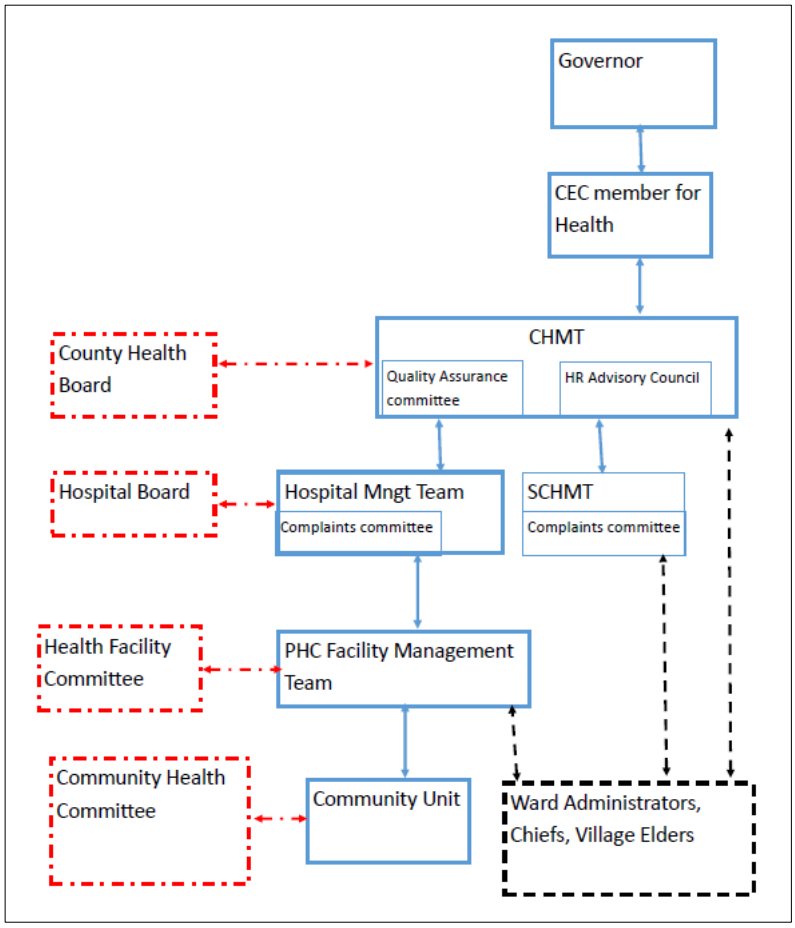

Figure 5.2: Community participatory structures and their links to health system management levels

Key: Red dash dot lines: participatory feedback mechanisms that include members of the public
Blue solid lines: governance structures and actors within the county health system;
Black dash lines-administrative structures
Abbreviations: CEC-County Executive Committee, CHMT-County Health Management Team, SCHMT-Sub-County Health Management Team
Source: Interview data

Despite the multiple feedback mechanisms highlighted in Table 5.4 and Figure 5.2 above, study respondents across levels perceived that there was little public feedback picked up by health system (HS) actors.

> *'We don't receive much feedback from the community. If we do [receive feedback], it's from about a quarter of the population that comes here for services' (HFA002)*

> *'We have suggestion boxes which we [health system managers] normally feel the community should document their concerns and complaint, but the strange part of i]t is that the community itself doesn't know that they should use the suggestion boxes. So, what I am seeing, not only in the health system but even in other systems of the county or even the country, there's that assumption that the public is aware of what is supposed to be done. But they don't know, and so we don't hear much from them.' (SCHMTB002)*

Respondents attributed the low public feedback received to low awareness about how and with whom to share their feedback. It was also not uncommon for members of the public to bypass

multiple health system levels and provide feedback to the local MCA, the Governor, or the CEC member for health directly. In the narrative below, I explore the utility of the feedback mechanisms in supporting HS actors at the sub-county and facility levels to receive public feedback.

To support the presentation of findings related to mechanism functionality I grouped the varied range of feedback mechanisms into three broad categories. This categorisation draws on the formal and informal distinction between the mechanisms and considers whether the mechanisms supported interaction between the public and HS actors (participatory mechanisms) or whether feedback was mainly unidirectional. *Formal unidirectional* mechanisms included suggestion boxes at the facility level, hotlines and client exit or satisfaction surveys. *Formal participatory mechanisms* included HFCs, the Community Strategy Structure and public participation meetings. Informal feedback channels utilised in this study included social media, public buzz in social gatherings such as funerals, and direct calls to political representatives or senior county decision-makers.

5.2.1 Unidirectional formal feedback channels

From interviews and FGDs, unidirectional feedback mechanisms picked up little public feedback. For example, *suggestion boxes* were reportedly present across most of the PHC facilities but were hardly utilised by the public, PHC facility managers and by their SCHMT supervisors. On paper, feedback from *suggestion boxes* was expected to flow upwards from the public to the PHC facility manager and then to the SCHMT (if issues could not be resolved at the facility level). However, health managers reported that the public rarely put in any suggestions, while they (facility and sub-county health managers) rarely opened the suggestion boxes to see if the public had put in any suggestions. Most of the study respondents reported that suggestion boxes had not been opened in the last two quarters in the PHC facilities visited for HFC data collection. Further, in two of the facilities, the suggestion boxes were not easily visible, and across all the facilities, there was no pen and paper nearby for the public to write out feedback. SCHMT members in both sub-counties perceived that low utilisation (by the public) of suggestion boxes was linked to low awareness of their presence, low literacy levels, concerns about anonymity and beliefs about their low utility in generating a response.

Client satisfaction surveys and hotlines were similarly under-utilised. National policy documents recommended that satisfaction surveys should be conducted annually. This appeared to be the case at the hospital level. Since devolution, CHMT respondents reported that two patient satisfaction surveys had been conducted by external consultants while three were conducted by the CHMT. However, at sub-county and PHC facility-level these were less frequent. In sub-county A, SCHMT members reported that a client satisfaction survey was last conducted in 2014 for a sample of PHC facilities. There was no record available at the SCHMT-A level of which PHC facilities were involved, what the findings of the survey were and what actions were taken in response to the findings.

Similarly in sub-county B, SCHMT members reported that surveys were infrequently utilised to learn about public feedback and were more commonly done in the sub-county hospital than in the PHC facilities. The few surveys that had been conducted in PHC facilities, were implemented (data collection and analysis) by NGOs who later shared findings with the SCHMT.

In contrast at hospital level, the CHMT appeared to be more involved in planning for the conduct of satisfaction surveys. A quality assurance committee within the CHMT members had responsibility for planning, data collection and implementation of recommendations from the client satisfaction survey report. Client exit interview data was reportedly handled in two broad ways. One, if the findings from the client exit interviews were related to healthcare worker conduct, this was directed to the Human Resources Advisory Committee at the county level which investigated and took disciplinary action where necessary. Second, where findings were related to service delivery concerns (for example long waiting times and drug stock-outs), a Quality Assurance committee at the county level supported the hospital management team to initiate improvement processes.

The use of *hotlines* was linked to service charters that were available in all public health facilities. One respondent explained:

> *"We have the service charters that outline the type of service, the duration that the service is supposed to take, and within that service charter we have a hotline, a number which a person can use to make their frustration or dissatisfaction or even compliments, positive or negative" (CHMT-001)*

However, in practice, the use of hotlines differed across the two case study SCHMTs. In SCHMT-B the functionality of hotlines was limited to reports of accident-related emergencies in sub-county B. In SCHMT-A, hotlines were reportedly not in use before the early days of the COVID-19 pandemic response. During the COVID-19 pandemic, new hotline numbers were shared with the public for them to call in and share their concerns and ask questions. Their use was unfortunately short-lived as they were plagued with multiple challenges (see section 5.3.1). At the time of data collection, these hotlines were not functional because the phone numbers had been deactivated due to non-payment to the service provider.

5.2.2 Formal participatory mechanisms

Formal participatory mechanisms included HFCs, the Community Strategy (CS) structure (comprising Community Health Volunteers, Community Health Committees and Community Health Assistants), and public participation meetings for budgeting and planning. These three feedback mechanisms reportedly contributed to receiving feedback from the public but had a much broader scope. These included planning and budgeting of services in health facilities for the HFCs, demand creation for PHC services and service provision in the community for the CS structures, and public

sector budgeting and planning (for the public participation meetings). These community participatory mechanisms are described in more detail in turn below.

Health Facility Committees

Like the non-participatory mechanisms, it was expected that public feedback received through, Health Facility Committees would first be discussed at the PHC facility level with the facility in-charges, then escalated to the SCHMT. For several health managers, HFCs were a valued source of public feedback, who reportedly supported facility-in-charges in shaping service delivery as they could listen to either facility staff or community grievances.

> *"The committee is the biggest advocate for both the community and the facility in terms of management of resources...the grievances that come from the community, the HFC are the ones who feed the facility with information on what the community reports, for example in Facility B, a committee member used to] come from the village to inform me what people are saying about certain staff within the facility, like this staff when he is on duty he does 1, 2, 3 this other one does this, this other one does this and people don't want to come to the facility when these people are on duty. So, that way you can isolate where the problem is and either move the staff or remind them or talk to them to change and then the needs of the community are felt. So, the committees are the best advocate for the community." (CHMT002)*

However, across both case study SCHMTs, members perceived that HFCs had low awareness of their roles, and little capacity to handle public feedback. For example, SCHMT members reported that HFCs scarcely documented public feedback. SCHMTs also perceived them to be under the control of the facility-in-charge, with their main role being to *'rubberstamp'* facility budgets, rather than actively participating and interrogating facility management issues. In SCHMT-B, most of the respondents did not view the HFC as a mechanism through which they could learn about public feedback, reporting that they commonly *'fuelled the fire'* when there was negative public feedback about PHC facilities where they were community representatives. SCHMT-B reportedly commonly received public feedback from the facility-in-charge rather than the HFCs.

HFC members reported that the HFCs received public feedback through *informal* ways such as direct calls from members of the public, community health volunteers (CHVs) who worked in the facility's catchment area, social media, discussions in public meetings (e.g. barazas) and social gatherings (e.g. funerals, public buzz). Feedback relayed by CHVs was commonly picked up during their monthly household visits, and community dialogue sessions. In HFC-D the HFC members also received feedback during face-to-face conversations with village elders, and *nyumba kumi* representatives.

HFCs also reported receiving public feedback through the ex-officio members such as chiefs and ward administrators who the public sometimes approached directly, and when they conducted facility monitoring visits. The chiefs and ward administrators were also members of other committees such as community policing committees, thus they reported any health facility issues that were raised in these committees to the facility-in-charge. While HFC members reported conducting facility monitoring visits, these appeared to be inconsistent across HFCs A to C. In facility A, one HFC member reportedly conducted monitoring visits which eventually stopped when the facility-in-charge informed him that he would not be able to reimburse him for the visits made to the facility. In Facility B and C, HFC members reported that they conducted visits when there were concerns from the public and therefore HFC members visited the facility to confirm reports they had received. Monitoring also commonly involved walking around the facility when they had been invited for a meeting or had gone to receive care. Data from facility-D staff and HFC-D members suggested that HFC-D had higher consistency and frequency with their monitoring visits to the facility. This was possible because as described above, every HFC member had a specific area that they handled.

Community Strategy structure

From interviews with PHC facility staff, CHVs working in the community had frequent contact with the CHA (through the monthly CHV feedback meetings; two to three community dialogues and monthly CHV household visits), thus CHVs often shared feedback from concerns raised by the public directly with the CHA, who in turn informed the facility-in-charge. SCHMT members sometimes learned of this feedback when they attended community dialogue meetings, when they participated in the monthly CHV feedback meetings, or when an issue was escalated to the SCHMT by the facility-in-charge.

The CS structure was perceived to be constrained in the extent to which it could collect public feedback due to the absence of functioning CHCs. On paper, CHCs were expected to govern CHVs and link with HFCs about health concerns including public feedback on service delivery [243]. However, CHCs were neglected particularly by NGOs who commonly supported the CHVs through training and payments of transport reimbursements and/or stipends when they (CHVs) were involved in NGO activities. It was reportedly commonplace for CHVs to operate without CHCs. As a result, there was a perception that CHVs mainly focused on report generation for the health system, rather than linking the community with the health system.

> *"That structure of Community Strategy is not functioning the way it was intended, the structures which ought to be there are neglected because apart from the CHV, we ought to have… a very active community health committee but it is now dead. And this [the CHC] is the avenue where the community members would sit, discuss their concerns, and come up*

with local solutions and those which are not within their means, they forward them to the higher management. But now that structure is not there, we have so many organizations who come and they are focusing on the CHVs, they neglect the role of the CHC, yeah, and that is the reason why most of the CHVs now it is like they are generating reports for higher levels but not for their consumption." (SCHMTB-002)

Public participation meetings

From interview data, SCHMTs also received public feedback during formal public participation meetings for budgeting and planning. These meetings were organised by the Department of Finance and Planning. The scope of the discussion in these meetings extended beyond the health sector to include other county government sectors. These meetings were a requirement by law as part of the budgeting process [249]. Across both SCHMTs, core team members such as the SCMoH, SCHA and SCHRIO reported attendance of these meetings. However, SCHMT's attendance at these meetings was reportedly inconsistent because SCHMT members attended as a replacement for a county health manager who was unavailable. At SCHMT level, therefore, the members were aware of some of the public feedback that was raised, however, they were unable to keep track of any trends in public feedback for the health sector from these meetings.

Non-Government Organisations

SCHMT respondents perceived that responsiveness to public feedback was not a key focus of many of the NGOs working in the study sub-counties. For example, NGO support for functioning of feedback mechanisms was commonly provided to achieve their program objectives rather than elicit and respond to broader public interests. At the time of data collection between July and November 2021, many of the NGOs working within the study sub-counties worked in the implementation of service delivery within specific vertical programme areas such as Water, Sanitation and Hygiene, Reproductive Health (RH) and HIV care and Treatment. In implementing these programs NGOs sometimes collected views and concerns from service users within these programmes which were shared with sub-county health managers. The main ways through which NGOs contributed to learning about public feedback were through conducting client exit interviews within the HIV service delivery point (Comprehensive Care Centre-CCC), '*mama*' (mother) open days at PHC facilities (provided a platform for pregnant and postnatal women to provide feedback about MCH services) and community dialogues for targeted issues such as Community Led Total Sanitation. NGOs supporting the implementation of RH services also had a variation of the mama open days, referred to as *Binti to Binti* (young women). *Binti to Binti* groups specifically targeted young women (considered a vulnerable group), to collect feedback about their pregnancy experiences (health service and non-health service related), and to support them during pregnancy and in the postnatal period.

5.2.3 Informal mechanisms

Members of the public commonly utilised informal feedback mechanisms such as direct phone calls and messages to channel feedback to higher system levels such as the CHMT, senior county officials or politicians. Other informal channels utilised by the public included social media and public buzz in social gatherings such as funerals. One county-level health manager noted:

> "*They [community members] may bypass the facility maybe it's something that has happened at the dispensary level it is not even taken to the MOH, it's not brought to our level we would sometimes hear it from the CS or from His Excellency the Governor it happens many times*" (CHMTA013)

SCHMT members perceived these informal mechanisms to be disruptive. They felt that feedback channelled through informal mechanisms was '*often exaggerated and difficult to substantiate*'. In several instances, county officials responded when the public had called them directly without engaging with the SCHMT. When the feedback came from the top-down (from senior county officials or county health managers), the SCHMT often had to quickly investigate in order to share the feedback upwards with the county, usually at the expense of previously planned activities. For example, during observations of SCHMT-A supervision activities, two separate incidences of PHC facility drugs being sold privately were received by SCHMT-A. The information in both cases was passed down from Senior County officials (from another county government department) to the Chief Officer in the CDoH, then to the SCMoH. In both cases, the SCMOH had to re-schedule ongoing and planned support supervision visits, to investigate the received feedback. At the time when I completed my observation two weeks later, the re-scheduled support supervision visits had not been done. The investigation of the shared feedback was not the only contributing factor hindering the resumption of supervision activities, as there were pre-existing resource challenges. First was a lack of fuel and second, when fuel became available, the SCHMT's utility vehicle was not available because it needed repairs. One respondent observed:

> *'Social media concerns are so many, and they usually occur at an unexpected time. First, you need to be online... but once we see them because they usually raise a lot of political pressure, they are usually handled very fast. An example, the other day, the Chief [Officer] and the head of Preventive [services] were at a health facility just because of a report on social media. The social media feedback of the community attracts a lot of political pressure…it is not good… because things usually are not the way they are reported [SCHMTA-003].*

Similarly, in SCHMT-B, when informal feedback, came from outside or higher up in the health system bureaucracy, there was an urgency to respond that required re-organisation of SCHMT-planned activities. The use of informal mechanisms, particularly where political representatives

called county health managers to share public concerns, was perceived by SCHMT-B members to be both a *'break in protocol'* and an illustration of the low awareness of the public about feedback mechanisms available to them. These findings related to informal feedback mechanisms and information flow across the levels of the health system suggest that actor interactions and power dynamics influenced responsiveness to public feedback. This is explored in more detail in Chapter Six.

5.3 Health system capacity to support mechanism functioning and processes for responsiveness

The findings above illustrate that there were multiple channels through which health system (HS) actors could learn about public feedback. However, these mechanisms were limited in their functionality suggesting that little feedback was received by HS actors. In the section below, drawing on Ellokor et al, who in turn draws on Aragon's organisational capacity framework (Figure 3.5), I explore hardware and software elements of the health system and how these contributed to mechanism functionality. According to the framework, hardware components include factors such as infrastructure, technology, and financial and human resources (staffing). System software includes the tangible software of management knowledge and skills and organizational systems [198, 199].

5.3.1 Hardware barriers constrained overall mechanism functioning including the process of receiving public feedback

Hardware barriers to the functionality of these mechanisms included resource constraints related first to scarce financial resources for the establishment of feedback mechanisms and support for their implementation beyond establishment. These barriers were expressed in relation to the conduct of satisfaction surveys, training of HFCs, and lack of formalisation of CHCs and CHVs. For example, regarding satisfaction surveys, sub-county team members acknowledged that they were rarely initiated by the department of health actors, in the few instances that they were done, their conduct was facilitated by NGO actors. Similarly, regarding the training of HFCs, in the early days of their establishment, HFCs had received significant support for their set-up through the consistent availability of training funds from a development partner. However, over the last two election cycles for the HFC members, it was difficult for the case study SCHMTs to carry out training for HFC members because of a lack of access to funds, as explained by the in-charge in Facility C:

> *"Yeah, that is ideal, after being elected, they should be trained on their roles, but now we have not been having funds for the same for the last 6 years. When health was devolved, we started lacking the funds to train them [HFC members]. So they just serve like that, but we do an orientation, the sub-county team calls a few of them, the chairperson and the*

treasurer. The other members don't go. The training should be 5 days, but they get a one-day orientation" (HFC-002).

The lack of training appeared to impact HFC functioning negatively, particularly in Facility D where there were reported tensions between HFC-D members, staff, and the facility-in-charge. These tensions are described in more detail in chapter 6 (see section 6.4).

The Community Strategy structure was also incompletely set up, as many Community units lacked functioning CHCs. These CHCs were on paper expected to link with HFCs to support receiving public feedback. Community units were commonly set up without CHCs because of resource challenges. CHVs were perceived to be the main 'workers' in the Community Structure, and NGOs who mainly provided the resources for initial establishments working in the community focused on training CHVs only, with little attention to set up of CHCs to reduce operations costs. As a result, a precedent was set-up such that many community units had CHVs but no CHCs who could link back with HFCs. This reportedly constrained the extent to which HS actors could learn about the views of certain vulnerable groups (such as PLWD) who were expected to members of CHCs and were inadequately represented in the HFCs.

In addition, there was low coverage of community units across the entire county. From interview data, sub-county A, reportedly had 11[12] community units against a target of 56 community units at the time of the first phase of data collection in June 2020. There were therefore few CHVs who were expected to cover large geographic areas. Lack of stipends was also a commonly mentioned factor that contributed to CHV attrition. According to CHMT respondents, CHV roles had not been formalised due to concerns that introducing a stipend for CHVs had significant budgetary implications which the county was not able to meet.

"The challenge we have is the stipends, because they want to be supported but then we don't have that kind of provision financially so we tried to incentivize them through trainings because at a training you get lunch, you get transport allowance but otherwise in terms of an allowance that we would give you on a daily basis or on a monthly basis right now we haven't really known how exactly that can happen because our budget cannot support that." (CHMTA-014)

Towards the end of the second phase of data collection in December 2021, the Community Strategy structure had benefitted from additional training of CHVs and set up of Community Units through NGO support. Notably, no new CHCs were set up.

[12] The number of community units has since increased and is now 43, against a target of 56 following training of CHVs by a development partner.

Most of the identified feedback mechanisms relied on implementation partners and donors for funding of initial establishment and training. This meant that training and functioning of the feedback mechanisms were linked to grant periods. Activities related to the mechanism therefore either stalled or slowed down significantly between grants or partners moving out of the sub-county. This was because often there was no allocated government funding to take over expenses that could support adequate functioning.

The second dimension of resource constraints was the absence of dedicated human resources to support the functioning of the feedback mechanisms. Study findings suggested that none of the case study HFCs and SCHMTs had assigned the responsibility for opening the facility-level suggestion boxes to a particular staff member. Respondents reported a wide range of staff across PHC facilities who opened the suggestion box. Among those mentioned by facility-level interview respondents were the facility-in-charge, the Public Health Officer, the Health Information Records Officer, and support staff. SCHMT respondents perceived that the HFC should be present during the opening of the suggestion box, while HFC members perceived that there should be an SCHMT representative when the suggestion box was opened. These inconsistencies regarding who and when the suggestion boxes were opened, suggested that they were rarely opened, and therefore little feedback was received through them. Hotlines also lacked the dedicated staff to receive and respond to feedback, a finding that was apparent during the early days of the COVID-19 response, when new hotline phones were introduced. The phones were assigned to SCHMT members who were on Rapid Response Teams and had to continue co-ordination of their programmes within the sub-county. This made it difficult for them to receive and respond to calls from the public. One sub-county team respondent explained:

> *"The hotline was a mess it did not work optimally the line was given to the same officers who were conducting follow up, who were conducting supervision they would be called even at 2 am 3 am so they ended up being overwhelmed" (SCHMTA004)*

Pre-devolution, HFCs were supported by a Facility Management Nurse (FMN). The post of FMN was created to support links between facilities, the community, and the district by strengthening the management of committees. This involved overseeing the selection of committee members, organizing training, and assisting committees in planning and continuously evaluating those plans. However, following devolution, though HFC members continued to be elected, the practice of having a dedicated member of the team within the SCHMT to support HFCs was not continued. Instead, providing support for HFCs became a broad responsibility of the entire SCHMT. As a result, it appears there was inadequate attention to HFCs. The majority of the recently elected HFCs had not been trained, and were perceived to be weak, with a low understanding of their roles:

"Many of our committees [HFC] are not very strong and it's not that they cannot be strong but it's because of the way the structure has been. Because when you've not given them their roles and responsibilities… if the health care workers behave a way that does not please the community, they [HFC] should come [to the SCHMT]…or even before coming to report they should sit with the healthcare workers at the facility telling them that we have observed this and this which we feel is not right but many times the health care worker becomes like their boss so they are at the mercies of the health care worker which is not right" (SCHMTA009)

"When health facility committees were elected 3 years ago, we thought the county will organize for training but it was not done and these HFCs are supposed to be dissolved we elect new ones in February [2022]...So, they [HFC] were there but it was like baptism by fire, they came there with a notion that when you are elected to be a committee member you are supposed to be a manager of the facility. So, it's like we are having parallel managers. The facility in-charge and his people, and the committee also managing as part of the facility, so most of the time we have been having conflicts, between our officers and the committee" (SCHMTB006)

5.3.2 Absence of a pro-active, consistent, systematic approach to receiving and handling public feedback undermined management of public feedback

Weak tangible software appeared to contribute to low mechanism functionality. These weaknesses were illustrated by the absence of a proactive and systematic approach to receiving and handling public feedback. First, despite SCHMT's rhetoric that they valued public feedback, across both case study SCHMTs, there were no procedures in place that outlined how public feedback would be managed. It was uncommon across both case study SCHMTs to actively seek out public feedback. For example, in explaining why client exit surveys were hardly conducted a sub-county health manager alluded to a reactive approach to receiving public feedback:

"We are supposed to do client satisfaction interviews at dispensaries and health centers. It is one of the performance indicators that we need to track, the same way we track staff meetings, facility management committee meetings, we should also be doing that, but we rarely do that. I think maybe we have not given it the seriousness that it deserves, I think the facilities have not seen it as important to have those client exit interviews or satisfactory surveys being done frequently. It is not seen as something very important. If the patient has a problem, they will state it, the problem is solved, and people carry on" (SCHMTA001)

Across HFCs, there was also little proactive seeking out of feedback. Most of the HFC members reported receiving feedback from their friends, relatives and members of the public who knew

them. Further, HFC members reported not having a systematised way of conducting monitoring visits in the PHC facilities that they served.

Second, in these findings, different feedback mechanisms that could have 'fed' the case study HFCs and SCHMTs are presented separately for descriptive purposes. However, it was apparent that this is how these mechanisms functioned within the health system. This was illustrated by most respondents who described receiving and responding to public feedback on a 'case by case' basis. From SCHMT data there was reportedly little linkage between HFCs and CHCs despite recommendations in policy documents. From HFC FGDs, the HFC members were not privy to feedback from other formal unidirectional mechanisms such as suggestion boxes and client satisfaction surveys. Public feedback generated from these channels was discussed in staff meetings or with the NGOs that supported their conduct. Across both SCHMTs and HFCs, there was little integration of feedback from the various channels, making it difficult to gain a broad picture of public feedback.

Given the case-by-case management of public feedback, it was unclear how public feedback was prioritised for action or response. Members of the case study SCHMTs emphasised that all public feedback was important. At the same time however, there seemed to be more importance placed on 'life and death' situations. One of the SCHMT members reported:

> *"In terms of prioritization, in our set-up, our orientation, my president in terms of health service delivery is the patient, anything to do with the patient is the priority number one to us. Especially when it touches on the bit of curative [services]. That's when we are looking at an individual's life. For example, every infant that died in a facility, every mother that loses her life out of pregnancy or is pregnant, we will do a post-mortem [a review of what happened]" (SCHMTA-002)*

Third, there was little documentation of the range of feedback received by both HFCs and SCHMTs. Where HFCs member conducted monitoring visits, these visits were informal, and findings were communicated to the facility-in-charge via word of mouth. The visits were also not systematic, save in Facility D where the facility-in-charge reported weekly visits from the various HFC members. However, even in facility D where the HFC members paid frequent visits to the facility, monitoring was not done with any kind of tool. Across both SCHMTs and HFCs there were often no records available of receiving or responding to public feedback. The lack of records extended even up to feedback collected through surveys supported by NGOs. The SCHMTs did not retain or file copies of the survey findings. In addition, these surveys were commonly one-off exercises aimed at meeting the NGOs' objectives. Feedback from other formally recognised structures within (such as Community Strategy, CS-comprising CHVs, CHCs and CHEWs) and outside the health system, but within the broader public sector (e.g. village elders, *nyumba kumi* representatives, community

policing committee) was also not documented. HFC minutes sometimes contained a record of public feedback and actions taken, but these were documented if the issue was reported during a quarterly meeting or if the issue was perceived important enough to warrant discussion with the full facility committee and or SCHMT.

A fourth organisational software barrier to feedback mechanism functionality was limited awareness and availability of guidelines and policies for handling public feedback. On paper, a sub-county complaints committee existed in every sub-county. This committee, according to county health managers was expected to have responsibility for receiving and generating responses to complaints raised by the public. However only one SCHMT-A member appeared to be aware of the terms of reference (TOR) for this committee. Similarly, a complaints policy that had been developed together with the TOR for the sub-county committee was relatively unknown across both SCHMTs. As a result, the sub-county complaints committee had never met. There were also no guidelines for how frequently (for example the unidirectional feedback mechanisms) should be accessed or utilised to learn about public feedback. For the HFCs, there was limited material (in the form of guidelines or a manual) at PHC facility-level that could be used to support ongoing familiarisation with their roles. The exception was in HFC-C, where the facility in-charge used a HFC training manual to support HFC member awareness of their roles and responsibilities. Notably, the HFC manual in use was one developed during the pre-devolution period. This HFC training manual had not been updated to reflect the current devolved governance structure.

5.4 Content of Feedback Received

Despite the limitations in functionality of the mechanisms described above, some public feedback was received. Figure 5.3 below illustrates the content of public feedback received at SCHMT level, majority of which mirrored HFC-level feedback. Across both SCHMTs and HFCs, the feedback received was disproportionately negative, with little positive feedback and few experiences of vulnerable groups.

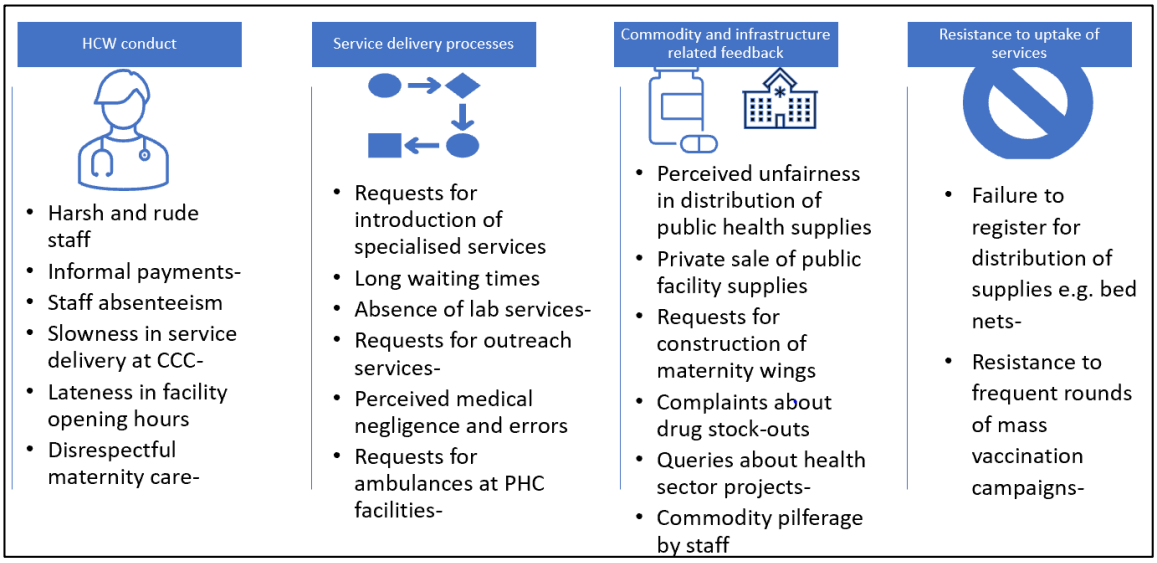

Figure 5.3: Content of feedback received at SCHMT level
Source: Author (from interview data and document review)

The experiences of a few vulnerable groups were picked up mainly by channels dedicated to these groups. For example, *mama open days* picked up feedback related to the experiences of pregnant women, while youth forums picked up feedback from the youth. Notably, the experiences of other vulnerable groups such as PLWD rarely featured in respondents' reports on content of feedback. Though PLWD were frequently mentioned as a vulnerable group whose participation in HFCs was a legal requirement, at the time of data collection none of the case study HFCs included a PLWD in their membership (see Table 5.4). Other groups considered vulnerable, for example, minority ethnic communities were also not included in HFC membership. One county health manager noted:

> *"There are areas where we have Waathas [a minority ethnic group], and you'll find only the other sub-tribes or the bigger regroupings, occupying all, all the slots in [the HFC] in fact, in most circumstances they are not considered as special. So, when the community is selecting the people, they will select and say we have chosen these ones, and then among the Waathas who are there, they feel like ok, they've elected but we are not represented" (CHMT002)*

Given the lack of representation of these vulnerable groups in the case study HFCs and the lack of disaggregation of the feedback received, it was unsurprising that little feedback concerning their experiences with the health system was picked up through available feedback channels. The HFCs and SCHMT members however perceived that these groups could share feedback through mechanisms specific to them such as Disabled Peoples' Organisations for PLWD and ethnic spokespeople for the minority communities, which had links to HS actors. It was unclear however how successful these linkages were in drawing attention to the feedback raised by these vulnerable groups.

5.5 Responding to Public Feedback: The nature and spread of responses, and communication to the public

This section presents findings related to the generation of responses in three parts. The first sub-section reports on the nature and spread of responses. Study findings suggest that there was some effort to respond to public feedback when it was received by HS actors. However, health managers also reported *'ignoring'* public feedback because it was '*incoherent and they had to balance with existing health system side plans'*. Figure 5.4 and Table 5.5 below illustrate how various forms of feedback were handled. Responses included escalation across health system levels where HFCs and SCHMTs perceived that certain feedback could not be addressed at their level. In the second sub-section I consider the extent to which HS actors communicated back to the public, whether or not a response was generated. In the third sub-section, I present findings related to visible responses for feedback received from vulnerable groups.

5.5.1 Varied, incident-driven, responses to public feedback

The responses generated varied with the form and perceived importance of the feedback. Across both SCHMTs and HFCs, there was a mix of informal and formal engagement involving multiple actors in the process of responding to feedback (see Figure 5.4, more detail in Table 5.5). For example, at the PHC facility level, HFCs commonly delegated the role of dialogue with HCWs when poor HCW conduct was reported to them to the facility in-charge. This dialogue was commonly an informal exercise that involved *'sitting down to talk to the colleague'*. In instances where concerns about HCW conduct were persistent, these were handled by the SCHMT team and a response like a transfer (combined with dialogue with the HCW) was generated. Where public feedback (for example about conflict between two HCWs) bypassed the facility level to higher health system levels, the SCHMTs also responded with dialogue and mediation at the first instance.

Dialogue and Mediation; PHC facility-level changes	-Approval of use of PHC facility funds -Resource mobilisation -Sub-county level changes	Reporting to higher authorities or political representatives
-HCW conduct	-Transfers across PHC facilities for persistent negative HCW conduct	-Perceived serious medical errors (negligence)
-Modifications to improve service delivery-e.g. instituting sign-in books	For non-capital intensive commodity and service delivery requests (purchase of drugs & equipment) -Non-severe staff shortages (locum)	Capital-intensive infrastructure and equipment related requests
-Introduction of specific clinic days for chronic disease (hypertension; diabetes) patients due to complaints of long waiting times	Redistribution of drugs across PHC facilities for drug stock-outs	

Figure 5.4: Variation of responses across form and perceived importance of public feedback
Abbreviations: HCW-Healthcare worker, PHC-Primary Healthcare

Table 5.5: Responses to public feedback across HFCs and SCHMTs

SCHMT generation of responses		
Form of public feedback	**Type of response generated at SCHMT level**	**Action taken communicated back to the public (Y/N)**
Requests for the introduction of new services and infrastructure	• Recommendation to the public to direct infrastructure requests to local politicians • Engaged local politicians directly to draw their attention to public requests/needs • Encouraged PHC facility management teams to respond to public concerns drawing on facility funds[13]	No
Complaints about drug stock-outs	• Re-distribution of drugs was localised to the facility and/or sub-county • Escalated to county health managers where county-wide issues	No
HCW conduct	• Dialogue with reported HCW regarding their conduct • Mediation where two or more HCWs were involved in a conflict • Transfer of HCW within the sub-county when misconduct persisted. • Investigation and sharing of reports upward with county health managers	Not commonly communicated to the public what action had been taken on the HCW
Questions about budgeted and proposed health sector projects	• Escalation to county health management level in the form of a report	Often no response was communicated to the public within the financial year until public participation in the next financial year's budget
HFC generation of responses		
Issue	**Response generated at HFC-level**	**Responses escalated beyond PHC facility level & communication to public**
HCW conduct		
Harsh and rude staff and Interpersonal conflict between staff reported by all case study HFCs	• HFC members delegated responsibility for dialogue with staff to the facility in-charge (All HFCs)	
Persistent HCW conduct issues (after dialogue and mediation)		HFC members reported to a higher authority (SCHMT)-(All HFCs)
Complaints about drug pilferage at PHC facility A		The public bypassed HFC to share with a senior county official who suspended the facility-in-charge
Lateness in starting service delivery	• Discussion at HFC level resulted in introduction of staff sign-in book. This book was reviewed by the facility-in-charge in HFC-A and by the HFC chairperson in HFC-B • Agreement to re-schedule staff meetings to mid-week in the afternoon when there were few patients in HFC-B	

[13] Facility funds at PHC level included Linda Mama and user fees foregone which were funds reimbursed by National Hospital Insurance Fund (NHIF) and the county government respectively.

Service Delivery Processes		
Long waiting time for chronic disease patients	• Patients were allocated a specific clinic day, and then information on specific clinic day was disseminated to members of the public by the facility-in-charge during health talks and HFC members (HFC-A) during community engagements	
Long waiting time due to few staff in the facility	• Explanations to patients waiting in the facility during health talks (commonly done when HCW staff were away on training, and few staff were left to provide service) • Approval of payment for staff to work on locum (HFC-C)	Reported to SCHMT
	• HCWs (nurses) in maternity and MCH departments took up additional roles of doing OPD consultations after completing maternity and MCH duties to reduce patients waiting time in the OPD but some patients usually had left and missed care	
Request to have FP and counselling services for youth separate from the main MCH building	• In collaboration with NGO, HFC and facility staff supported the set-up of a youth-friendly centre including the placement of a counsellor at the identified building (HFC-B)	
Commodity, equipment and infrastructure-related feedback		
• Drug stock-outs • Interruptions in service delivery due to malfunctioning equipment (blood sugar machines, and fridges for drugs requiring low temperatures)	• Approval of purchase of drugs (up to a limit of Kshs,30000) (HFC-C)	-Resource mobilisation by reaching out to stakeholders-MCAs, NGOs, private companies • MCAs approached higher level decision-makers (e.g. SCHMTs, CHMT) about commodity and staffing issues • Purchase by individual MCAs of 'low cost' equipment such as a blood sugar machine and blood sugar testing strips and fridges

Abbreviations: CHMT-County Health Management Team, HFC-Health Facility Committee, SCHMT-Sub-county Health Management, HCW-Health care worker, MCA-Member of County Assembly, NGO-Non-Governmental Organisation

From Table 5.5, most responses were immediate and one-off except in a few cases where follow-up action was required to support the change brought about by a response. For example, responses generated by the Facility A in-charge following HFC-A reports about long waiting times for chronic disease (diabetes, hypertension) patients included *allocation of a specific clinic day* in which the chronic disease patients were prioritised for care. The facility in-charge, then *communicated the specific clinic days* during health talks before the start of service delivery. HFC members, through their interactions with members of the public in social gatherings and via phone calls also communicated the specific clinic day.

Because PHC facilities operated bank accounts that received funds from the NHIF and the county government, two case study HFCs (C and D) also responded to some forms of public feedback (such as drug stock-outs and staff shortage) by approving the use of PHC facility funds for the purchase of drugs and hiring of locum staff respectively. SCHMTs, however, did not have such an option as they were not an accounting unit. However, they could access other resources that they used to support responses. For example, when drug stockouts were a persistent problem, the SCHMT members themselves organised utility vehicles and borrowed across facilities in their sub-county.

From interview and FGD data, all the case study SCHMTs and HFCs also mobilised resources from stakeholders to support responsiveness. SCHMT resource mobilisation efforts were commonly aimed at supporting the functioning of especially the broader scope feedback mechanisms such as HFCs (to support orientation into their roles after being elected) and CHVs (to prevent attrition by negotiating for payment of stipends to CHVs for NGO-led community activities). Both case study SCHMTs also encouraged the HFCs to seek out stakeholders to mobilise resources in direct response to a public request, where it was perceived that facility funds would not be sufficient to generate a response.

Responses that involved resource mobilisation such as requesting stakeholders (such as MCAs, private companies, and NGOs) to support construction or purchase equipment, or to support CHVs (at the community level) were mainly written formal engagements. However, engagements with MCAs were a mix of both formal and informal interactions. For example, it was not uncommon for the HFC chairperson to make requests for equipment or supplies with the MCA verbally or by inviting the MCA to visit the facility to 'see' the gap in service delivery. At higher health systems levels, it was also not uncommon for MCAs to make phone calls to county health managers and the CEC member for health to follow up on issues that had been reported to them, in efforts to generate responses.

Despite the efforts at resource mobilisation described above, drug and staffing gaps were often beyond the capacity of HFCs and SCHMTs to respond to. Even when resolved for a short while, it was difficult for some responses to be maintained. For example, Facility D had received a one-off drug donation from an NGO working in their catchment area. However, HFC-D still received public feedback about drug stock-outs in another quarter when there were delays from the national supplier. Concerning staffing gaps, in the same facility D, the same NGO employed one nurse to work in the facility's MCH department on a long-term contract. The addition of the NGO-supported nurse contributed to a reduction in complaints about long waiting times at the MCH because the nurse prioritised delivering services here (the MCH department). However, members of the public waiting for services from other departments such as the OPD continued to experience long waiting

times. The SCHMT had received feedback about this, but beyond escalation to the CHMT, these complaints were not within their remit to act on.

Across both case study SCHMTs, there was a perception that a few instances of public feedback had contributed to sub-county-wide changes in service delivery. This spread of change was reportedly supported by monthly meetings that the SCHMTs had with PHC facility-in-charges. At these meetings, the SCHMT communicated public feedback from one facility and encouraged other facilities within the sub-county to adopt changes that arose out of public feedback. For example, in response to public feedback about missing immunisation services on certain days in some of its facilities SCHMT-B members recommended that all the facilities in Sub-County B offer immunization services on all the days of the week rather than on select days. This was reportedly an easy change to make because SCHMT members presented it to facility-in-charges as a way in which facility-level missed opportunities for immunisation could be reduced. This (reducing missed opportunities for immunisation) was a service delivery target that facility staff were required to meet.

5.5.2 Communication to the public about actions taken in response to feedback

From interview and FGD data, it was rare for the public to receive communication about actions taken in response to their feedback. Respondents at the SCHMT level cited the practical difficulties of communicating actions taken in response to public feedback. First, was the challenge of communicating in situations of anonymous reports from the public. Second, was when public feedback had come from higher up in the health system. Often, the practice in such cases was to share a report up-wards with the county health manager who had shared the issue with the SCHMT. Third, SCHMT members acknowledged the slow nature of change in response to some forms of feedback such as HCWs with poor attitudes, and explained that this made it difficult to communicate to the public when action relating to their feedback had been taken:

> *"Because if the grievance is something to do with the say for instance the staff attitude, you know it's something that fine it can be addressed, but changing an attitude is a very slow snail speed process… Because even if that person changes, now informing the public that ok, he changed or she changed, it's difficult, because it's something that you got the complaint here, you informed the facility team maybe or talked to that healthcare worker directly but going back to the public and saying now it has changed, ah…. maybe even if you call a meeting that person who raised that concern might not be there" (SCHMTB-01)*

Beyond practical challenges, across both SCHMTs and HFCs, there was also a perception that responses to public feedback would be apparent when the public saw or experienced a change in service delivery at the facility level. Thus, it was uncommon especially in HFC-A and HFC-B for the HFC members to report back to the public on responses that had been generated. HFC-C members

however reportedly went back to assure the public that their feedback had been shared with the relevant actors and that they should expect to see changes.

In HFC-D, a few HFC members sought specific individuals, or community leaders (for example the chief or village elders) to communicate responses that had been generated for feedback received by HFC members. Most HFC-D members however were reluctant to report back to the public that action had been taken. Like HFC-A and HFC-B members, they felt that the public would *'see for themselves'* if a change had truly occurred. This reluctance was underpinned by the uncertainty of whether a change would truly occur even when there was the promise of action:

> *"Personally, if I get complaints from there (community) and bring it here I am unable to take back the response given to the community because if it's a response which they will sit and discuss it and a change is made then when a community member visits the hospital they would like to first see the changes then they come back to me and tell me that they saw the changes. That's when I will know that the issue has been resolved. But I just can't tell them that this is what was said. If it doesn't happen, they will still follow me asking me why it never happened." (FGD-004)*

5.5.3 Responses to vulnerable groups

Given that the content of feedback rarely included the concerns and views of vulnerable groups, there were few visible responses targeted at vulnerable groups. However, where observed responses to feedback from vulnerable groups appeared to be generated in collaboration with NGOs who worked with these groups. For example, in SCHMT-B, young mothers who raised concerns about inadequate resources for providing care for their infants during their antenatal and post-natal visits were linked to a livelihoods programme run by an NGO that worked in the health system to improve MCH indicators. Similarly, an NGO concerned with the welfare of PLWD had supported the construction of toilets in public health facilities that were disability friendly, in one of the facilities supported by SCHMT-B. This however had not spread to all the other PHC facilities within the sub-county.

5.6 Chapter Summary

I found that there were multiple channels through which the SCHMTs and HFCs could receive public feedback. However, these mechanisms had limited functionality, commonly functioned in isolation, and inadequately represented vulnerable groups. When public feedback was received, it was uncommon to 'hear' the voices of vulnerable groups except in cases where there was a deliberate effort to target vulnerable groups. These kinds of efforts were commonly implemented by NGOs.

The study findings also showed a passive orientation to receiving public feedback across both HFCs and SCHMTs, a lack of documentation and integration of feedback from various channels, and low

awareness of existing county policy on handling public feedback such as complaints. To generate responses to feedback HFCs and SCHMTs utilised a mix of informal and formal engagements that varied with the form and perceived importance of public feedback. Both SCHMTs and HFCs responded to public feedback with actions within their sphere of influence. For example, HFCs generated some local-level responses, but many of these had transient effects due to long-standing resource constraints. Similarly, SCHMTs functions did not include resource allocation, which influenced the extent to which they could generate responses. When responses were generated, they were often not communicated to the public. This lack of communication was linked to practical challenges of communication, and uncertainty regarding generation of responses. Though there were few systemic and sustained responses to public feedback, in a few instances, changes in response to public feedback from one PHC facility were used to create a standard for service delivery across PHC facilities.

Overall, the SCHMTs and HFCs were observed to have low to middling performance in mediating HS responsiveness. A key finding across the case studies is the multiplicity of actors involved in receiving and responding to public feedback. These actors interacted across multiple health system levels including outside the health system. I will explore these interactions more deeply in the subsequent chapter which considers the influence of actor relations and power dynamics on health system responsiveness.

Chapter 6 The influence of actor relations and power dynamics on responsiveness to public feedback

6.1 Introduction

This chapter explores the third objective of the study and examines how actor and power relations shaped responsiveness to public feedback. In the previous results chapter, I have described multiple feedback mechanisms with little utility in supporting receiving of public feedback and overall weak responsiveness to public feedback across case study HFCs and SCHMTs. To explain these findings, in this chapter I will focus on the role of interactions between actors, their interests and their exercise of power and how these impacted responsiveness. The findings I have presented here draw on cross-case analysis of the case study HFCs and SCHMTs and I highlight specifics for each case where relevant.

I have presented the manifestations of power in this chapter in relation to the general functioning of the case study SCHMTs and HFCs, and in the specific processes of receiving and responding to public feedback in these spaces. This chapter has three sections, the first section highlights the multiplicity of actor interfaces, the second section focuses on actor interactions and exercise of power in relation to receiving public feedback, and the third section presents findings on actor interactions and exercise of power in relation to the functioning of feedback mechanisms and generation of responses. The second and third sections each have sub-sections in which I first identify observed forms and practices of power at various actor interfaces and second, examine the actor lifeworlds underpinning the forms and practices of power observed. In this chapter, I will italicise the dimensions of actor lifeworlds when discussed to draw attention to their role in underpinning the exercise of power.

6.2 Multiple Actor Interfaces observed in relation to SCHMTs and HFCs functioning

Actor interfaces are described by Long as the points of interaction between actors in relation to the implementation of a policy [201, 210]. In this work, I observed multiple actor interfaces in the processes of receiving and responding to public feedback across the case study SCHMTs and HFCs. I have categorised these into interfaces that were formed between the public and HS actors, within the health system, and in the broader governance context. Figure 6.1 below highlights the relationships and interconnectedness between various actors. Figure 6.1 also illustrates that the public formed interfaces with multiple actors such as their community representatives within the health system (CHVs and HFCs), with local politicians (MCAs) and with appointed senior county officials. These interactions occurred across and within Gaventa's spaces and levels of power. For example, within the health system (HS), the public interacted with health managers at the county, sub-county, and facility levels to share feedback with them. In relation to spaces, the diagram illustrates interactions between the public and actors in an invited space within the health system

(HFC), and in a closed space- (the SCHMT) where public feedback was received. More detail about the closed and invited spaces is provided in section 6.3.2.

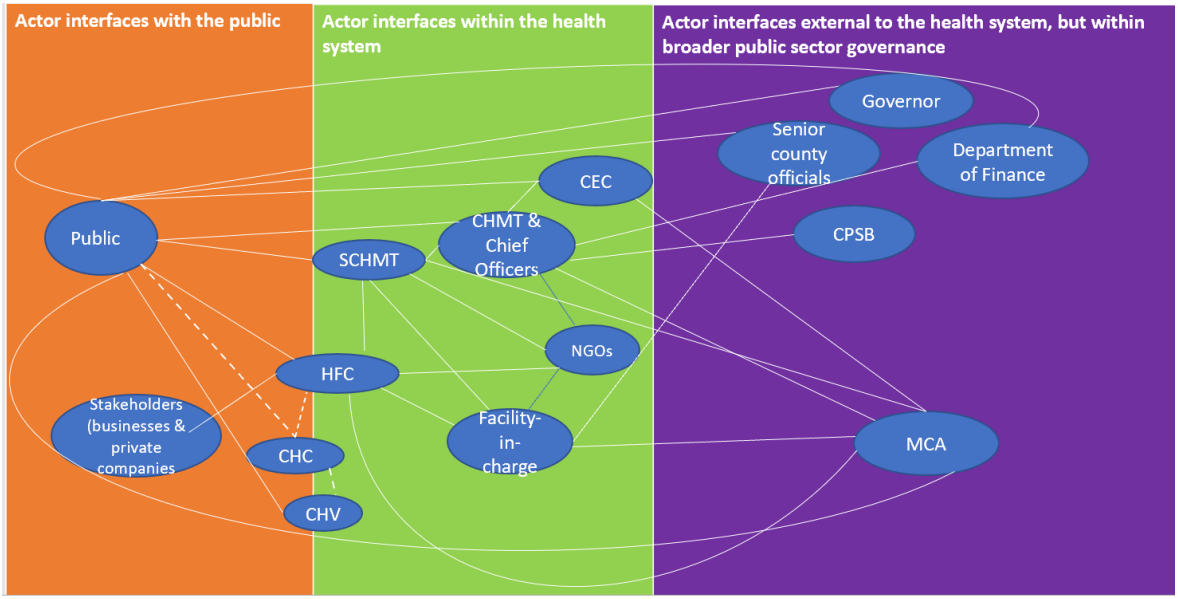

Figure 6.1: Actor interactions in processes of receiving and responding to public feedback

Abbreviations: CEC-County Executive Committee member for Health, CHC-Community Health Committee[14], CHMT-County Health Management Team, CHV-Community Health Volunteer, CPSB-County Public and Service Board, HFC-Health Facility Committee, MCA-Member of County Assembly, SCHMT-Sub- County Health Management Team

The public formed interfaces with health system actors (such as health managers-SCHMT, CHMT, and Facility-in-charges) in the process of sharing public feedback. Health system actors also interacted among themselves after receiving feedback from the public as illustrated in Fig 6.1 (green section). Most of the interactions amongst HS actors were aimed at generating responses to public feedback. A few interactions were related to supporting feedback mechanisms to function well, and therefore indirectly impacted the process of receiving feedback. Health system actors such as health managers and health providers also interacted with non-health system actors within the broader public sector (purple section of Figure 6.1), such as actors in the County Department of Finance and the County Public Service Board. The exercise of power at these interfaces affected how feedback mechanisms functioned, and whether HS actors could generate responses to public feedback. These interactions are examined in more detail in the sub-sections below in relation first to processes of receiving feedback, and second to the functioning of feedback mechanisms and generation of responses to this feedback.

6.3 Actor interactions and exercise of power in relation to receiving public feedback

Study findings suggest that, overall, HS actors received little feedback from members of the public. Table 6.1 below illustrates how at the various actor interfaces the exercise of invisible and hidden

[14] The interactions with the CHC are presented with broken lines because CHCs were inactive in the case study SCHMTs and HFCs and therefore were often not involved in receiving and responding to public feedback

power commonly led to the domination of the public by health system and broader public sector actors. The effects of these exercises of power included constraining the process of receiving public feedback and hindering the inclusion of vulnerable groups in participatory feedback mechanisms. These actor interactions and their consequences for responsiveness are discussed below.

Table 6.1: Actor interfaces, practices and forms of power concerning receiving public feedback

Row Number	Actor interface	Exercise of power		Observed effect on responsiveness element
		Forms of power	Practice of power	
1	Public/health managers/health providers	Invisible power expressed as low confidence and low awareness on how to share feedback by the public	Domination over the public	Hindered receiving of public feedback by HS actors
2		Invisible power of socio-economic concerns among the public and vulnerable groups		Undermined meaningful public participation by keeping the public from attending meetings which occurred when many people were at work
3	Department of Finance/SCHMT/public interface	The Department of Finance exercised hidden power over the SCHMT and the public by limiting the duration of public participation meetings to one day	Department of Finance dominated the SCHMT and public	Constrained receiving public input on planning, and budgeting for the health sectors
4	SCHMT/public	Invisible power of organisational norms among SCHMT members who were focused on service delivery indicators and paid little attention to public feedback channels	Domination over the public	Most of the feedback channels were poorly functioning; some mechanisms were not set up, limiting the amount of public feedback that was received
5	Public/HFC	Invisible power expressed in an organisational culture of electing only those that attended public meetings.	Domination of vulnerable groups	Resulted in little inclusion of vulnerable groups. The HFC had no youth, PLWD representation and few women representatives
6		Hidden power expressed in the restriction of elections of HFC members to village elders and/or household representatives		The absence of vulnerable groups from participatory feedback mechanisms limited the range of feedback available through HFCs
7	Public/HFC and Public/SCHMTs	Public exercised visible power by bypassing facility-level actors	Contestation over the public bypassing SCHMT and HFC to share feedback with senior county health and/or public officials, and political actors	Generated responses in some instances, but resulted in reactive responses that undermined system functioning in the long run
9	Public/Department of Finance /SCHMT	Public reactions to the exercise of visible power by the Department of Finance	Resistance and contestation by disrupting public participation meetings where the public did not get responses to queries about the county budget	Such disruptions discontinued public participation meetings, hindering any inclusion of public views or input into the budget

Abbreviations: HFC-Health Facility Committee; HS-Health System, PLWD-People Living With Disability, SCHMT-Sub-county Health Management Team

6.3.1 Forms and practices of power hindered receiving of feedback and inclusion of vulnerable groups in participatory feedback mechanisms

The actor interfaces highlighted in Table 6.1 above were formed during the process of receiving public feedback. The actors involved included the public, SCHMT and HFC members, the Department of Finance, and politicians. Across the case study HFCs and SCHMTs, the exercise of power prevented the public from sharing feedback and influenced the composition and functioning of feedback mechanisms such as HFCs and public participation fora.

Table 6.1 illustrates that invisible power was a predominant form of power associated with the domination of the public, expressed in several ways. On the side of the public, invisible power included a low understanding of how the health system functioned, a lack of confidence to share feedback, and socio-economic concerns that kept the public (particularly vulnerable groups) away from public participation meetings. Regarding the lack of confidence among the public to share feedback, one county health manager noted:

> *"The level of confidence is very low, because…and this I have seen for the longest time I've worked in the community…it is through the public forums that the public like talking, where they are many. So, they know if they talk, these other people will assist me but [when a member of the public is] alone... it's very hard, you [health manager] hear rumours, but when you try following up, they don't open up" (CHMT-002)*

The quote above and perceptions of facility-level staff about fear among members of the public suggested that invisible power was also expressed in socio-cultural norms that created a reluctance to criticise health providers, and hindered the public from providing feedback:

> *"There's that fear of saying, first because you don't know who to tell, so we can say lack of knowledge about who to tell. Then [because] even if you know, you don't know how they will take it. Then thirdly there's fear because if you say a healthcare worker did something to you, you don't know if when you go to the facility you will be served, or they will fail to serve you." (HFB-003)*

Invisible power was also expressed in a status quo of low participation, as the public appeared to act against their interests by failing to show up for public participation meetings. One MCA perceived that this was linked to the low value attached to public participation meetings as a mechanism for sharing public input. He stated:

> *"Even those from the nearby areas cannot be counted on to attend [public participation for budgeting & planning], the informed people are busy at work, they do not take time off work to attend the participation meetings... the ones who are not formally employed, they*

are constrained by cost concerns, they say…I cannot waste a day at that meeting when all that is given is water" (MCA-004)

On the health providers' and managers' side, invisible power was expressed in the form of organisational norms, first in relation to the selection of HFC members, and secondly in the tendency for the SCHMTs to rely mainly on service delivery indicators for decision-making, rather than a combination of these indicators and information from unidirectional feedback mechanisms and broader participatory processes of participation. This organisational norm of relying heavily on service delivery indicators may partly explain why there were several mechanisms proposed for collecting public feedback but most of them were reportedly non-functional (see section 5.2). Related to non-functional feedback mechanisms, Figure 6.1 above draws attention to one non-functional mechanism, the Community Health Committee (CHC) represented in broken lines to show the expected link on paper to HFCs. On the ground, however, the CHCs were neglected and none of the case study SCHMTs and HFCs reported an active community health committee. Yet these were also avenues for community participation and could have served as feedback mechanisms.

During the selection processes for HFC members, at the HFC/public interface (Table 6.1, Row 5-6), vulnerable groups (PLWD, HFCs) were dominated by being excluded from HFC membership. This was an exercise of invisible power given the unconscious way in which local chiefs and health facility managers perpetuated election of those who showed up at the chief's baraza, a practice which influenced HFC composition. Members of these vulnerable groups often did not show up to the community barazas where the election of representatives took place. Yet, there was no indication that there were specific efforts made to ensure their attendance. Failure to attend meant that these groups, for example, the youth did not receive much of the public health sector information relayed to the public through the chiefs' *barazas*. Several HFC members held the view that '*the youth ignored attendance of these meetings, and so were responsible for their lack of awareness about health service issues*.' However, youth were kept away from these *barazas* by the invisible power of structural issues such as socio-economic concerns. The chief's barazas were held during the day, at a time when most youth were at work. The kind of work most of the youth did in the facility's catchment area paid a daily wage. Therefore, a missed day of work meant that they would not have an income.

In Facility C the chief and village elders dominated the public by restricting the election of HFC-C members to either *Nyumba Kumi*[15] representatives, or village elders. This was an exercise of hidden power because people already in powerful roles controlled who could participate as HFC members.

[15] Nyumba kumi is a strategy of anchoring Community Policing at the household level or any other generic cluster. In the Kilifi context, this cluster is usually every ten households in a village

Given that the village and household representative roles were mainly occupied by middle-aged men, a consequence of electing HFC members from only among them was the exclusion of vulnerable groups. HFC-C comprised nine elected community members, but there were only two women HFC members and no youth or PLWD representation. One FGD respondent noted:

> *"We have started by saying that we elect each other as village elders, those who are elected are village elders, so, how hard an individual works or how industrious someone is, is what will make you be called there, and the way you live in the community, that's what will make them choose you to be in that position, so it doesn't matter to have men or a few women, it's the way you serve the community."(HFC-D003)*

The Department of Finance limited resources for public participation processes to a single day for multiple departments within the county government. Requests by SCHMT members to extend the number of days for public participation were met with a response by Department of Finance representatives that *'resources for public participation were only allocated for one day' (SCHMT-A005)*. Public views were cut short to make room for every department to present its budget proposals. This was evidence of hidden power exercised by the Department of Finance (Table 6.1, Row 2-3) since budgeting issues were taken off the discussion table. At this interface too (Department of Finance/SCHMT/public) invisible power and hidden power interacted to result in the domination of the public by constraining the process of receiving public feedback. This is because, as noted earlier, invisible power (reflected in the public's socio-economic concerns) kept most of the public away from public participation processes while the few who attended had inadequate time to express views and ask questions.

6.3.2 Public's power practices in reaction to constraints to sharing public feedback

Even though the public was commonly dominated as illustrated in the section above, the public themselves exercised their agency by, *bypassing* feedback mechanisms at lower health system levels to engage with higher-level system actors, using social media to share public feedback and resisting public participation exercises that they perceived to be a mere formality (Table 6.1, Row 8-9). Thus, informal feedback mechanisms for receiving public feedback evolved out of the public's power practices in response to perceived low responsiveness. Gaventa describes claimed spaces as those formed by less powerful actors from or against the power holders[195]. Claimed spaces may form as a result of popular mobilisation, or around identity or issue-based concerns, or like-minded people coming together to debate issues' [205, 260]. In this study, the informal mechanisms I judged to be claimed spaces were not associated with members of the public who had a particular identity or specific issue-based concerns. However, these mechanisms ranging from social media, informal calls to local politicians and high-ranking county officials, and the use of mainstream media (Table 6.2) shared a unifying characteristic in that they provided an alternative avenue for public

voice to be heard by HS actors. Thus, I judged these informal mechanisms to be claimed spaces. These claimed spaces often included interactions across multiple levels of the health system and the broader public sector (see Table 6.2).

Table 6.2: Characterisation of case study spaces for processing feedback drawing on Gaventa's spaces of power

Space	Characterisation drawing on Gaventa's spaces of power	Levels where power was exercised
SCHMT	**Closed space**-comprised health managers only who received, discussed, and acted on public feedback without involving members of the public in decision making	Across sub-county and county levels
HFC	**Invited space**-The public was 'invited' by H/S actors (government) to participate in decision-making on PHC facility issues –financial management, and the link between the public and PHC facility	At the local facility level
Informal feedback channels-direct calls to senior health managers, county officials, social media	**Claimed space**-These were utilised by the public who bypassed the SCHMTs, HFCs and PHC facility staff to leverage a response from the health system	Cut across multiple levels as members of the public engaged senior health managers, county officials and political actors who had linkages to the local, sub-county and county levels

Abbreviations: HFC-Health Facility Committee, PHC-Primary Healthcare, HFC-Health Facility Committee

The public's power practice of evolving claimed spaces in reaction to being dominated by HS and non-HS actors was aimed at challenging or neutralising unequal power structures. However, these claimed spaces mostly failed to change the power imbalances observed between members of the public and more powerful actors. For example, concerning public participation meetings, the public reportedly did not know until the following financial year whether and why (or why not) their views on the previous year's budget had been taken up. Thus, there were instances where the public due to the frustration of feeling unheard, *disrupted* the public participation meeting for the county budget. When the meetings were aborted, the county bureaucrats still dominated the public by adopting the budget as it was, even when it had not been fully discussed. In these instances, the public was unable to tilt power in their favour. In describing the public participation exercise for budgeting and planning, both case study SCHMT members acknowledged that there was little meaningful public participation.

> "*My attendance is not consistent, it is not a guarantee that you will always be invited [to the public participation meeting] ... these budgets once they are already done, they are done, going back to the drawing board it's expensive. Now redoing it, it's not very easy like I have told you most of the time it's like a ceremony, you see this is what we have done,* ***so maybe their [the public's] suggestions do not count much yes, they [the public] have to swallow it the way it is****" (SCHMTB-006, my emphasis)*

"We decide for them [the public], that's what happens which is not right…the constitution promotes public participation, but it is not participation on paper whereby you can prove participants signed your list. No, it is where their views are taken into consideration. Up to what level did you implement what they requested; you know that is public participation. But in our case, unfortunately, sometimes we present an attendance list, which is not enough" (SCHMTA-005)

A closer look at the claimed spaces highlighted in Table 6.2 suggests that perhaps the reason these claimed spaces had challenges was their transient and fragmented nature. These claimed spaces were mainly used by the public as a last resort when they perceived existing feedback mechanisms were inadequate for voicing their concerns.

6.3.3 Actor lifeworlds underpinning practices of power in relation to receiving public feedback

Table 6.3 below highlights that in relation to receiving public feedback, power relationships embedded in the organisational and social positions of actors appeared to be the predominant lifeworld underpinning actors' exercises of power. Across varied forms of power, practices of domination and control were commonly exercised by those in higher societal or organisational positions. For example, in Table 6.3 (Row 1), *societal power relationships* reflected in the social status and respect accorded to healthcare workers enabled domination of the public. This lifeworld created a power imbalance between the public and HCWs that perpetuated the practice of the public not providing feedback. At the public/SCHMT/Department of Finance (Row 4), *power relationships at the organisational level* reflected in the organisational power and budgetary control of the Department of Finance underpinned the Department's domination over the public and SCHMT. As actors with responsibility for ensuring that the county budget met the required constitutional timelines, the Department of Finance appeared to prioritise meeting the budgeting and planning timelines over meaningful public participation.

Table 6.3: Underpinning actor lifeworlds at observed actor interfaces and practices of power

Row Number	Form or practice of power observed at actor interface	Underpinning lifeworld elements		
		Positional power relationships	**Personal concerns/Characteristics**	**Social, cultural Ideological worldview**
1	Invisible power hindered the public from sharing feedback at the public/health provider/health manager interface	Social status and respect accorded to HCWs by members of the public	Public's previous negative experiences with HCWs; Concerns among the public about victimisation after sharing feedback	
2	Members of the public bypassed HFCs and SCHMTs to share feedback with senior county and health managers, and political actors	Public's social connections to political actors and senior county officials HS managers had indirect accountability to political actors	Political actors and political appointees' interests to appeal to a voter base	Public's belief in their right to air grievances
3	Contestation over the public's bypassing of HFCs and SCHMTs, and use of social media to share feedback		Concerns among health ex-officio HFC members and SCHMT about their facility/department reputation	
4	Domination of the public and SCHMT by the Department of Finance by limiting the duration of public participation meetings	Organisational power and budgetary control of the Department of Finance		
5	Control and domination over payments for SCHMT activities to support the training of newly elected HFC members	Organisational power and budgetary control by the Department of Finance		

Abbreviations: HCW-Health care worker, HFC-Health Facility Committee, SCHMT-Sub-County Health Management Team

While most instances constraining receipt of public feedback were linked to organisational and social power relationships, other actor lifeworld dimensions such as personal concerns or characteristics also underpinned power practices that kept the public from sharing feedback. For example, at the public/health manager/health provider interface (Table 6.3, Row 1), societal power relationships interacted with the *personal concerns* of some members of the public that they would be victimised to constrain them from sharing feedback. The fear of victimisation was illustrated by interviewee's reports that members of the public who had had negative experiences at the hands of HCWs hardly ever reported those incidents. Hence, health managers perceived that most members of the public lacked the agency to share feedback. One respondent observed:

> *"It is like there is a code that people have, see no evil hear no evil. I'm telling you most of the time the complaints that you hear, come from one person who is probably new in the community, or an outspoken person in the community. Only 1 or 2 or 3 they are the ones who will raise an issue when you ask, is this true? But in a public forum, you will get*

surprised at how many people have gone through the same thing in the past and they have never reported yes" (CHMT002)

"There's that fear of saying, first because you don't know who to tell, so we can say lack of knowledge about who to tell. Then even if you know, you don't know how they will take it. Then thirdly there's fear because if you say a healthcare worker did something to you, you don't know if when you go to the facility you will be served or they will fail to serve you." (HFB-003)

As noted in the previous section (6.3.2), despite the public being commonly dominated, some members of the public exercised agency to reclaim some power to share feedback. The public's power practices were enabled by two actor lifeworlds: *societal power relationships*, revealed by the public's political connections and *ideological worldviews* reflected in a perceived increase in the public's awareness of their right to air grievances. Respondents across the case study HFCs and SCHMTs perceived this awareness to have increased following broader governance changes (devolution). Several members of the public reportedly had the confidence to go directly to the senior county officials and local politicians because of the proximity afforded by the recently (since 2013) devolved context of the health sector.

"Because you know the community member of today is empowered and hence knows all his/her rights. You will find that when others get problems, they look for leaders sometimes even call them to inform them of what they saw while being given service. For example, someone may call the County Secretary or call me the ward administrator directly and tells me, I have been to this health centre, this happened, and I wasn't pleased" (FGD-002)

A reinforcing lifeworld that further enabled the public's exercise of power was on the politician's side. Many political representatives and senior county officials (often political appointees) freely gave their contacts during social gatherings and meetings with the public. Underpinning these leaders' orientation to public feedback were two interacting actor lifeworlds: a desire to appeal to their voter base which reflected their *personal concerns* to maximise their chances of being (re)elected and the organisational *power relations* manifested in the authority of politicians and senior county officials to whom health system actors were indirectly accountable.

Despite acknowledging the public's right to share feedback, the public's action of using informal means to share feedback created tensions and contestation. In SCHMT-A and HFC-A, these contestations appeared to be underpinned by *personal concerns* about the image of the department (SCHMT-A) and a desire to maintain a positive image with superiors.

"But we don't want the public to go to the media, we don't want them to go to Facebook, to Whatsapp and Twitter. It is a way of communication, yes, but let them come to us, we shall listen, because when they go to the media, Facebook, Whatsapp...okay it creates a lot of concern, a negative picture to the department and we do not want to look like we are not working." (SCHMTA-001)

HFC-A members (particularly ex-officio members, who were public sector employees) perceived being bypassed by the public as ill-motivated and undermining protocol.

"If the main objective for the one that gave that information [to higher system level actors] is to get a solution to the problem, they should use the protocol but not go to the top, for example, do we call the president now and tell him everything and he has placed people even at the bottom? So, it depends with the complainants, he might be thinking maybe if I do that [tell the people at the top], these people [at facility-level] will be punished, maybe that is their aim" (FGDA-002)

The tension and contestation described above may have slowed down the generation of responses, given the unwillingness of the SCHMT and HFCs to receive public feedback through these informal mechanisms. In earlier sections of this analysis, 'protocol' was also used to lock out meaningful public participation through restrictions on duration of meetings. The preference for 'protocol' over informal feedback even at HFC level, further illustrates the power of public sector bureaucracy including how it operated at various system levels and how deeply ingrained it was. Nonetheless, these interactions in relation to the public's efforts to reclaim power have value for the process of receiving feedback because they illustrate actor lifeworlds that could be potentially leveraged to strengthen the process of receiving public feedback. These include for example the personal concerns of political actors and health system actors such as the SCHMTs and health providers.

6.4 Actor interactions and exercise of power in relation to the functioning of feedback mechanisms and generation of responses

This section builds on the findings presented in Figure 6.1 above, which highlighted that there were multiple interfaces formed within the health system (HS) (green, Figure 6.1), and across the HS with broader public sector actors (purple, Figure 6.1). This section explores the implications of different types and practices of power for supporting feedback mechanisms and generation of responses. I also consider in this section the actor lifeworlds underpinning the observed power practices. I present these findings in four parts. The first (6.4.1) considers interactions related to the functioning of feedback mechanisms (i.e., channels through which public views, concerns and inputs are received). The second (6.4.2) explores the reasons behind the exercise of power by considering which actor lifeworld dimensions underpinned the power practices identified in section

6.4.1. The third (6.4.3) considers interactions related to the generation of responses by the case study SCHMTs and HFCs, while the fourth (6.4.4) presents the underlying actor life worlds for practices of power identified in sub-section 6.4.3.

6.4.1 The exercise of visible power was associated with varied power practices and varying effects on the functioning of feedback mechanisms

How feedback mechanisms function is important because this has implications for whether they can pick up public feedback or not. The main feedback mechanism considered in this section is the HFC. Table 6.4 below (in rows two to five) highlights that the functioning of feedback mechanisms was mainly supported by the exercise of visible power. However, actors also exercised visible power resulting in negative effects on the functioning of feedback mechanisms. For example, the Department of Finance (Row 1) exercised visible power to undermine SCHMT activities that could support HFC functioning. Facility-in-charges exercise of power varied, in some instances supporting, while in others hindering the functioning of HFCs.

Table 6.4: Exercise of power in relation to the functioning of feedback mechanisms

Row Num-Ber	Actor interface	Exercise of power		Observed effect on responsiveness element
		Forms of power	Practice of power	
1	Department of Finance/SCHMT	Department of Finance exercised visible power to prioritise payments to suppliers over payments to SCHMTs that were intended to support the training of newly elected HFC members	Domination of payments made out to departments	Constrained SCHMT access to resources for training newly elected HFCs, indirectly constraining HFCs from carrying out their roles
2	SCHMT/NGO	Visible power of SCHMT managers (managerial authority) -Access to resources among NGOs	SCHMT-A and B collaborated with NGOs to support the training of newly elected HFC members, and reimbursement of CHVs for community-level activities	Training HFC members empowered them to carry out their roles including those of receiving feedback and communicating it to the facility-in-charge -Reimbursement of CHVs for community-level activities contributed to the retention of CHVs who provided feedback to HS actors
3	SCHMT/Facility-in-charge	Visible power of SCHMT managers (managerial authority) and Facility-in-charges' access to facility-level resources	SCHMT-B facilitated the functioning of the HFCs by negotiating with facility-in-charges to allocate some direct	A few trained HFC members who could carry out HFC functions including receiving and

			facility funds to training newly elected HFC members	responding to public feedback
4		Visible power-SCHMT exercised managerial power to overrule the facility-in-charge who wanted to put a stop to HFC community member monitoring visits	SCHMT-A facilitated the functioning of the HFC through the exercise of managerial authority that prevented the facility-in-charge from stopping HFC member monitoring visits	HFC members continued monitoring visits, an activity that supported receiving public feedback
5	Facility-in-charge/facility staff	Visible power-Facility-in-charge exercised managerial power by choosing to support monitoring visits by HFC members rather than stopping them	The health facility-in-charge facilitated the functioning of the HFC-A by explaining the mandate of the HFC members to his facility staff	
6	Facility in-charge/HFC	Facility-in-charge exercised visible power (access to resources) to enable HFC members to call and visit to share public feedback	The facility-in-charge facilitated the HFC-C role of sharing public feedback by cushioning the costs incurred by community members who needed to share feedback	Continued HFC monitoring visits supported learning about public feedback.
7		Facility-in-charge exercised visible power to limit HFCs actions to replace inactive HFC member	Contestation between elected HFC members and facility-in-charge about the replacement of an HFC member who was inactive	The area represented by the HFC member stayed for a long duration without representation

Abbreviations: CHV-Community Health Volunteer, HFC-Health Facility Committee, NGO-Non-Governmental Organisation, SCHMT-Sub-County Health Management Team

As noted above, visible power was associated with varying power practices. For example, at the Department of Finance/SCHMT interface (Row 1, Table 6.4), the exercise of visible power was linked to domination and control. Here, the Department of Finance prioritised payments to suppliers over payments allocated for training of HFCs by SCHMTs. This undermined HFC functioning as many newly elected HFCs remained untrained, and therefore could not carry out their functions including those of receiving and responding to public feedback effectively.

At the SCHMT level, the exercise of visible power was linked to more positive power practices (Table 6.4, Rows 2-4). These included collaborations with NGOs in both case study SCHMTs, negotiations with facility-in-charges to allocate facility funds to train HFCs, and over-ruling frontline managers who were resistant to the HFC's role of monitoring service delivery on the mandate of HFCs. Regarding SCHMT-A overruling PHC facility-in-charges and facility staff who resisted the HFC service monitoring function, this exercise of power supported the continued functioning of HFCs. One SCHMT member explained:

"In one of the facilities, the in-charge used to call me telling me that, "This chairman doesn't have any other work to do, he is always in the facility" but [the HFC chairperson] used to know every issue in that facility. The facility officers felt that the chairman was interfering, but I felt good because that chairman could walk from the facility to our [SCHMT] offices and tell us, this is what is happening and this we've done and this we've not done. So, I asked the in-charge, does the chairman come to sit where you are seeing the clients? "No". Now, what is the issue? The chairman comes, he is outside there looking at whatever things are happening… If he is affecting service delivery that you want to see your clients and he is here calling for a meeting during service delivery time, there we can discuss." (SCHMTA009)

The varying power practices associated with visible power were also observed at facility-level. For example, at the facility-in-charge/staff interface in Facility-A, the facility-in-charge exercised his managerial power to facilitate an HFC member to continue monitoring visits to the facility (Row 5, Table 6.4). This power practice strengthened the functioning of the HFC as a feedback mechanism. The HFC member through his visits reportedly picked up on feedback that the facility in-charge used to strengthen service delivery. However, in the same facility A, at the facility in-charge/HFC interface, there was also contestation about how to handle the issue of an HFC member who had become inactive in their role (Row 7, Table 6.4). Having inactive HFC members potentially hindered the process of receiving public feedback. At the time of data collection in facility A, there were only four active community members for an extended period, with one ward lacking an active representative for an extended period.

In HFC-C, interactions at the facility-in-charge/HFC interface appeared to be significantly different from other case study HFCs. The facility-in-charge exercise of visible power included facilitative practices such as ongoing engagement with the HFC members and cushioning HFC members' costs of sharing public feedback with him. For example, the facility-in-charge often asked the HFC community members to make 'reverse calls'[16] when they needed to call him to share some public feedback or reimbursed their [HFC members] fares when they made a physical visit to the facility outside of the scheduled quarterly meetings. All of these supported the functioning of the HFC to receive and respond to public feedback.

None of the other case study HFCs reported such practices. In the other HFCs reimbursement to members for facility visits was limited to quarterly visits. This may have been linked to varying amounts of funds available to the facilities as funds deposited in facility bank accounts often depended on facility workload. This is discussed in more detail in section 7.2.1

[16] A telephone service that allows a customer to make a phone call without airtime and the receiver of the call pays on the caller's behalf.

6.4.2 Actor lifeworlds underpinning power practices in relation to supporting the functioning of feedback mechanisms

Table 6.5 below summarises some of the actor lifeworlds that underpinned the power practices observed above in section 6.4.1.

Table 6.5: Actor lifeworlds underpinning power practices in relation to supporting the functioning of feedback mechanisms

Row Number	Form or practice of power observed at actor interface	Underpinning lifeworld elements		
		Positional power relationships	**Personal concerns/Characteristics**	**Social, cultural Ideological worldview**
1	Exercise of visible power and domination of SCHMT by the Department of Finance who failed to allocate payments for SCHMT activities such as training of HFCs	Organisational financial power and budgetary control by the Department of Finance		
2	Exercise of visible power for collaboration between SCHMTs and NGOs to train newly elected HFC members and reimburse CHVs for community-level activities	Managerial authority of SCHMTs; NGOs access to resources		Belief in the value of HFCs and CHVs as participatory mechanisms with a feedback role
3	Exercise visible power (managerial authority) to decline requests to stop HFC members' monitoring visits	Managerial authority over PHC facility in-charge and staff	Understanding of the oversight role of HFCs	Belief in the mandate of HFC members as a public feedback mechanism
4	Exercise of visible by HFC-A facility in-charge to facilitate continued HFC member monitoring visits by declining staff requests to stop community members from conducting frequent visits to the facility	Managerial authority over PHC facility staff	Understanding of the oversight role of HFCs	
5	Exercise of visible power by HFC-C facility in-charge to facilitate elected community members to share public feedback with him by i) cushioning costs of sharing feedback and ii) planning for teaching sessions during HFC quarterly meetings that allowed more discussions of scenarios related to facility management including how to react to and respond to public feedback	Access to resources Professional expertise	Understanding of the oversight role of HFCs	Belief in the value of HFCs as a channel for learning about public feedback
6	Contestation between facility-in-charge and HFC members regarding replacement of inactive HFC member	Organisational power of facility-in-charge as head of the facility		HFC members belief in the active representation of catchment areas linked to the facility; Facility-in-charges belief in procedural replacement of inactive HFC member

Abbreviations: CHV-Community Health Volunteer, HFC-Health Facility Committee, HS-Health System, NGO-Non-Governmental Organisation, SCHMT-Sub-County Health Management Team

In Table 6.5 for each of the practices of power, I have presented the actor lifeworlds that contributed to the observed exercise of power at the specific actor interfaces. Table 6.5 illustrates that most of the observed power practices appeared to be underpinned by organisational power relationships. For example, collaborative practices between SCHMTs and NGOs were underpinned by power relationships specifically their SCHMTs' *positional authority as managers,* which they leveraged to seek NGOs' support for CHVs, and NGOs' *access to resources* and desire to achieve their objectives (Table 6.5, Row 2).

The SCHMT/NGO collaborations mentioned above were limited because few NGOs supported health system governance programmes or interventions at the community level in this study context. One SCHMT manager reported:

> *"You know the NGOs are not many but sometimes in one region, you'll find a partner that is not supporting governance directly but for their activities to happen the governing structure must be on board. So, now in that way then we [SCHMT] get support to facilitate training sometimes we train like even if one-day orientation, or a 2-day orientation then it's done so that this partner can also come in with their objectives and describe how they hope the HFC can facilitate this partner in achieving their objectives, and in that, of course, we as a department are also achieving in terms of our agenda." (SCHMTA009).*

These collaborative practices with NGOs were necessary because top-down flows of visible power within the county government bureaucracy frequently undermined the support SCHMT members could provide for feedback mechanisms. This happened even when the SCHMT had planned for and received approvals of their Annual Work Plan (AWP) activities that included, for example, the training of newly elected HFC members. In this case, *positional power relationships* reflected in the County Treasury's (Department of Finance) budgetary control and access to county revenue, underpinned the domination of the County Department of Health (CDoH) and in effect the SCHMT by prioritising payments other than those to the SCHMT allocated for training of HFCs. One SCHMT member noted:

> *"When we make requests to do an activity like [HFC] training, the requests wait for a long period, sometimes a year or more, or the requested funds do not come at all…in fact, to get the monies [for planned activities like training] because any time there is money at the treasury, they have other priorities like, the suppliers have not been paid…. so, when you go to the treasury you are told there is no money, your voucher is still pending" (SCHMTA-009)*

Table 6.5 above also highlights the interaction of various actor lifeworlds in underpinning observed power practices. For example, where facility-in-charges acted to support HFC feedback functions such as in HFC-A and HFC-C (Row 4-6), their exercise of power was underpinned by their

organisational *power relationships* reflected in their managerial role and authority as facility-in-charges, *personal characteristics* revealed by their understanding of the oversight role of HFC members, and their *worldviews* which manifested in a belief in the mandate of the HFC that included receiving public feedback. In the case of Facility-C, where the facility-in-charge cushioned HFC members' costs of sharing public feedback, this power practice was enabled by *power relationships*, specifically his access to facility resources. This lifeworld interacted with this *ideological worldview* reflected in how he valued the HFC role of relaying information between the facility and the public. This in-charge explained:

> *"I told them [HFC-C members] if somebody has some feedback about this place, just come, I can give them transport as I give my staff when they go to get drugs. That transport helps them to bring feedback. So, I say, here take Ksh 200, it's not what you usually get [when they attend quarterly meetings] but you've taken the time…they go away happy. In other facilities, HFC members bring feedback, but they get nothing, and they have left their work. It's not right. Sometimes, HFC members say, send me airtime, Kshs 20, I tell you something, I tell them, you make a reverse call or send a 'please call me', I will call you. Because I'm entitled to some money for airtime. HFC members have a lot from the community for us, and we have got a lot from the facility for them and what I am after is to make sure that everybody is helped." (HFC-001)*

Despite the power practices to support HFC functioning discussed above, sometimes contestation between actors appeared to undermine HFC functioning. For example, in Facility-A at the HFC/facility-in-charge interface, contestation about replacement of an inactive HFC member resulted in inaction for a long period, over one year. This contestation was underpinned by differing worldviews. On one hand, the HFC community members' *worldview* was reflected in the belief that continued active representation of every catchment area was important, while the facility-in-charge held the belief that it was more important to be procedural in replacing the inactive HFC member by taking time to meet with her and dig deeper to understand her reasons for being inactive.

6.4.3 The exercise of power had mixed effects on the generation of responses

This sub-section presents findings about the exercise of power in relation to generation of responses to public feedback. These findings are summarised in Table 6.6 below, which illustrates that overall, there were mixed effects of the exercise of power on responsiveness. Invisible and hidden power, observed to be associated with dominating and controlling power practices appeared to hinder responsiveness. Visible power, commonly associated with facilitation seemed to enable generation of responses across the case study SCHMTs and HFCs. Table 6.6 also shows that the form (or content) of feedback often influenced responsiveness including whether a

response was later communicated to the public or not. These findings are discussed in more detail below, beginning with interactions at SCHMT-level and followed by interactions at HFC-level.

Table 6.6: The exercise of power in relation to generation of responses to public feedback

Row number	Actor interface	Exercise of power		Observed effect on responsiveness element
		Forms of power	Practice of power	
1	Public/health managers/health providers	Invisible power-An organisational culture of defensiveness when the public raised concerns about medical negligence.	Domination of the public by health managers and health providers	• Few responses were generated to complaints about medical negligence • Responses on medical negligence issues were hardly ever communicated to the public
2	Public/health managers/health providers	Hidden power by higher-level HS actors 'removed' issues of medical negligence from discussion in the public domain	Domination of the public by HS actors in matters of perceived medical negligence	Few responses to public feedback related to perceived medical negligence
3	HFC/SCHMT	SCHMTs exercised visible power (managerial authority) to respond to public feedback related to poor HCW conduct	SCHMTs had dialogue and mediation with HCWs about whom negative public feedback was shared	Response to public feedback was generated but change was reportedly slow
4	SCHMT/CHMT	CHMT exercised visible power (hierarchical managerial authority) over SCHMT by failing to communicate back to SCHMT	Tensions and contestations at SCHMT/CHMT interface	SCHMT were often reluctant to share feedback with CHMT
5		CHMT exercised hidden power over SCHMT during health sector planning and budgeting. The SCHMT were commonly unaware of what was included in final health sector consolidated budget	CHMT dominated SCHMT by not providing timely access to budgets to support	Few responses to health sector budget and planning questions raised by members of the public.
6	SCHMT/MCA/public	SCHMTs exercised visible managerial power: i) to encourage MCAs to lobby the CHMT and the Executive to generate responses to public feedback ii) over MCAs and the public by failing to act on issues perceived to promote unfairness	Both case study SCHMTs facilitated generation of responses by encouraging political actors to engage CHMTs	Resulted in generation of responses in several instances in relation to construction of infrastructure, purchase of equipment.
7	SCHMT/MCA/Public		Failure to act when MCAs called SCHMT members in attempts to get preferential treatment for members of the public connected to them	Promoted fair treatment of members of the public who were waiting for services
8	HFC/Facility-in-charge	HFC members exercised visible power drawing on their oversight mandate for service delivery	Negotiated with the facility-in-charge in Facility B to have staff meetings in the middle of the week rather than on Monday mornings to	Generated a response to public feedback about long waiting times

			reduce patient waiting times	
9			Dialogue with facility-in-charge about specific HCW's conduct (for example lateness in starting service delivery), and performance in Facility A, B, C, D	Often resulted in a reduction in complaints about HCW conduct except in Facility D where there was perceived to be a long-standing problem
10		HFC members exercised visible power drawing on responsibility for financial management	Approved purchase of drugs using facility-level funds in response to complaints about drug stock-outs in Facility C	Generated a response that alleviated shortage of drugs for specific categories of drugs in Facility C.
11		HFC members exercised visible power drawing on their oversight mandate for service delivery	Tensions and contestation in Facility D over perceived slow and ineffective responses by facility-in-charge to public feedback about poor HCW conduct	Strained relationship between HFC members and Facility staff (including facility-in-charge) which undermined the functioning of the HFC
12	HFC/MCA	MCAs exercised visible power to generate responses to public feedback received from HFCs	MCAs facilitated generation of responses using personal resources, lobbying the County Executive for the inclusion of public priorities in the County Budget	Resulted in facility-level responses to service delivery where drugs, and other supplies were purchased as needed. (Facility-C)
13	HFC/NGOs and private businesses	HFCs exercised visible power to mobilise resources from NGOs and private businesses such as by making requests for the purchase of drugs, and to fill in staffing gaps	HFCs facilitated generation of responses for drug stock-outs and under-staffing	NGOs and private businesses commonly responded by meeting requests in kind e.g. providing drugs, employing a nurse for the facility (Facility-D)

Abbreviations: CHMT-County Health Management Team, HCW-Health Care Worker, HFC-Health Facility Committee, HS-Health System, MCA-Member of County Assembly, NGO-Non-Governmental Organisation

Interactions between SCHMTs and other actors

From Table 6 .6, the exercise of invisible and hidden power appeared to undermine responsiveness by hindering generation of responses and communication to the public. For example, at the public/health provider/health manager interfaces (Row 1), responsiveness to service delivery concerns were weakened by the invisible power of an organisational culture of defensiveness. This defensive mindset hindered the extent to which responses could be generated for public feedback. The public were therefore often dominated by SCHMT managers and healthcare providers who appeared reluctant to be held accountable particularly for public feedback related to medical errors or negligence. One county health manager noted,

"Like for example when interrogating people that were on duty that day [when a mother had a stillbirth delivery perceived by the public to be due to medical negligence], most of them would ask you, we had 21 deliveries that day, what makes this one unique? Was it because her baby passed away and every day babies are passing away in maternity so, it makes it . . . sometimes internally it looks like a normal occurrence that occurs...and is unpreventable." (CHMT-02)

Table 6.6 also highlights that the observed culture of defensiveness was reinforced by hidden power (Row 2) which weakened responsiveness by limiting HCWs or health managers' responses during incidents of negative public feedback. High-level HS actors were reportedly the only ones who could issue a public comment about negative public feedback, but this was in practice a rare occurrence. The public was thus dominated by health managers and decision-makers when feedback related to perceived negligence was taken off the table, and not discussed with the those who had raised concerns. One manager observed:

"You know we lose so many patients in the line of duty and it's unfortunate. Had it [death of a patient due to perceived medical negligence] happened in a private facility, probably there would have been an apology, but then in our public facilities, that never happens. As a staff in that facility, you are not allowed to communicate externally. We only communicate internally. We should escalate the issue to the department, and then if it's a public apology it comes from the department, not from the facility." (SCHMTA-05)

Sometimes, the exercise of power enabled responsiveness to public feedback. For example, at SCHMT-level, at the SCHMT/facility-in-charge/facility staff interface (Table 6.6, Row 3), SCHMTs exercised visible power to generate responses which included engaging individual HCWs in dialogue and mediating between conflicting HCWs or conflicting HCWs and HFCs. In instances where poor HCW conduct or conflict among HCWs was persistent, SCHMTs also transferred staff across facilities within their sub-county. Transfers were reportedly complemented by advice to the transferred HCW encouraging them to change:

"As much as we transfer [staff] we also do so with counselling, so we say…these are the things which have been here which have led to your transfer, now as you go there [to the new facility] please, this issue should not come back, so we just do with counselling and with caution" (SCHMTB006)

The exercise of visible power did not always support responsiveness. Table 6.6 (Row 4) highlights tensions and contestation at the SCHMT/CHMT interface that delayed response generation. Among SCHMT members, there was a prevailing sense that sharing public feedback upwards *'did not generate responses'* and was an invitation to have directions *'dictated to them [the SCHMT].'* Further the SCHMTs perceived, that the CHMT was 'too bureaucratic', which often led to delays in

generation of responses. For example, in response to requests by the public for the construction of public toilets at a PHC facility in sub-county B, SCHMT-B members exercised their managerial authority to engage a stakeholder who could support construction at the facility. At the time of data collection, this stakeholder had not begun the construction work they had agreed to support because the CHMT reportedly '*kept asking for letters' (SCHMTB-004).* SCHMT members reported that most responses from the CHMT were negative or 'no action' responses for which there was a lack of clarity on the rationale for the decision. One SCHMT-A member noted:

> *"...one thing that we have been lacking as a department I am sorry to say, we (the SCHMT) take our complaints [to the CHMT] but we don't get feedback that this can be acted on, and this cannot, and why it cannot be acted, we need to get that feedback," (SCHMTA-01)*

An illustration of slow generation of responses, and lack of clarity in the rationale for action at the CHMT level was a recommendation by SCHMT-A (in response to public complaints) to resume all the services that had been shut down in Facility-A, which operated as a COVID-19 isolation centre. However, at the time of data collection, only HIV care and treatment services had been re-opened, and the public in Facility A's catchment area had to seek treatment elsewhere. The CHMT and senior county-level decision-makers cited national-level guidance to have infrastructure that could separate COVID-19 patients from those seeking general OPD services before re-opening services to the public. SCHMT-A respondents reported a lack of information on why the construction of this infrastructure had not been prioritised to support the resumption of other services. In this instance, the CHMT exercised visible power to dominate SCHMT-A in their decision to maintain only COVID-19 isolation services, without offering information on why there were delays in construction despite public outcry at having to incur high travel costs to access a public facility. Facility A stopped offering Outpatient Department, Maternity and Maternal Child Health services to the public in November 2020 and only resumed in November 2021, following a decline in COVID-19 patients who required isolation.

The CHMT also dominated the SCHMT and limited their ability to generate responses when they exercised hidden power by failing to deliberate with SCHMT members who attended public participation for budgeting and planning on the content and rationale for the consolidated health sector budget (Table 6.6, Row 5). Thus, SCHMT members who did not have the power to agree to requests made by the public at these meetings, could also not offer explanations to the public concerning the content of the health sector budget. One SCHMT-A member explained:

> *"As the presenter [SCHMT member who had attended a public participation forum] I don't have all the powers to say fine, we will not open facility C, we will equip the level four facility within your ward for better service provision. I would have now to give that feedback to my*

supervisor, and the supervisor now forwards it to the CHMT for consideration" (SCHMTA-005).

Given the tensions at the CHMT/SCHMT interface, in efforts to be responsive to public feedback, the SCHMT sometimes exercised their visible power as health managers to encourage politicians (Table 6.6, Row 6) to engage the CHMT themselves. In this way SCHMT members facilitated generation of responses for public feedback about issues that required higher HS decision-makers to act:

"At times we tell the MCAs to contact the CHMT and through that, we also get some support, yeah, we tell them just go straight to the county and say there are no drugs, because at times when we [SCHMT] speak…they [CHMT] think we are part of the system and we should understand, but once the politician moves and makes noise about his people not being able to get a certain service that the county is supposed to provide then at times it helps, yeah" (SCHMT-001G)

Interactions between HFCs and other actors

Like the SCHMTs' experiences, visible power was the predominant form of power exercised to generate responses across the case study HFCs. Visible power was associated with practices such as negotiation at the HFC/Facility-in-charge interface to institute changes in response to complaints about long waiting times, delegation of responsibility (to facility-in-charge) to have dialogue with facility staff over HCW conduct feedback (across all HFCs), and consensus decision-making about the use of facility funds to respond to complaints related to drug stock-outs (Table 6.6, Row 8-10). In HFC-C members, approval of the use of facility funds to buy drugs following complaints of drug stock-outs evolved into a practice that was adopted even before complaints could be raised by the public. HFC-C (with the facility-in-charge) had identified drugs that they perceived to be essential such as chronic disease drugs, but for which there were frequent gaps in supply by the national-level supplier. They would then purchase these drugs to keep in stock to keep the public from missing them when they were prescribed. One HFC member stated:

"Right now, you cannot miss drugs for pressure [hypertension], asthma, and diabetes, we buy them. We have three drugs that we must purchase. That's what the committee agreed to because someone suffering from pressure or diabetes, the condition can kill at any time. So, the doctor must have those drugs so you cannot miss those drugs here, and we don't wait to be brought, we buy them" (HFCC-003)

Contrasting experiences were observed in Facility D where despite frequent dialogue with the facility-in-charge, HFC-D members, felt that many of the responses (particularly those related to complaints about HCW conduct) were ineffective. There were tensions and contestations at the HFC/facility staff interface, which at one point evolved into outright resistance when the HFC

chairperson declined to sign HFC minutes. The HFC minutes supported a change of signatory from the outgoing facility-in-charge (who had been appointed to the SCHMT) to the new facility-in-charge in the facility's bank account. The stalemate between the HFC community members and facility-in-charge over the change of signatory led to delays in the facility's access to funds, including for paying support staff salaries despite there being money in the facility account. The impasse was later mediated by the SCHMT who engaged the HFC chairperson, staff, and facility-in-charge in dialogue. However, these contestations between the HFC, the facility-in-charge, and facility staff contributed to perceptions by the facility staff that HFC-D were ill-prepared to carry out their functions, while HFC-D community members perceived the Facility-D staff (including their in-charge) as un-responsive. These interactions damaged the HFC/health provider relationship and undermined the functioning of the HFC as a feedback mechanism.

Finally, HFCs also exercised visible power by seeking out their local politicians (MCAs) and stakeholders such as NGOs and private companies (Table 6.6, Row 12-13) to mobilise resources in response to public feedback related to resource shortages at the facility level. The MCAs and NGOs in turn exercised their visible power drawing on their political authority (MCAs) and access to resources (NGOs). The HFCs' efforts bore fruit in the short term, for example in HFC-D, one NGO provided donations of drugs, and employed one staff to work in the facility's MCH unit. In HFC-A, the MCA engaged SCHMT and CHMT members and visited the county hospital to get drugs for the facility while in HFC-C the MCA purchased equipment to meet the facility's service delivery gaps.

6.4.4 Actor lifeworlds underpinning the exercise of power in relation to generating responses to public feedback

This section presents the actor lifeworlds underpinning the practices of power discussed above starting with SCHMT-level interactions, and then HFC-level interactions. These interactions summarised in Table 6.7 highlights that positional power relationships were again the predominant actor lifeworld supporting the exercise of the various forms of power and their related power practices.

Table 6.7: Actor lifeworlds underpinning exercise of power in relation to generation of responses to public feedback

Row num -ber	Form or practice of power observed at actor interface	Underpinning lifeworld elements		
		Positional power relationships	**Personal concerns/Characteristics**	**Social, cultural Ideological worldview**
1	Invisible power of organisational culture of defensiveness hindered generation of responses to feedback related to perceived medical negligence at the public/health provider/health manager interface	Professional position of health managers and frontline HCWs; Low knowledge of members of the public		Organisational norm of admitting liability
2	Hidden power manifested in the form of healthcare workers and sub-county health managers being restricted from commenting or responding to public feedback related to perceived medical negligence at the public/health provider/health manager interface	Higher-level county officials (Chief Officers and CEC) have positional authority over CHMT and SCHMT		Organisational norm of not admitting liability
3	Dialogue and mediation with healthcare workers conducted by SCHMTs in response to public feedback about poor HCW conduct at the public/health provider/health manager interface	SCHMT A and B Managerial authority over PHC facility staff	-Commitment to continuing service delivery; Concerns about the safety of HCWs	
4	Tensions and contestation at CHMT/SCHMT interface over appropriate responses to public feedback in relation to the construction of public toilets following public request	CHMT organisational authority over SCHMTs	Mistrust of CHMT intentions in delaying generation of response by SCHMT-B members	SCHMT Belief in the mandate to respond to public feedback at their level -CHMT belief in following due process
5	Tensions and contestation between CHMT and SCHMT over failure by CHMT to communicate a rationale for responses taken or lack of response to SCHMT members when SCHMT escalated issues to the CHMT	CHMT organisational authority over SCHMT;		CHMT belief that SCHMT were part of the health system and therefore were aware of system problems
6	SCHMT failure to respond to questions raised by the public concerning the health sector budget at the public/SCHMT interface	SCHMTs low access to information about the consolidated health sector budget; SCHMTs limited sphere of influence as		

		middle-level managers;		
7	SCHMTs' (A and B) efforts to generate responses to public feedback by encouraging political actors to engage with CHMT members	SCHMTs' awareness about the health system processes; MCAs' positional power and oversight responsibility for budget approval	Personal interests of local politicians to appeal to voter base	
8	SCHMT (B) failure to act on the feedback shared by MCAs, especially about waiting time	SCHMT managerial authority	Personal interests of local politicians to appeal to voter base	SCHMTs belief in fair treatment of all members of the public
9	Exercise of visible power across all HFCs by initiating dialogue with the facility-in-charge concerning public feedback	HFC mandate for oversight over facility delivery;		Belief that public sector workers should report to work and leave as per public sector working hours
10	Exercise of visible power by HFC-C members who approved the use of facility funds for the purchase of drugs during periods of drug stock-outs	HFC authority and control over facility finances	Commitment to ensuring continued service delivery	
11	Contestation between HFC-D members, facility-in-charge, and facility staff		HFC members' anger and frustration over perceived slow and ineffective responses to complaints about HCW conduct by facility-in-charge; Facility staff discomfort with confrontational HFC monitoring visits	Belief that defending the facility against bad publicity is an HFC responsibility

Abbreviations: CHMT-County Health Management Team, HCW-Health Care Worker, HFC-Health Facility Committee, HS-Health System, MCA-Member of County Assembly, PHC-Primary Health Care

Table 6.7 also highlights that within the SCHMT space, the specific elements of organisational *power relationships* varied. These elements included the professional position of health managers and frontline HCWs in relation to the public (Row 1), higher organisational positions of senior county officials over CHMTs (Row 2), SCHMT's managerial authority over frontline HCWs (Row 3) and the CHMT's managerial authority over the SCHMT (Row 4).

Though less frequently identified, other dimensions of actor lifeworlds interacted with organisational power relationships to influence power practices in generating responses at SCHMT-level. For example, concerns about the safety of frontline HCWs, and a commitment to continue

service delivery reflected the *personal concerns* of SCHMT-B members. This lifeworld coupled with managerial authority (*power relationship*) over frontline staff drove SCHMT-B members to urgently mediate the contestation between HCWs and HFC-D members in Facility D. One SCHMT-B member reported:

> *"So, we had to go down there, before the community protested. . .we thought we would have to take away our staff and close the facility. We did a series of meetings, we met the Area County Commissioner there, the ward admin, and we met the HFC and facility staff. We listened to all their complaints and then we came up with a way forward. After 2 weeks, we went back, we met the committee to evaluate, to observe how far they are, and there was some improvement, we had established communication between the HFC and the in-charge" (SCHMTB006)*

The *personal concerns* of politicians reflected in the desire to appeal to their voter base was also an important actor lifeworld underpinning power practices that supported generation of responses to public feedback (Table 6.7, Row 7). SCHMT-A members highlighted this while explaining why they engaged with MCAs. The quotes below draw attention to the organisational *power relationships* reflected in the political power held by the MCAs, and the MCAs' *personal concerns* manifesting in the interests related to winning elections.

> *"For me, I will do a report, facility A needs a delivery room, so, at the budgeting level, it is for the executive to decide, the money is not enough but do we prioritize facility A or B, you know the county is vast, and because of resources, we also need a political push. That is why I call MCAs and say mheshimiwa (honourable) this one will help you help the people. So, help me make this feasible…can you put money from your kitty or can you come and push the department. So, we also like, not play politics but also engage because I want a delivery room which will make things much better. I am thinking of my people. Yeah, I employ those tactics, it's not that I am going against my bosses but I'm just trying to be aggressive to get things done" (SCHMTA-007)*

> *"You know they[MCAs] are the ones who are given this feedback in the community and they are the ones who will give a Probox [a vehicle] because the ambulance is not available to ferry an expectant mother in labour, so they are the ones who feel this thing when they go down there and they will do what they can to help because that is where they will be judged when it comes to the re-election" (SCHMTA-006).*

Despite the positive experiences described above, interactions between MCAs and SCHMTs were sometimes contentious. For example, in SCHMT-B several members perceived that MCAs interfered with service delivery, and *'did not follow protocol'*. These SCHMT-B members also perceived that the oversight role of the MCAs was more appropriately carried out at the County Assembly than by

MCAs calling SCHMT members directly to share concerns raised by the public. Thus, for certain service delivery concerns (such as facility opening hours, long waiting times and HCW conduct), there was contestation at the public/MCA/SCHMT interface as multiple actor lifeworlds interacted (Table 6.7, Row 8). In these instances, the MCAs, on one hand, attempted to generate responses for public feedback, leveraging their *position* and political power, a practice underpinned by *personal concerns* to appeal to their voters and advance their political careers. On the other hand, the SCHMT failed to act on public feedback shared via MCAs, particularly where they perceived that the members of the public with political connections expected to be treated preferentially. This failure to act was underpinned by a *worldview* that public health service delivery should be fair to all. One manager noted:

> *"Those people who are highly connected normally call those influential people complaining of delays, but as service providers, we should not discriminate by virtue of position, financial or economic status. We should treat people equally, so you cannot let a person because he is connected to some big individual pass the queue while a mother who has come there as early as 6a.m, queueing the whole day, it's not justice. So, we find facts, and we respond according to the findings*." (SCHMTB-003)

Both case study SCHMTs appeared to be limited in generating responses to public feedback by top-down flows of visible power from the CHMT. This domination was not only underpinned by the *organisational power relationships* revealed by the middle-manager position of the SCHMT versus the more senior position of the CHMT. Rather, there were also differing worldviews underpinning the observed tensions and contestations at the SCHMT/CHMT interface. For example, in relation to SCHMT-B's efforts of resource mobilisation in response to public requests for public toilets, SCHMT-B members' exercise of power was underpinned by a *worldview* expressed in the belief that they were exercising their mandate of responding to public feedback, while the CHMT had a *different worldview* reflected in the belief that it was important to *'ensure that due process was followed' (SCHMTB-005).* A third actor lifeworld that underpinned the contestation at this interface was the *personal concerns* of SCHMT-B members who mistrusted some of the CHMT members whom they perceived to be looking for a loophole for informal payments in the form of kickbacks from suppliers when the tenders for the construction work were awarded:

> *"There's too much reporting up-wards, a lot of bureaucracy. For example, the public requested for toilets [at a PHC facility]. We [the SCHMT] found a stakeholder who is willing to support the construction, but we had to write a series of letters to the CHMT, first to inform them of the request, and then the CHMT wrote back to acknowledge the request. Then this letter was shared with the stakeholder who wrote another letter to state that they were willing to support the construction. This is like seeking permission to do what is already*

in our mandate. It brings unnecessary delay, and I think it is linked to creating a loophole for informal payments." (SCHMTB-05)

Within the HFC space, at PHC facility level, power practices related to generation of responses to public feedback were largely underpinned by organisational power relationships. These *power relationships* were reflected in the HFC's positional authority based on their formal mandate for facility oversight (Table 6.7, Row 9-10). Power practices in these instances were also enabled by other interacting actor lifeworlds such as, the *worldviews* of HFC members reflected in their beliefs about how workers in the public sector should conduct themselves. This belief was highlighted in the experiences of HFC-B members in responding to public feedback related to HCWs' lateness in opening the health facility and long-waiting times due to staff meetings held during prime service delivery hours:

"We took the visitor book and commented on it and the bosses [SCHMT] had to see it [during facility supervision visits], so it brought about a discussion, we talked over it and things changed so since they were civil servants reporting time was supposed to be at 7.30 by 8 you were supposed to have settled at work. We rectified that and things run smoothly" (HFCB-001)

"So that issue [delay in starting service delivery] was taken in with a lot of seriousness, we discussed and agreed with the in-charge that when the staff come here in the morning its only work that is being done, meetings are held after work, they sacrifice that time once in a week because they must do briefings. The public should not come here very early and wait for staff until 11 a.m. When you get there, you find the person you were to help has fainted, another one has died just because of you, you will claim it's an important meeting which we agree, but the services are required. So that issue was well received the in-charge took it up talked to the staff and right now everything is going on smoothly." (HFCB-002)

Like SCHMTs, HFCs also experienced some limitations in responding to feedback. Table 6.7 highlights the contestations at the HFC/facility-in-charge/facility staff interface in HFC-D, which appeared to be underpinned by HFC-D members' *personal concerns* reflected in the anger and frustration reported by HFC-D members at the lack of lasting solutions to the facility's challenges. This lifeworld interacted with the staff's *personal concerns* revealed by discomfort with the HFC's frequent monitoring visits to the facility. Facility D staff referred to these visits as '*visits that created tension*' and perceived that HFC-D members harassed the support staff (patient attendants, watchman, groundsman), whom they (HFC members) claimed to have employed (because they were paid by the facility-level funds for which the HFC had oversight). Another interacting lifeworld,

the HCW's *worldview* that the HFC members ought to defend the facility staff against negative public feedback, rather than being '*quick to fan the fire' (HFD-003)*, also appeared to underpin the observed contestation between facility staff and HFC members.

The contestation described above in HFC-D reflected an extreme situation in which multiple lifeworlds interacted to influence the overall functioning of the HFC. Other contextual factors at play in HFC-D and other case study SCHMTs and HFCs are considered in the subsequent chapter.

6.5 Chapter Summary

Overall, the power dynamics described in this chapter partly explain the weak responsiveness to public feedback described in Chapter 5. While some of the problems with responsiveness could be attributed to general systemic constraints, study findings suggest that actor relations and power dynamics contributed to many of these challenges. In this chapter, it has emerged that practices of domination and control were associated with the exercise of invisible and hidden power. Together, these forms and practices of power hindered HS actors from receiving public feedback and excluded vulnerable groups from participatory mechanisms. Study findings show that the public reacted to domination through resistance and contestation, power practices associated with the exercise of visible power. These contributed to the evolution of claimed spaces by the public, but these spaces were not always effective in restoring power to the public in terms of leveraging responses for feedback they shared.

Study findings on the functioning of feedback mechanisms illustrated that the exercise of visible power was associated with positive power practices such as collaboration, facilitation, and negotiation across the case study SCHMTs and HFCs. These practices supported the functioning of feedback mechanisms, and therefore receiving of public feedback. Visible power was also exercised to support the generation of responses to public feedback and was associated again with positive power practices such as mediation, negotiation, and resource mobilisation. However, in several instances, visible power was also linked to domination, tensions and contestations, and power practices that hindered the functioning of feedback mechanisms and slowed down the generation of responses.

The actor lifeworld analyses (Table, 6.3, 6.5 and 6.7) made it possible to identify the reasons why actors exercised power, and therefore factors that enabled and constrained responsiveness. It appeared that responsiveness to public feedback was strengthened when actors used their lifeworld experiences to support the functioning of feedback mechanisms, processes of receiving feedback and generation of responses. For example, positive power practices where HFC and SCHMT members exercised their agency to leverage political power supported the generation of responses to public feedback on issues within the interests and influence of political actors. These issues included infrastructure, capital-intensive equipment, and development planning. In

contrast, misalignment of the lifeworld constructs with an element of the responsiveness pathway often resulted in limited responsiveness. For example, actors used their organisational power to prioritise other department processes (for example at the Department of Finance/public/SCHMT interface), to restrict access to information (CHMT over SCHMT), and to remain unaccountable to the public (health managers and providers/ public interface).

The findings in this chapter illustrate that responsiveness practices were influenced by a complex interplay of practices of power. This complexity was illustrated by the multiplicity of actors, actor interests and varied interactions. It was not uncommon to observe multiple power practices at one interface, one actor lifeworld underpinning positive power practices in one instance, and negative power practices in another instance. These varied interactions in turn had varying effects on the functioning of feedback mechanisms, the inclusion of vulnerable groups, and receiving and responding to public feedback.

Chapter 7 : Understanding the influence of organisational context on SCHMT and HFC practice of responsiveness

7.1 Introduction

In this chapter, I present findings related to objective four, on how contextual factors influenced the practice of responsiveness in Kilifi County, including the implications of a health system shock. Some of the findings in this chapter expand upon and add depth to those already reported in Chapters 5 and 6, including, for example, system hardware barriers to the optimum functioning of feedback mechanisms (reported in Chapter 5, linked to revenue flows and resources in this chapter), and engagements between the public and political actors (reported in chapter 6, linked to oversight mechanisms and their limitations in this chapter). The contextual influences presented in this chapter appeared to cut across the case study SCHMTs and HFCs, but I offer HFC or SCHMT-specific experiences where relevant. The findings presented in this chapter are based on inductive analysis of the study data.

I have organised this chapter in two sections: in the first section I present findings focusing on the dynamic interaction between the health system and wider public sector contextual influences on HFC and SCHMT responsiveness to public feedback. In the second section I focus on a significant contextual factor influencing HS responsiveness at the time of my fieldwork: the Covid-19 pandemic and how public feedback was received and responded to during this period of significant 'shock' to the health system.

7.2 How health system and broader public sector factors influenced responsiveness to public feedback

I have organised the findings in this section around three broad themes which highlight the varying ways and extent to which contextual factors contributed to the weak responsiveness observed in this study. These themes include, influence of revenue sources, oversight mechanisms and provider norms, and are discussed in turn below.

7.2.1 Source, flow, and decision-making authority over funds across SCHMTs and HFCs

From interviews and document review data, the main source of financing for the SCHMTs and HFCs was the national government through the MoH and county government. Table 7.1 below presents the revenue sources for Kilifi County between 2018 and 2021, indicating that the main source of county revenue was the equitable share from national government. Other sources included conditional grants from national government and donors and own source revenue collected at the county level. More than 70 per cent of the county's budget was funded by the equitable share. Thus, timely intergovernmental cash flow was critical to the implementation of the county budget and had implications for the capacity of SCHMTs and HFCs to respond to public feedback.

Table 7.1: Revenue sources in Kilifi County

	Approved budget allocation						Percentage of the Budget funded from:				
Financial year		Equitable Share (Kshs Billion)	Conditional grants (Kshs Billions)	Own source revenue (Kshs billion	Cash Balances	Other sources of revenue	Equitable Share	Conditional grants	Own source Revenue	Cash Balances	Other Revenue
2018/19	12.86	10.83	1.06	0.79	0.18	0	84	8	6	1	0
2019/20	12.51	9.54	1.29	0.79	0.89	0	76	10	6	7	0
2020/21	14.1	10.44	1.64	0.834	0.63	0.6	74	12	6	4	4

Source: Controller of Budget Quarterly Budget Implementation Reports 2018/19 – 2020/21

Once received from national government, allocations to the CDoH were reportedly at the discretion of the county government, except for the conditional donor grants which went into a Special Purpose Account and were ring-fenced from re-allocation to other departments at the county level. At the time of data collection, PHC facilities also received direct funds into their facility bank accounts through three main mechanisms: *Linda mama* (Protect the mother), DANIDA funds and user fees foregone. DANIDA funds are an example of conditional grants from donors, while user fees foregone are a conditional grant from the national government. *Linda Mama* fees were disbursed through the National Health Insurance Fund (NHIF).

SCHMTs received resources from the county government for their support supervision and managerial activities in kind in the form of vehicles allocated to the unit and fuel. They also received some funds, which were a proportion (25%) of the funds collected from the hospital user fees, to plan for activities such as training and meetings with PHC facility managers. However, these funds first arrived at the hospital account before they could be released to the SCHMTs, who were then required to access the funds by way of imprest for their activities. There were often delays in the flow of funds, starting from national treasury to county treasury, and into the hospital account. The source, control over and availability of these revenues influenced the practice of responsiveness across the case study SCHMTs and HFCs as described below.

Financial accountability responsibility supported inward and upward accountability at the expense of attention to public feedback

Given that the government (county and national) were the primary source of resources, health managers' approach to supervision and performance management appeared to encourage accountability upwards to health system actors, rather than to the public. Most health providers and health managers paid relatively little attention to public feedback, undermining responsiveness. For example, SCHMT members reportedly only sought out public feedback when they perceived that performance indicators had declined:

"Most of the discussions will be just observations from [sub-county] officers…that services

in this facility, we feel they are not very good, probably because in the last three months some indicators have not been improving. But rarely will this come directly from a community member and it's not because the community members are satisfied..." (SCHMTA009)

Across both case study SCHMTs, health managers reported that they valued public feedback, however, this rhetoric appeared to be mismatched by health managers' focus during support supervision, as study findings from document review of SCHMTs and HFC minutes, and annual work plans suggested that measurement of responsiveness and monitoring of feedback mechanisms was uncommon. For example, while various indicators had been developed to monitor service delivery and health system activities, there appeared to be no indicators developed to measure receiving and responding to public feedback, and only a few feedback mechanisms were monitored. From document review, I found that the Kilifi CIDP (2013-2017) and (2018-2022) only had performance targets for the implementation of the Community Strategy, which were focused on increasing the number of CHWs during the implementation periods of the plans. SCHMT and facility Annual Work Plans (AWPs) also focused on the Community Strategy, and in the Kilifi CIDP (2013-2017) and (2018-2022), community dialogues conducted by Community Health Volunteers (CHVs) and Community Health Assistants (CHAs) were the only form of feedback mechanism for which targets were set. The inattention to monitoring and measuring receipt of and response to public feedback was further illustrated by findings that during performance management meetings with their supervisors, health facility staff and managers rarely discussed public feedback indicators:

"No…when we go for supervision, we normally check service delivery. Anything from the community we don't capture. Every SCHMT member goes to his section, the records person goes to records, the Public Health Officer goes to see his CHEW [and] the public health officers. The Sub-County nurse checks on the nurses. Everyone has his specific area but not on issues of public [feedback]." (SCHMTB003)

The absence of indicators for public feedback was acknowledged by health facility managers who reported never having seen indicators concerning public feedback, and by county health managers who confirmed ad hoc collection of public feedback:

"What we have [in the District Health Information System] is like the number of this and this but in terms of recording or documenting public feedback, there is a gap, but I'm sure, that [public feedback] can be summarized and passed to the higher levels …as the management, we need to look for a structure that is systematic because what we do is ad hoc… we need a system that collects information, collects those feedback [and shares them] upwards" (CHMT001)

This meant that issues of public feedback could easily be overlooked. Further, given the importance placed on indicators within the health system, their absence appeared to orient frontline providers and their managers away from public accountability. This contributed to a view from one of the SCHMT-A members '*that healthcare workers were not accountable to their clients they are only accountable to their supervisors'. (SCHMTA006)*

The lack of orientation to public feedback was further illustrated by how, in recent changes within the CDoH (Figure 7.1), there was a lack of clarity about which committee or focal person had responsibility for public feedback. At the time of the first phase of data collection in June 2020, there was a 35-member CHMT, which had a focal person for handling public feedback related to grievances about service delivery. There were also committees, for example, the county complaints committee that on paper linked to a sub-county complaints committee, which were expected to discuss complaints raised by the public. Other committees included a Human Resource advisory committee that received public feedback related to HCW conduct issues, and a Quality Advisory Committee that had the mandate to plan for satisfaction surveys. However, these were unaccounted for (even on paper) in the new CDoH structure.

> *Those [complaint] committees were established when we had the previous CHMT…after the disbandment, they were not coordinated well. Because, we had people, a person responsible for that, the health promotion officer was mandated to handle issues of grievance redress, but now, it's like health promotion was dissolved at the county level. At the programmes level now it's upon the focal person of each program to come up with ways and means of doing this" (CHMT002).*

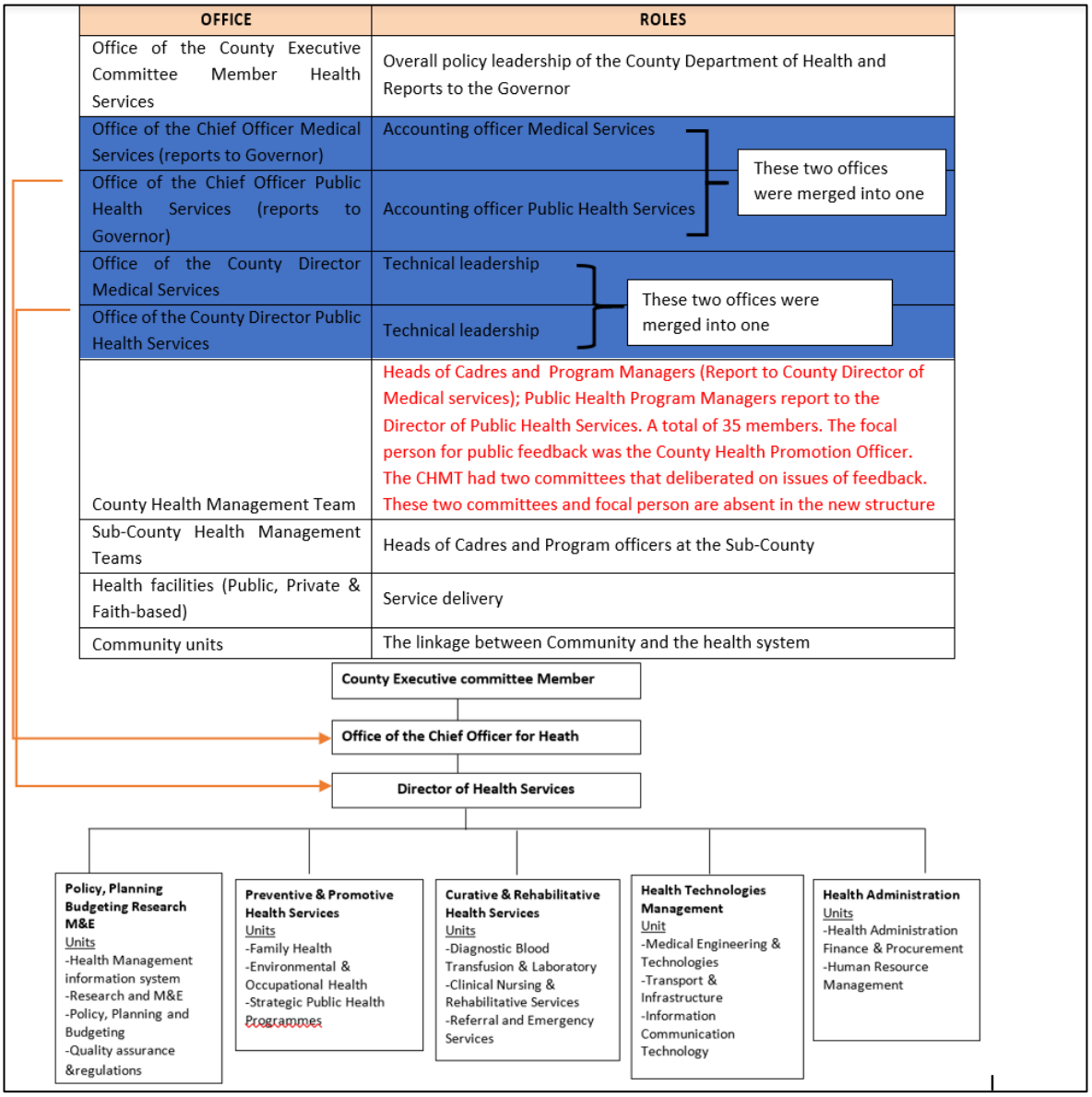

Figure 7.1: Changes in the structure of the CHMT during the data collection period
Source: Author (from document review and interview data)

During the second phase of data collection in June 2021, the new CDoH organogram had been in place for six months but there lacked clarity on which docket would handle public feedback issue.

Low decision-making authority over resources reduced the range of responses that could be generated by case study HFCs and SCHMTs

At the facility level, *Linda mama* and other direct facility-level funds were a resource through which HFCs could generate responses to public feedback. Ideas for spending facility funds were commonly presented for discussion to the HFC members by the in-charge, who sought their approval and informed the linked SCHMT of their plans. Despite HFCs' access to facility funds, they operated within the hierarchy of the health system and were limited in the extent to which they could spend facility funds to support responsiveness to public feedback. One respondent in HFC-C expressed frustration with this, noting the high level of workload at his facility, yet they could only spend a

specified amount of Kshs 30,000 per month to procure drugs when they were out of stock. The Facility-C facility-in-charge felt that this constrained them from responding effectively:

> *"We buy drugs, but we are limited, we can only buy drugs for Kshs 30, 000 per month. Tell me with 30,000 per month…you saw on Monday, on Tuesday, we are seeing over maybe 20, 000 outpatients and some drugs are very expensive like septrin [which is out of stock] one tin is Kshs 2000, I use four tins every week, that's 16 tins in a month. Will 30000 be enough? No, by the end of the month we have shortages of essential drugs." (HFCC002)*

Sub-county health managers acknowledged this limitation but perceived that the limit on how much HFCs could spend was important to meet requirements instituted at the national level, that any request for purchase above Kshs 30,000 for drugs would have to come from the county level to the national supplier. That this was a national-level regulation illustrates the limitations to decision-making even at the decentralised county-level government.

> *"[PHC] Facilities may have money to buy but there are some regulations that are not very favourable in terms of facilities just procuring drugs, especially when they are not procuring from KEMSA [national supplier of drugs]. And KEMSA in the last few about 2 years has not been very reliable in terms of fill rates [supplying what is ordered]. Still, anything that must be bought and it's not from KEMSA always must be referred to the county… we don't buy without referring to the county because of regulation, if you procure elsewhere, it becomes an audit query." (SCHMTA006)*

The case study SCHMTs were also limited in responding to public feedback about facility-level supplies, equipment, and infrastructure. For example, concerning drug stock-outs, while SCHMTs could re-distribute drugs in response to complaints about drug stock-outs at a PHC facility this was only a stop-gap measure until a drug supply was received from the national supplier, a factor that was outside the SCHMTs' control.

Further, concerning public feedback related to HCW conduct issues, SCHMTs reported that responses were limited to dialogue, mediation, and transfer of HCWs to other facilities. Transfer of staff was implemented as a last resort because a change in staffing in one PHC facility often required changes in other PHC facilities to ensure the adequacy of staffing and skill mix to support minimum service delivery. Transfers could not be done across sub-counties because SCHMTs influence was limited to facilities within their sub-counties. These challenges with authority in decision-making were worsened when the Universal Health Coverage (UHC) project at the national level, posted healthcare workers from the national level directly to the facility level, bypassing both the CHMT and SCHMT level. In SCHMT-A, this situation undermined the SCHMTs' authority further, as described by one health manager:

"At times these staff are posted direct from headquarters [MoH], for example, these guys who have been newly posted in the system, came directly from Nairobi. So, you hear a staff reported without the knowledge of the County directors. They are paid their salary direct from Nairobi. There was a case from XXX facility involving two staff employed through UHC. This case was reported by the public to a high-level officer. When we went to intervene, these two ladies, were even [challenging] us. One of those ladies recorded us on the phone so that she could report to the higher authority. Now that is insubordination, now imagine how will you act on such a colleague…" (SCHMTA002)

Inconsistent financial flows and significant resource deficits at facility and sub-county levels undermined responsiveness

The case study HFCs and SCHMTs reportedly operated in a context of inconsistent financial flows. Most of the SCHMT respondents reported 'delayed funds' as a reason for failure to train newly elected HFCs, or to continue support for changes initiated in response to public feedback. A manager in SCHMT-A noted:

Unfortunately, we were not able to sustain the mama open days, because last year [2020] the funds were not consistent. It wasn't any better this year [2021], people were just claiming but no funds. The mama open days depended on Linda mama funds from DANIDA. When these funds dry up, they cause a lot of things to stop. And the [NGO] partner was introducing it to us to allow us to sustain it (SCHMTA-007)

HFCs were also unable to generate responses to public feedback due to variations in how funds arrived at facility bank accounts. When facility funds were delayed, the HFCs reportedly prioritised payment of casual staff salaries. This meant there was little funding available to support the functioning of feedback mechanisms or for use in responding to public feedback.

"You see, we [at PHC facility] pay our support staff ourselves, so we can't have support staff going for four months without salaries and then when money comes in, we take that money and do an activity [outreach in response to a request from the public]. I think there's a challenge there. If the support staff were paid by the county like before, we would use those funds for activities where the public has raised concerns. We put all the activities in the Annual Workplan, but the funds are delayed. So, we must prioritize." (HFC-03)

The broader health system context of resource constraints (particularly infrastructural gaps and understaffing) also influenced the functioning of both case study SCHMTs and in effect their willingness and ability to respond to public feedback. For example, due to long-standing facility-level staff shortages, both case study SCHMTs frequently generated responses that appeared to

address public feedback in the short term (particularly for HCW conduct) rather than in the long term. As one sub-county health manager noted:

> *"All right, as I have said earlier, what we had to do was to talk because you cannot say [to a frontline HCW reported to have poor conduct], don't work here anymore, work in another area, because who else are you going to allocate to that area? So, ours was just to give the feedback, and ask probably the-in charge to talk to the named person, so that she may change her attitude" (SCHMTB-01)*

Staffing shortages were not only reported at the facility level. Across both case study SCHMTs, staff shortage was evident from the multiple roles that SCHMT members played, raising questions about SCHMTs' capacity to effectively pay attention to public feedback. For example, in SCHMT-A, the Sub-County Health Administrator served two sub-county teams (SCHMT-A and one other SCHMT in the county) and one sub-county hospital. In the same SCHMT-A, several members had county coordination roles for vertical programmes or coordinated more than one programme at the sub-county level. In SCHMT-B, the sub-county public health nurse also served as the sub-county focal person for vaccines. Further, in SCHMT-B, to cope with staffing challenges, the CHMT had directed that the SCHMT-B programme officers work from PHC facilities so that they could co-ordinate programmes at the sub-county level while supporting service delivery.

These resource deficits were reflected in the content of public feedback (section 5.4) which mainly included feedback related to inadequate resources. Further, though the CDoH was allocated the highest proportion of the county budget in comparison to other departments, these allocations were perceived to be inadequate. Document review of the county budgets for previous years was concurrent with these views. For example, analysis of the health expenditure for Financial Year (FY) 2016/17 to 2017/18 revealed that allocations to the CDoH were below recommended allocations that would guarantee the delivery of basic health services to the public in the County whether by NHIF cover or by the recommended health expenditure per capita by WHO (Table 7.2]).

Table 7.2: Resources allocated to Kilifi CDoH against expenditure

Estimated Population	Financial year	Allocation	Expenditure	Per Capita Expenditure	Cost of NHIF	% of per capita expenditure against NHIF	Cost as per WHO recommendations	% of per capital against WHO recommendation
1,545,211	2018/19	3,784,650,799	3,431,509,440	2,221	6,000	37%	8,600	26%
1,496,094	2017/18	3,124,111,953	2,982,445,186	1,993	6,000	33%	8,600	23%
1,447,670	2016/17	2,962,009,071	2,284,238,146	1,578	6,000	26%	8,600	18%

Source: Kilifi County Health Sector Medium Term Review 2020/21

This context of resource scarcity shaped the attitude (of SCHMTs) toward public feedback. For example, SCHMT-B respondents perceived that any satisfaction survey conducted would only highlight the negative aspects of service provision due to long-standing health system challenges such as healthcare worker shortages, and de-motivated staff.

> *"The staff providing services are often overwhelmed and they feel aggrieved because their welfare is not catered for. With two staff on duty at a health facility who are expected to run four departments (maternity, Child Welfare Clinic, OPD, HIV) there are bound to be complications when the staff divide the departments between themselves. If a complication arose in maternity, patients waiting to be served in all other departments will have to wait. If you do a satisfaction survey at this time you will not get the real picture of the facility." (SCHMTB004)*

This suggests that public feedback was a low-priority issue given the existing staffing challenges and related health worker demotivation which were perceived to be far more pressing issues. According to several sub-county health managers, '*they [health managers] were already aware of* most issues that would be picked up from the few satisfaction surveys that were conducted. These views combined with sentiments across both SCHMTs that conducting surveys would require additional resources from an already under-resourced health system appeared to keep the SCHMT from planning for resources for the conduct of satisfaction surveys specifically and oriented them away from public feedback more generally.

Given existing resource constraints, SCHMTs commonly interacted with NGOs as noted above to support the implementation of activities that met both SCHMT and NGO objectives. This had mixed effects. On one hand, where SCHMT and NGO objectives were related to strengthening the functioning of feedback channels, there was a positive effect on responsiveness (section 6.4.1). On the other hand, in some instances, activities supported by NGOs appeared to further divert SCHMT attention away from public feedback. For example, during data collection, between the months of August and September 2021, few weekly meetings were held across both case study SCHMTs (where public feedback might have been discussed) because many of the SCHMT members were out of the office attending and facilitating NGO-supported training. In SCHMT-A, a visit to facility-A that had been planned in response to a complaint raised by the public was frequently postponed due to the unavailability of quorum among the SCHMT members. Eventually, the facility visit was not done.

In summary in this section, study findings suggest that the source of revenue significantly influenced SCHMTs' and facility managers' attention to public feedback as they were commonly focused on fulfilling upward responsibilities to their supervisors. However, it was not just the source of revenue that influenced the practice of responsiveness. I also found that the funds from the national

government were frequently delayed. This negatively influenced the ability of the SCHMTs and HFCs to sustain changes made in response to public feedback or to support feedback mechanisms. Finally, the SCHMTs and HFCs had little authority over the resources allocated to them, which limited how responsive they could be.

7.2.2 Oversight mechanisms introduced following devolution had mixed effects on responsiveness

The literature suggests that reforms such as decentralisation and community participation bring formal oversight closer to the public and may encourage responsiveness to public needs and desires [20, 261]. A decentralised governance arrangement forms the broader context of this study. A form of oversight that might have enhanced responsiveness to public feedback therefore included political actors such as the Governor, MCAs, and politically appointed county government officials. This sub-section focuses on MCAs and the mechanisms through which they are expected to support responsiveness. On paper, MCAs could accomplish their oversight roles in three ways. First, they served as ex-officio members of HFCs, where they could present public feedback directly to facility in-charges. Second, was through the County Assembly health committee which received petitions from the public, conducted site visits to public health facilities, and had the power to summon the CEC and CHMT members to explain health system and service delivery gaps. There was also a County Budgeting committee of the County Assembly which conducted public participation to ensure that public views were incorporated into resource allocation decisions for all sectors of the county government. Third, MCAs could pass county-level legislation to enhance health system responsiveness. MCAs were also required to facilitate public participation during the development stages of county legislation. Public participation in such cases reportedly happened after a bill had been assigned to the relevant departmental committee of the Assembly. The specific committee was then expected to initiate public participation through varied means such as public hearings, inviting submission of memoranda, and consulting relevant stakeholders and experts on technical issues.

Study findings suggest that the interactions between the SCHMT, HFC and oversight mechanisms introduced by decentralisation had mixed effects on responsiveness. These interactions were characterised by 1) informal engagements that supported the process of receiving public feedback and promoted responsiveness in the short term; 2) little formal engagement with the public in avenues that could support political oversight; and 3) few system-wide and long-term responses linked to limitations on MCA political power. These findings are discussed in turn below.

Informal engagements supported the process of receiving public feedback and promoted the generation of responses in the short term

Study findings suggest responsiveness to public feedback was enhanced following decentralisation given the proximity of political decision-makers to the public. This appeared to be mainly through informal access to politicians and political appointees rather than through formal feedback channels. Some members of the public reportedly had direct access to politicians and senior county-level officials, and could call them to report issues or seek assistance:

> *"If you are very harsh to them [the public], you are very rude and just not considerate, you will end up finding yourself in a high office because they have the numbers of the governors, the top leadership in their arms and so I think that caused people to not be rough with the public" (SCHMTA004)*

As illustrated in the quote above, this kind of informal feedback appeared to shape health providers' and managers' responsiveness by triggering a fear of repercussions. Among the reported repercussions were incidents of HCWs being transferred across county departments and suspension for failing to act in response to public feedback as directed by a senior county official.

Most SCHMT-B members perceived this kind of 'oversight' as political interference. According to SCHMT-B respondents, some members of the public used their political connection to be prioritised for services. One SCHMT-B member reported:

> *"The member of the public calls the MCA who calls the governor, the governor calls the department [County Department of Health senior official], 'do this and this'... they impose what must be done, and you know there are others that need that service, and they are waiting in line, and this connected person calls so that they are served first. That's very unfair you see." (SCHMTB003)*

SCHMT-A members felt that it was unfortunate that political actors influenced processes within the health sector. However, they acknowledged that in their oversight role political appointees and elected representatives could be a mechanism through which the public could learn more about the health system, and through which health system actors could be supported to generate responses to public feedback.

> *"It's difficult that the politicians speak on our behalf, but I think waziri [CEC member for health] has a role. I don't know how but he has the role now to talk to the representative of the people, those are the MCAs [he should explain] 'that this is how the department [of health] operates; I know when you are in the communities there, you receive all manner of complaints, but this is the much we are doing and this is how things are running and these are…' So then once the MCA or the representative of the people understand our side of the*

story, maybe they will also in a way, either defend or if not defend then come with policies that will improve the situation" (SCHMTA006)

SCHMTs' discomfort with political oversight by MCAs appeared to stem from the approach used by several MCAs. These MCAs either bypassed facility in-charges and sub-county health managers to engage with the highest official in the department of health (the CEC member for health) or attempted to intimidate health providers by showing up unannounced at health facilities to confront staff about complaints made by the public. MCAs on the other hand perceived that facility-in-charges and health managers were often too slow to respond or withheld information when public feedback was unfavourable.

Despite the seemingly antagonistic interactions between MCAs and health managers, sometimes MCAs were able to generate some responses to public feedback at the facility level. For example, most MCAs attempted to respond to HFC requests related to supplies, equipment, and infrastructure, especially for supplies they perceived to be *'low-cost*.' However, these responses especially those that included the purchase of supplies by the MCAs (as illustrated in the quote below) were often a coping mechanism that did not truly contribute to a responsive system, as the responses generated were usually one-off or short-term, unsustainable, and tended to distort the role of the MCA.

"There is a day we had no food in the facility. We had no money to buy food, especially for the mothers who come there to deliver. One of the community members had brought their relative and I had to tell them, "Eeh today you will have to make alternate plans, we have no food". So, they were like, "what's the problem? "I said there is no money, and we are still waiting for facilitation from our higher authority. So, they went out. I thought they were angry, but they went and called the MCA. After a few minutes, I received food, like five bundles of maize flour, rice, and cooking oil and we were good to go." (HFA001)

The non-systematic nature of some of the responses generated by MCAs was perceived by several respondents to reflect the pressures faced by MCAs because of public expectations. From SCHMT and MCA interview data, the public expected that the MCA would respond to public feedback, even when the issues were not within the MCA's sphere of influence. The public then reportedly used the MCA's ability to generate responses to judge whether they would re-elect them. Responses such as MCAs purchasing supplies and equipment filled immediate needs and were possible because of the closer interaction between the public and their political leaders afforded by decentralisation. However, they were unlikely to promote system-wide, systematic responses to public feedback necessary to solve long-term issues or issues arising in multiple facilities and across health system levels.

Little formal engagement with the public through proposed feedback mechanisms

In addition to learning about public feedback from HFC members, MCAs could also receive public feedback through memoranda raised by the public, and during public participation meetings for county planning and budgeting and other county legislation. However, these formal engagement mechanisms were not commonly utilised by the public. MCAs reported that the public rarely submitted memoranda, a finding linked to the perceived low capacity of the public to develop memoranda. Further, there were practical hindrances such as requirements that a hard copy of the memo be physically delivered to the Assembly where it would be stamped by the County Assembly clerk and passed on for discussion.

Public participation meetings were also reportedly poorly attended resulting in little public feedback being picked up through this mechanism. One MCA noted:

> *"In these participation meetings, the public appear in such low numbers, you can find the social hall has about 200-300 people only, yet like this sub-county has over 100,000 voters" (MCA003)*

The costs associated with attending were a major hindrance. Most public participation meetings were held in the town areas of the county, which required that most people travel long distances which they could not afford. These meetings were also held during weekdays when most individuals were away at work. To encourage higher public turnout, public participation meetings were sometimes held at the ward level rather than the sub-county level to reduce the burden of attendance on the public. However, this was rare, and MCAs reported that it happened when there was external support from a sponsor. For example, a recent bill for which there was reported high attendance of public participation meetings was initiated by a Civil Society Organisation that had petitioned the County Assembly to legislate on issues of PLWD. The bill sought to provide for the rights and rehabilitation of persons with disabilities and to establish the County Board for Persons with Disabilities. The CSO also mobilised people by sharing timely information about the content and venue of public participation, and brought the participation meetings to the ward level, making it possible for more people to attend.

During the COVID-19 pandemic, given restrictions on gathering large numbers of people, public participation meetings were not held. The main mechanism to get feedback on the budgets was through memoranda, but this mechanism was not utilised by the public.

Institutional limitations to local political power hindered generation of responses

Interviews with MCAs revealed their limitations to responding to public feedback, particularly where feedback included requests for capital-intensive equipment and infrastructure. While MCAs had the role of budget approval and could lobby for the inclusion of public priorities in the County's

Annual Development Plan and later in the County Budget, these had to be in line with the broader County Integrated Development Annual Plan (CIDP). Further, the MCA reportedly had to be well-aligned with the County Executive. Thus, despite perceptions among the public and most health managers that MCAs wielded control over the Ward Development Fund, there were limitations on how they (the MCAs) could use it. One MCA reported:

> *"Even though there is a Ward Development Fund, this fund is not really at the discretion of the MCA, it's more of an agreement between the Executive and the MCAs, so the MCA can propose what projects are a [public] priority in his area, but the Executive, also has to 'agree'... for the Executive to agree…there also has to be some political goodwill from them." (MCA004)*

Generation of responses at county level through budget allocation was also hindered by delays in disbursements of funds from the national government. For instance, concerning public feedback about drug stock-outs, one of the MCAs acknowledged that there had been delays of up to three months in the national government disbursement to the county. As per the Public Finance Management Act 2012, the national treasury ought to disburse funds to the counties no later than fifteen days after the commencement of each quarter (Section 17 (6)). In practice, these were commonly delayed, particularly in the first quarter of the financial year as shown in table 7.3.

Table 7.3: Lag in national-level disbursement of funds to Kilifi County for FY 2019/2020 and 2020/2021

Financial Year 2019/2020				Financial Year 2020/2021			
Description	Expected date of disbursement	Actual Date of disbursement	Amount	Description	Expected date of disbursement	Actual Date of disbursement	Amount
Equitable share for July 2019	15th July 2019	19-Sep-2019	522, 225,000	Equitable share for July and Aug 2020	15th July 2020	13-Oct-2020	1,723,342,500
Equitable share for Aug & Sep 2019		25-Sep-2019	1,295,118,000	Equitable share for Sep 2020		22-Dec-2020	887,782,500
Equitable share for Oct 2019	15th October 2019	13-Nov-2019	835, 560,000	Equitable share for Octo 2020	15th October 2020	19-Jan-2021	835, 560,000
Equitable share for Nov 2019		06-Dec-2019	1,044, 450,000	Equitable share for Nov 2020		26 Feb-2021	887,782,500
Equitable share for Dec 2019		08-Jan-2020	940,005,000	Equitable share for Dec 2020		25-Mar-2021	835, 560, 000
Equitable share for Jan 2020	15th January 2020	31-Jan-2020	1,096,672, 500	Equitable share for Jan 2021	15th January 2021	16-Apr-2021	887, 782, 500
Equitable share for Feb 2020		26-Feb-2020	940,005,000	Equitable share for Feb 2021		11-May -2021	887, 782, 500
Equitable share for Mar 2020		27-Mar-2020	835, 560,000	Equitable share for Mar 2021		23-Jun-2021	740,005,000
Equitable share for Apr 2020	15th April 2020	30-Apr-2020	1,096,672,500	Equitable share for Apr 2021	15th April 2021	23-Jun-2021	200,000,000
Equitable share for May 2020		24-Jun-2020	940,005,000	Equitable share for May 2021		23-Jun-2021	835, 560, 000
Equitable share for Jun 2020		05-Aug-2020	898, 227,000	Equitable share for Jun 2021		30-Jun-2021	835, 560,000
		Total	10,444,500,000				10,444,500,000

Source: Kilifi County Budget Review and outlook paper 2019/2020-2020/2021

Due to these delays, the Executive and the County Department of Health (CDoH) reportedly purchased drugs for public health facilities on credit. When the funds arrived, there was always money owing to creditors which had to be paid first. Sometimes not all the funds from the national government were disbursed, limiting the quantity of drugs that could be purchased from the national supplier. This limited the amount of pressure MCAs could apply on the county government to respond to public feedback on issues that required budget allocation of resources.

7.2.3 Provider norms shaped by training and work conditions undermined responsiveness to public feedback

In this section, I present findings that illustrate how provider professional norms characterised by low information-giving and low receptivity perpetuated low responsiveness to public feedback. I use the term 'norm' to mean informal unwritten practices and attitudes (and not documented standards and regulations) held by a group of people, in this case by actors with professional

healthcare training such as nurses, clinicians, laboratory technologists, pharmacists, doctors and their health managers. Receptivity here refers to the willingness to consider or accept feedback from the public. The norms described below were identified across both case study SCHMTs and HFCs.

Low information-giving was commonly discussed by sub-county health managers in terms of negative communication experiences in which the public received little attention and time. SCHMT-A respondents highlighted how common it was for the public to receive little or no communication about their own or their family member's health status, and situations such as the absence of drugs in facilities.

These provider norms around poor communication, particularly giving little information to members of the public, were deeply ingrained from professional training where little attention was given to how to communicate to the public and patients. Secondly, interactions with instructors and students were hierarchical. Health providers reportedly replicated these command-and-control interactions learnt from engagement with their teachers:

> *"In school, we [health providers] are never taught in fact... and in some schools, that bit of communication is never there. The frustration starts in school. First, you know when there is a senior consultant around then for you there isn't much you can do [but watch how they do things]. So, there isn't I mean that kind of communication course for how to communicate to your clients…. Then we come here and now we feel like now the client is under our mercies. You know so your word is final, they have no opinion in their management, in their treatment, in their medical care and we believe now you own the client instead of giving them that space to participate in their treatment and medical processes…" [SCHMTA006]*

Health managers perceived that provider norms around communication with the public were further reinforced by the absence of induction of new HCWs into the public health system. Induction of staff following public sector employment was said to be standard practice before devolution, where staff were introduced to a code of regulation for public sector workers and offered broader preparation for service delivery including how to communicate with the public. Most of the healthcare workers who were employed following devolution had not undergone this induction. Staff who were posted directly from the national level, without the involvement of county and sub-county health management teams had also not gone through induction processes and were described by sub-county health managers as particularly difficult to supervise.

Low receptivity to public feedback appeared to be linked to 1) a widespread perception among HCWs that the public had a low understanding of health system functioning and 2) health provider

working conditions. Regarding the former, there was a sense that public feedback lacked coherence and was focused only on specific individual-level issues. Consequently, health managers reportedly had to balance between the priorities generated by the health system actors' side and public views. As reported in chapter five, one county health manager reported that public views were often *'ignored'* unless it was a 'life and death' issue. Even then, interview findings suggested that a common reaction to public complaints was for sub-county health managers and frontline providers to defend themselves, citing poor health provider working conditions. County and sub-county health managers noted that frontline providers worked under difficult conditions in which they were understaffed and where many experienced burn-out. They described providers' inadequate information giving and harsh language as linked to the little time they had to engage with service users.

> *"I think that you cannot entirely blame the staff [for providing little information to the public] because of how the [health] system is. Because when you have a hundred or fifty patients waiting [and] you hardly have fifteen minutes it's difficult to give a lot of information. But again, I think there are those… I have interacted with some colleagues who say you'd rather tell them to come tomorrow and deal with five - that I will give real quality care. But how many of us will do that?" [SCHMTA-006]*

At the facility level, similar issues related to working conditions and public feedback were raised. In facility A, the facility-in-charge on receiving public feedback from HFC-A community members perceived that '*the public complained too much*', yet the staff at the facility were doing the best they could:

> *"You'll find one clinician can be struggling daily . . . and the more you are struggling to see them, to attend them, to give them quality medication, quality service, they think you are very slow because the queue is lengthening, hour after hour. So, instead of their understanding 'ooh today we only have one clinician', some will just go home, thinking that the doctor or clinician who is there is not doing his job, wasting time, and patients are piling up. They will even come to the manager to the in-charge room and complain, "There is no doctor there, there is no doctor" (HFA-003)*

In this facility, even though members of HFC-A were involved in generating responses to public feedback about long waiting times for chronic disease patients, there appeared to be some form of condescending treatment from the health providers. I judged this based on the way public feedback was responded to. For example, members of the public were informed that they could only come to the clinic on their scheduled date in response to complaints about long waiting times for people with chronic diseases, particularly diabetes. To get the members of the public to honour their clinic dates, the facility-in-charge required that HFC members also communicate to the public that

complaints from patients with chronic disease on long waiting times would only be considered legitimate if they were on the patients' clinic day. This suggests a conditional willingness to be responsive to the public's complaints.

In Facility D, despite several instances of dialogue and mediation to address complaints about HCW conduct and performance, HFC-D members felt that there was little improvement as illustrated in the quote below.

> *"We are elected as committee members, but we have had a hard time because sometimes you are doing things which are not moving, sometimes you may find someone is working but it looks as if he has lost network [i.e. he has lost interest]. That's why [in the community] there are complaints about them [HCWs]. When we get such stories, we sit and think of a way forward but sometimes it completely fails. In a previous meeting we had arranged as the committee that we need to get other healthcare workers, because if these ones can't do what we are saying then they better leave because we've talked with the in charge but still there are no changes. Every time they are told [to change their conduct], but when you go back out [to the community] you hear 'so and so', 'so and so'…and it's a challenge we are having up to now" (HFCD004)*

The staff in facility D however, often referred to material and human resource shortages and viewed these as causes of the negative public feedback on health worker absence, harshness, and denial of services:

> *"What we have currently is like a fraction of what [staff] we need. We have 2 clinical officers…we have a deficit of 6 clinical officers then we have no specialized clinical officer. For the nurses we only have 5 nurses…we have a deficit of 24 nurses and those 24 are in different categories, certificate nurses, midwives, and general nurses. And then we have other officers not yet deployed because of our level, like a nutritionist, pharm techs… no nutritionist, no radiographer, no physiotherapist… For a setup like a health centre as I told you, we should have all those officers and in that requirement from the analysis we have a gap of 64 officers…by the way we have only one driver doing 24 hours." (HFD001)*

The lack of commodities (mainly drugs) was also a demotivating factor for HCWs. Several HCWs in Facility D had attempted to cope with drug stock-outs by purchasing drugs with their resources so that they could sell to the community, but the public perceived this to be a strategy for personal gain because they expected PHC services to be free. The facility staff, therefore, felt that they should not be held responsible for incidents that resulted in negative patient outcomes since resource scarcity constraints were beyond their control. Given the reported resource constraints, facility staff expected HFC-D members to be more supportive rather than confrontational when

negative public feedback was shared. Across the other study HFCs, members reported clarifying to community members some of the problems related to working conditions that were faced by health providers. This was commonly done for example in relation to understaffing when staff needed to be away for training or meetings, and when there were multiple clinics running leading to long waiting times.

SCHMT and CHMT managers also perceived that HCW performance gaps and conduct issues were linked to their working conditions. These managers perceived that there would be greater responsiveness to public feedback if HCW concerns about working conditions were addressed.

> *"There is a lot of demotivation I'm telling you…burnout. Burnout - that's the highest cause of…health workers are…they are exiting, the county government is not replacing, so, we have a big challenge. But what do we do? And those are the challenges: the public speaks against the health workers, and you are there you can't do anything, you are the only one, and you have asked for a replacement. Hakuna [there are none]. You are a human being you are tired you want to go on leave you are told, wait, wait. You'll go crazy. Right now if you survey staff motivation, you'll see, people are depressed" [CHMT001]*

7.3. Responsiveness practices during the Early days of the COVID-19 pandemic

7.3.1 Organisational changes to support pandemic response and their effects on HS responsiveness

Fear and uncertainty reportedly hindered consideration of public views when the initial announcements of COVID-19 cases were made in the country. Health managers reported waiting on the Ministry of Health (MoH) to guide what actions should be taken. At the time, there was reportedly little consideration of public feedback, as acknowledged by one SCHMT member:

> *"At first, there were no community views which were incorporated. Everyone was afraid, and everyone was depending on the MoH to give guidelines and the way forward. So, no one even had the time to sit with the community so that they could suggest what we can do. And the community was confused. Eh, they didn't know what they were dealing with, so I doubt they even had suggestions or [specific] concerns." (SCHMTA003)*

More attention was given to public views and concerns when the CHMT developed an organogram with focal persons (Fig 7.2 orange boxes) responsible for different aspects of the COVID-19 response, including receiving public feedback.

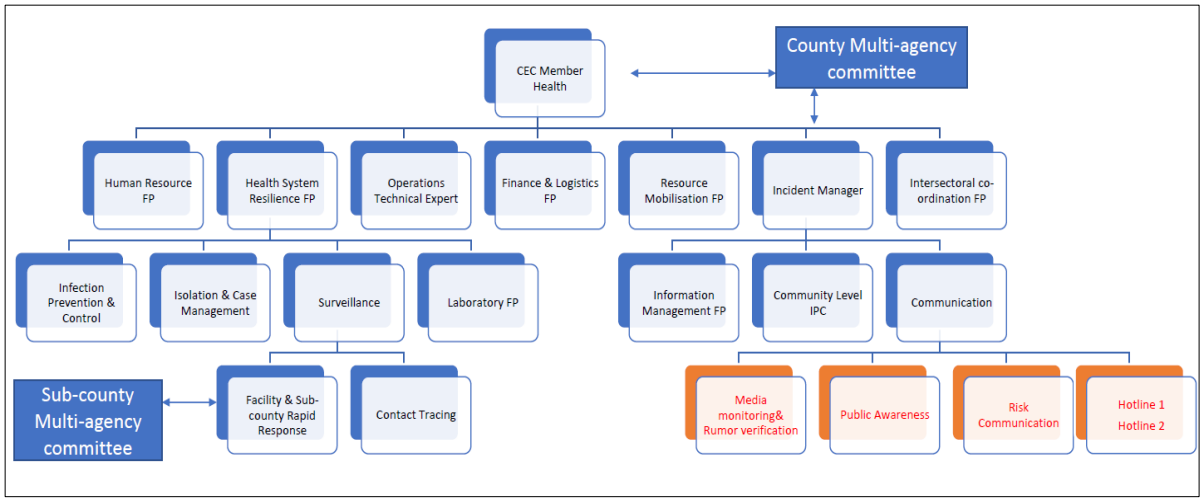

Figure 7.2: CHMT incident command system for the COVID-19 response
Source: Author from document review and in-depth interview data
Abbreviations: CEC-County Executive Committee; FP-Focal Person; IPC-Infection Prevention and Control

Having focal persons dedicated to communication with the public contributed to a more proactive approach to receiving public feedback compared to routine times. According to the respondents, the incident command system was helpful as it assigned everyone responsibility and reduced the potential for burnout. Before the set-up of the incident command, county health managers reported that '*everyone seemed to be doing everything*'. For example, every CHMT member including the Chief Officers participated in tracing contacts following the announcement of the first COVID-19 case in Kilifi County. Further, the hotlines were initially managed by the incident command manager and the health promotion officer who was also in charge of community mobilization. The CHMT quickly learned that this was not working well, since these CHMT members (incident command manager and health promotion officer) were often too busy with broader response issues to efficiently handle the hotlines. Thus, as illustrated in Figure 7.2, the hotlines were handed over to other members of the CHMT, freeing up the incident command manager and the risk communication focal person to focus on other elements of the pandemic response.

The organogram also had links to other stakeholders through multi-agency committees at county and sub-county levels. The County multi-agency committee was co-chaired by the Governor and County Commissioner and included stakeholders such as other county government departments, business groups representatives, religious leaders, and Non-Governmental Organisations (NGOs). The sub-county multi-agency committee included the Sub-County Medical Officer of Health (SCMoH), the Sub- County Commissioner and sub-county level stakeholders. These links to stakeholders, while not specifically identified as feedback channels, provided an avenue for the public to contribute their views on the pandemic response.

7.3.2 Public feedback mechanisms and procedures for receiving feedback during the early days of the COVID-19 pandemic

'Information provision' by CDoH officials was the most heavily utilised way of engaging the public. Messages were passed through public address systems by public health and health promotion officers, who traversed all 35 electoral wards in Kilifi County. Radio -mostly local FM stations- was also utilised. Periodically, the County Governor (joined by other senior county officials) issued press briefings on the status of the response in the county and encouraged the public to adhere to prevention measures. The decision to involve the senior county leadership in conducting messaging around COVID-19 was informed by a perception that their involvement would signal to the public the importance of the control measures that were being put in place.

The county response team also used pre-existing (before the COVID-19 outbreak) channels such as county Facebook pages, WhatsApp groups, and a newly introduced channel (two hotline numbers) to keep track of community concerns and rumours. The use of community participatory structures such as CHVs and HFCs for COVID-19 community engagement happened later rather than earlier in the pandemic response. Community members frequently had follow-up questions, which they mainly asked CHVs, but CHVs were not any better informed than other community members as they were sensitized on COVID-19 later. The low and late utilisation of CHVs was linked to the low coverage of community units, budgetary constraints to support them, and low availability of Personal Protective Equipment.

Generalised messaging strategies and piecemeal engagement of vulnerable groups

Early community sensitization efforts were generalised with few specific messaging strategies and packaging for different groups. There was little mention of engagement with vulnerable groups such as youth and PLWD. CHMT respondents acknowledged this initial lack of attention to vulnerable groups but reported that there were ongoing efforts to develop engagement activities that were more inclusive of particularly PLWD and youth groups. A significant challenge among youth was that they preferred gatherings and were reluctant or lacked the means to be engaged in virtual meetings because of the cost implications in terms of internet requirements.

Acknowledging the youth's economic challenge of participating virtually, the CHMT focal person for communication with the public negotiated for meetings with limited numbers of young people in large social halls, where they offered them lunch and face masks. These youth were then sent out to be ambassadors to other youth who had not attended the meeting. At the time of data collection, two such meetings had been conducted.

Public feedback and approaches to engaging with the public evolved as the pandemic unfolded

Fig. 7.3 below summarises the changes in public feedback and the approaches to engaging with the public over time. In the early days soon after the announcement of the first case of COVID-19 in

Kenya, much of the feedback picked up by the risk communication team was myths and rumours related to the spread of COVID-19. At the time as noted above, generalised information provision was utilised to counter the misinformation and rumours.

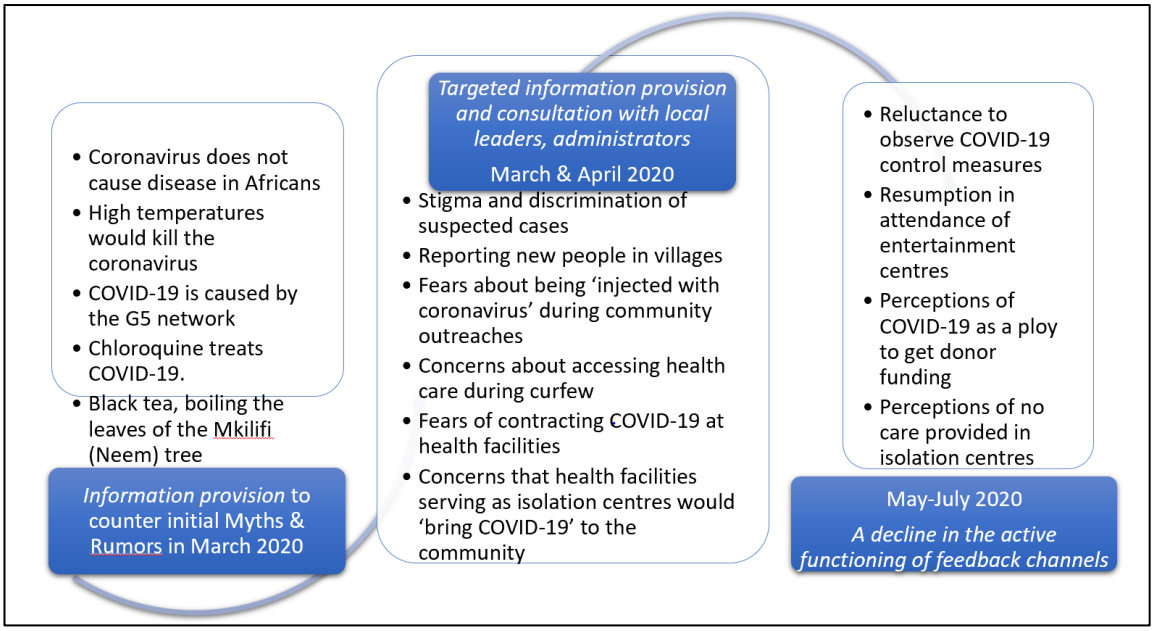

Figure 7.3: Changes in content of feedback and approaches to engaging with the public

However, when the first case of COVID-19 was reported in Kilifi County, the myths around contracting COVID-19 appeared to be overtaken by significant fear among members of the public. This fear reportedly resulted in multiple calls to the hotline number as people reported new entrants to their neighbourhoods and requested testing for COVID-19. Unfortunately, this fear also resulted in the stigmatization of community members who were suspected cases. For example, a person suspected of having COVID-19 was denied the use of water points and shops in one village. In another village, community members almost burned down the home of a COVID-19 suspect. Communities also resisted the use of their health facilities as isolation centres, with perceptions that they were '*being brought COVID'*. Other public feedback that reached the CHMT risk communication team included concerns about contracting the virus within facilities and fears of being quarantined if one tested positive for COVID-19 following screening. There were also reports from the community of mothers delivering at home due to difficulties in getting transport to health facilities during the curfew hours. At this point, the approach to engaging with the public evolved to more targeted information provision and consultation with local leaders and administrators where there was more interactive discussion.

Soon after the initial crisis period characterised by fear and uncertainty, there appeared to be low levels of public trust illustrated by perceptions among the public that government and government workers were benefitting from the COVID-19 pandemic. SCHMT members reported that the public

perceived that '*COVID-19 was a creation of government to attract donor funding',* and when the CHMT and SCHMT went out to encourage the public to have handwashing stations, ensure social distancing and wear masks, the public assumed that they had received money from donors. This period was also accompanied by less engagement with the public characterised by fewer meetings with members of the public or their representatives and a decline in the use of the hotline numbers.

7.3.3 Weak documentation and processing of public feedback

Attempts to document and analyse public feedback were short-lived. As noted in section 7.3.1. several CHMT members charged with managing feedback from the hotlines and social media had begun to maintain a register, but a review of this register confirmed that only a few entries were made in the early days of the response. Feedback from other mechanisms and interactions with the public mentioned in section 7.3.2, was also not documented. Consequently, little analysis of feedback was conducted.

There was also a lack of clarity in procedures related to managing the feedback received and generation of responses. For example, while the hotlines provided important feedback, resource constraints, weak coordination and communication weakened responsiveness to concerns shared through them. Study respondents reported that the hotline phones could not make outgoing calls and were inconsistently loaded with airtime. The persons handling them sometimes used their personal phones to respond to the public's calls or messages. There were also challenges in 'closing the feedback loop' to ensure that members of the public who called in were responded to appropriately. For example, people who called for an ambulance experienced challenges in getting it. First, there was reluctance among a few facility managers to release ambulances to pick up community members from their homes. Second, even when ambulances were released, there were delays, and in one case a pregnant woman who needed transport to the hospital delivered on the way. Third, there were no measures to track the implementation of the directive that ambulances could pick up community members from their homes such as the expected turn-around time to deliver the labouring mother to a health facility. Finally, there was no mapping of ambulances to determine which were nearest to which facilities to enable efficient deployment based on need.

7.3.4 Using public feedback to shape the COVID-19 response

Despite the challenges described above in managing and generating responses to feedback, study findings suggest that there were several instances when public feedback was responded to and utilised to shape the COVID-19 response. These responses included increased information provision through organising community consultations, and efforts to support access to care during curfew hours. In response to fears about COVID-19 being brought to the community, CHMT members engaged directly with community leaders in specially organised meetings, observing social

distancing, to get their buy-in for use of identified facilities as isolation centres. These community leaders included village elders, sub-county and ward administrators, chiefs, community health committees and health facility committees. Even though the facilities were eventually used as isolation centres, their use remained contentious as acknowledged by one CHMT member:

> *"Let me start with XX facility, we went to XX first, and we talked to the staff, and they were like, "we are not willing to release the facility for that kind of activity". They also incited the rest of the community, and we were not able to get the facility, yet it was a good place to do isolation. We went to YY, the community around there was resistant to making YY an isolation centre but it was, either way pushed to become an isolation centre because it's a public facility. In the current isolation centre, it has been the same there has been a lot of push and pull between the public and the department of health, but we tried to involve them, for example, we always shared with them the intentions of changing facilities to isolation centres" [CHMT002]*

In some cases, community concerns resulted in multiple responses at various health system levels. For example, in response to concerns about accessing care during curfew hours, some SCHMTs identified together with community members, transporters who were given passes by the police. To supplement these efforts, at the county level, the hotline numbers (initially set up for the COVID-19 response) were shared again through radio and social media for community members to call and request pick-up by ambulance during curfew hours.

When health managers were faced with resistance from the public, particularly about accepting positive COVID-19 results and agreeing to transfer to isolation centres, they resorted to invoking provisions of existing public health laws to trace individuals and compel them into isolation to reduce the public health risk. However, invoking the Public Health Act contributed to much imposition of prevention transmission measures on the public with little incorporation of public feedback, particularly in the initial reactions to the COVID-19 response:

> *"The public was not given a chance, because if they were given a chance so many things would not be the way they are. For example, the public view has always been that we can fight this disease and live our lives the way we used to. But the government imposed most of the measures without public participation. So, I would say we have...even in the department of health we have not sought so much public participation including in the initial days of COVID when we used to quarantine people by force, that was not the wish of the public" (CHMT002)*

7.4 Chapter Summary and Implications of COVID-19 for health system responsiveness

In this chapter, I have presented contextual factors that contribute to the low responsiveness to public feedback reported in preceding chapters. I found that heavy reliance on national and county

government financing for health system activities shaped SCHMTs' supervision approach such that upward accountability was prioritised over outward accountability to the public. Delays in the disbursement of funds hindered the extent to which responses to public feedback could be sustained, while limited decision-making authority constrained the range and longevity of responses to public feedback. Oversight mechanisms introduced following the devolution of health services had mixed effects on responsiveness. First, the public frequently shared feedback informally with MCAs and political appointees. These informal engagements sometimes supported generation of responses. However, the responses generated were often individualised and short term. Finally, provider norms characterised by low information-giving, and low receptivity to public feedback perpetuated overall low responsiveness to public feedback.

Concerning the implications of the COVID-19 pandemic response to health system responsiveness, overall, in Kilifi County, multiple mechanisms and approaches were used to receive and respond to public concerns and feedback during the COVID-19 outbreak response. The approaches relied on existing relationships and mechanisms within the county health system. While there were efforts to learn about and respond to public views and concerns, documentation, and analysis of these views to support systematic and system-wide responses were less frequent. Across the practices of receiving, processing, and responding to public feedback, the challenges identified brought into sharper focus the constraints to health system responsiveness already existing during routine times. One health manager observed: '*the health system has not been responsive to public concerns or needs, and it was unlikely that the Covid-19 pandemic would make the health system more responsive.'*

Chapter 8 Discussion of study findings and implications for policy, practice, and research

8.1 Introduction

I have organised this last chapter into four sections. In the first section, I present an overall synthesis that integrates the study findings presented in Chapters 4 to 7. In the second section, I present the contributions of this research work to existing HPSR literature on responsiveness, HFCs and DHMTs. In the third section, I present the policy and practice implications of this research work, propose strategies that could be adopted to strengthen responsiveness, identify study limitations, and suggest areas for further study. In the fourth section, I present a summary of the chapter that includes recommendations for various actors who have a responsibility for HS responsiveness. These recommendations are drawn from the implications for policy and practice, and areas for further research. I conclude with a brief reflection on the current strategic directions in the current Kenyan health sector policy documents that have potential to impact HS responsiveness.

8.2 Overall synthesis of study findings

This study set out to answer the overall research question: how do policy and county-level contexts and actor and power dynamics influence the practice of health system responsiveness? To answer this question, I designed this study with five objectives. Table 8.1 summarises the core study findings by each objective.

Table 8.1: Study objectives and summary of key related findings

Specific study objective	Key related finding
To analyse the policy and legislative context for health system responsiveness in Kenya	1. Some provisions support responsiveness within the Kenyan legislative instruments and policy documents. These include: • Legal requirements to include the public in the development and implementation of policy • Actors with responsibility for ensuring the involvement of the public in policy formulation and implementation • Proposed mechanisms that can support receiving and responding to public feedback 2. The framing of responsiveness within health sector policy documents was focused mainly on clinical service delivery. 3. Despite frequent mention of responsiveness, there was no overarching strategy for responsiveness as characterised by: • Varied ways in which responsiveness was described across health sector documents • Lack of clarity and consistency in the measurement of responsiveness across health sector policy documents 4. There was inadequate detail in policy documents on the proposed functioning of feedback mechanisms. There was no detail on: • How feedback collected through these mechanisms would be utilised to enhance responsiveness • Human resources required to support the functioning of the feedback mechanisms • Costs associated with the functioning of the mechanisms • How these mechanisms would be monitored and evaluated to track their functioning
To analyse the practice of responsiveness in Kilifi County	1. There were multiple channels through which the public in Kilifi County could provide feedback to health system actors. These mirrored those proposed in the analysed policy documents. However, the mechanisms had problems with functionality including: • Little utilisation by the public • Little representation of the experiences of vulnerable groups 2. Inadequate systems hardware (funding) allocated undermined mechanism functionality. There was also no dedicated team, actor, or unit within the CDoH that supported the functioning of public feedback mechanisms. 3. Tangible system software challenges also undermined responsiveness: • Little awareness of existing county terms of reference for handling public feedback such as complaints. • Little proactive collection of public feedback across case study HFCs and SCHMTs. • When public feedback was received, it was not commonly documented and was often not integrated across multiple feedback channels. 4. Responses to public feedback generated at HFC & SCHMT levels were local-level responses and rarely communicated to the public.
To critically examine how actor and power relations impact responsiveness to public feedback in Kilifi County	1. HFCs and SCHMT members interacted with multiple actors in receiving and responding to public feedback. At interaction points between actors (interfaces) various forms of power and power practices impacted the practice of responsiveness. 2. Power practices of domination and control were associated with the exercise of invisible and hidden power. Together, these forms and practices of power hindered HS actors from receiving public feedback and excluded vulnerable groups from participatory mechanisms. • Invisible power kept the public from sharing feedback and was manifested in a low understanding of how the health system functioned, a lack of confidence to share feedback, and socio-economic concerns. • Invisible power also manifested in organisational norms: only electing HFC members who attended chief's barazas; and a culture of defensiveness. • Hidden power in one HFC manifested in a decision to elect from village elders and *nyumba kumi* representatives.

	• SCHMTs were often dominated by powerful actors who exercised visible and hidden power by limiting support for relevant activities:
	  ○ The Department of Finance exercised visible power to dominate the entire CDoH (including SCHMT) by limiting the duration of public participation meetings, and the SCHMT by re-allocating HFC training funds to other payments.
	  ○ The CHMT exercised hidden power over the SCHMT by failing to provide details on the consolidated health sector budget when SCHMT members were sent to represent the CHMT during public participation in county budgeting and planning.
	3. The public reacted to domination through resistance and contestation, power practices associated with the exercise of visible power, contributing to their claiming spaces. These spaces were often informal feedback shared directly with political representatives and political appointees. They were not always effective in leveraging responses to public feedback.
	4. Collaboration, facilitation, and negotiation across SCHMTs and HFCs supported feedback mechanism functioning and public feedback receipt. These power practices, linked to visible power, were underpinned by organisational power relationships of SCHMTs, NGOs & HFCs
	5. Responsiveness to public feedback was strengthened when actors used their lifeworld experiences to support the functioning of feedback mechanisms, processes of receiving feedback and generation of responses. E.g., where HFC and SCHMT members exercised their agency to leverage political power supported the generation of responses to public feedback.
	6. Misalignment of the lifeworld constructs with an element of the responsiveness pathway often resulted in limited responsiveness.
	  • For example, actors used their organisational power to prioritise other department processes to restrict access to information (CHMT over SCHMT) and remain unaccountable to the public (health managers and providers/ public interface).

To examine the influence of contextual factors including health system shocks for health system responsiveness in Kilifi County	1. The Kilifi County health system was mainly funded through national government disbursements managed at the county level:
	  • This shaped SCHMTs' supervision approach such that upward accountability was prioritised over outward accountability to the public. Thus, there was a predominance of service delivery and internal performance indicators and no public feedback indicators.
	  • Efforts to be responsive to public feedback at both SCHMT and HFC levels were limited by the level of autonomy over resources allocated to the SCHMT and HFC.
	  • When SCHMTs and HFCs could generate responses, these responses were often short-term due to inconsistencies in the release of funds to the health facilities and health management units such as the SCHMT.
	2. Decentralisation by devolution had mixed effects on responsiveness. These included:
	  • The proximity of political representatives empowered the public to share feedback informally, with few, short-term responses.
	  • Formal feedback mechanisms were poorly utilized, limiting public feedback.
	  • Local political representatives' power and responsibility to support the generation of responses to public feedback was limited by their political alignment with the County Executive, and resource flow bottlenecks between national and county treasury.
	3. Provider norms illustrated by poor communication to the public and low receptivity to public feedback undermined responsiveness:
	  • Norms were shaped by pre-service training that ignored public communication and by health system working conditions that made it difficult for providers to a) communicate effectively and b) prioritise public feedback over other work demands.
	4. Receiving, processing, and responding to public feedback during the COVID-19 pandemic highlighted routine challenges:
	  • Uni-directional feedback mechanisms were prioritised in the early days while more participatory mechanisms were adopted later.
	  • Processes of handling public feedback were underdeveloped, and feedback loops were not completed.
	  • Software weaknesses before the pandemic continued and impacted responsiveness during the early days of the pandemic.

Analysis of policy and legislative texts, presented in Chapter 4, showed that there were some provisions for responsiveness which included various processes and actors with roles related to achieving health system responsiveness. However, there was significant variation in how responsiveness was referred to and in its framing across legislative instruments, and public and health sector documents. I identified five different frames of responsiveness across the analysed texts. These included responsiveness as, feedback on clinical service, non-clinical dimensions of care (WHO framing), public participation, accountability between the public and health system, realisation of the right to health (Fig 4.5). A predominant 'clinical service delivery' framing of responsiveness appeared to influence the focus and measurement of responsiveness such that the policy documents mainly emphasized clinical interactions and adopted patient satisfaction levels to assess system responsiveness. Further, understanding responsiveness as 'how the health system receives and responds to feedback from the public', I found there was little attention to specific and important elements that could support the development of a responsive health system. These included:

- little detail on the functioning of feedback mechanisms,
- little evidence of intention to integrate feedback from multiple channels to support system-wide responses,
- little provision for monitoring and evaluation of proposed feedback mechanisms, and
- even less attention to responses from health system actors to public feedback.

These gaps in Kenyan policy documents suggest that the macro policy context was not supportive of a comprehensive approach to health system responsiveness. Indeed, the findings about the practice of responsiveness (Chapter 5) illustrate how gaps in written policy may manifest in practice. For example, the lack of coherence in health sector policy on responsiveness in the country was reflected in the lack of clear procedures and guidelines for managing public feedback at county and sub-county levels. The absence of details on the functioning of feedback mechanisms in policy documents appeared to be manifested in the absence of dedicated persons or teams with responsibility for public feedback at county and sub-county levels. Further, from the document analysis, feedback mechanisms were presented in isolation with a single feedback mechanism which often handled a specific type of information. This was reflected in practice given the SCHMT members' reports of case-by-case approach to public feedback and HFCs' rare involvement in other facility-level feedback mechanisms such as satisfaction or client exit surveys. Priority-setting and oversight arrangements within the health sector need to meet public needs and values [13]. Yet, these were rarely mentioned within health sector policy documents, which framed responsiveness in terms of service use. This is important because as Bachi points out, framing can influence

decision-making around resources and governance arrangements [262]. A narrow focus on clinical service delivery could translate to meagre resources being allocated to health system responsiveness. In this study, this was observed in practice by the often-reported funding constraints that hindered optimal functioning of most feedback mechanisms.

Using a framework of organisational capacity, the findings in Chapter 5 also suggest that the capacity of the sub-national health system to enhance health system responsiveness relies on both hardware and software dimensions of *meso* or organisational context. The hardware includes the resources (funding and human resource) to establish and support feedback mechanisms. The software includes both the tangible elements such as the guidelines and procedures for receiving and processing public feedback as well as the intangible elements such as communication and power. In the absence of adequate funding for and staffing of feedback mechanisms (hardware), and procedures and guidelines (tangible software) I found that there were problems with mechanism functionality, and this generated weak responsiveness. In addition, the absence of resources and procedures and guidelines that might illustrate organisational support raised questions about the extent to which responsiveness to public feedback is valued (intangible software) vis a vis other health system priorities.

Study findings from Chapter 6 expand on the software dimension elicited in Chapter 5 and illustrate that responsiveness was influenced not just by the *macro*-policy context, but also by *micro*-level interactions between actors (Chapter 6). In examining the micro-level interactions between actors through a power lens I found that the process of receiving feedback was hindered, not just by hardware factors such as staffing and funding levels, but also by power dynamics (intangible software) on both the public and health system organisational and provider sides. Amongst the public, invisible power manifested in a low understanding of how the health system functioned, a lack of confidence to share feedback, and socio-economic concerns that kept the public (particularly vulnerable groups) away from participation in feedback mechanisms. On the health manager and provider side, invisible power manifested in an organisational culture of undervaluing public feedback and maintaining a status quo during the formation of HFCs, which in effect limited the inclusion of members of vulnerable groups. Hidden power, meanwhile, contributed to there being little space for public feedback as powerful actors limited the level of participation by both the public and SCHMTs. But power dynamics at the micro-level did not always impact responsiveness negatively. For example, facility-in-charges and SCHMTs leveraged their organisational power relationships to facilitate HFC functioning and responsiveness to public feedback while the public also exercised their agency by sometimes bypassing health managers to share feedback with and leverage responses from politicians and senior county-level officials. Overall, considering the forms

and practices of power, and the underpinning motivations of actors in the processes of receiving and responding to public feedback revealed the complex nature of health system responsiveness.

Several of the hardware challenges identified in Chapter 5 are also expanded upon in Chapter 7 which presents findings that illustrate that responsiveness was also influenced by *meso*-level organisational factors at the county level. All the interactions described in Chapter 6 played out in a decentralised governance context (Chapter 7). A decentralised context is likely to enhance responsiveness to the public [263-265] but the study findings in chapter 7 suggest that the influence of decentralisation on responsiveness was mixed. On one hand, following devolution, the public in this study setting could more closely engage with political decision-makers due to physical proximity. On the other hand, informal interactions were utilised more than the formal mechanisms that were intended to be a conduit for public voice. These informal engagements enabled some members of the public to share feedback, and sometimes supported generation of responses to feedback. But these informal interactions mainly led to individual-level and short-term responses. Despite the proximity of political decision-makers because of devolution, the reality was that only members of the public who had the phone numbers of political actors could leverage political connections, a finding that suggests inequitable responsiveness.

Findings from Chapter 7 also highlight that at the meso-level, the health system organisational hierarchy interacted with a context of resource scarcity (in terms of funding and staffing levels) and procedural challenges that affected the flow of funds from national to the county to health management units. The effect of these interactions was to undermine the support that SCHMTs could give to feedback mechanisms and the extent to which they could be responsive to public feedback. A low level of resourcing across the case study SCHMTs limited attention to feedback by promoting approaches to supervision that emphasised inward and upward accountability, at the expense of public accountability. Further, low resource levels limited SCHMT ability to generate responses, while delays in the flow of funds hindered the extent to which responses to public feedback could be sustained across case study SCHMTs and HFCs. Power dynamics illustrated in limitations on the authority to make decisions in turn limited the range of responses to public feedback. These features of the organisational context and their influence on responsiveness became more pronounced during the COVID-19 pandemic, which formed a part of the study context.

Overall, the study findings suggest that the Kenyan health system can be characterised as offering limited responsiveness and that this has foundations in weak policy design, that is, a focus on service interactions and more attention to the collection of feedback than the response to

feedback, predominant in the clinical service delivery frame across most health sector policy documents. The participation and rights-based frames within legislative, public sector and a few health sector documents present greater breadth in their framing of responsiveness in going beyond service use to include processes that the public (including vulnerable groups) should be involved in. Frames also legitimise which actors can participate in policy processes [222]. In this study, the participation and rights-based frames include multiple actors within and outside the health system. The 'responsiveness as feedback on clinical service delivery' and 'responsiveness as accountability' frames however narrow the focus to providers (and their managers) and patients. Thus, it is unclear how for example state actors with responsibilities for ensuring functioning of feedback mechanisms (as described in Kenyan legal instruments [170, 171, 249]) facilitate health system responsiveness with so little attention given to them within health sector policies. Further, the clinical service feedback frame predominant in health sector policy documents largely neglected phases of the policy process other than implementation. Specifically, equity challenges and power and knowledge differentials between population groups and between the public and health system actors are neglected, yet, these are important considerations given that Kenya has a history of inequalities in health service access and distribution [76].

Simultaneously, weak responsiveness is also a consequence of actor interactions and power dynamics that contributed to the public, particularly vulnerable groups being constrained from sharing feedback and health system actors being oriented away from public feedback and ii) meso-level contextual factors such as under-resourcing of the health system and low resourcing of feedback mechanisms that worked to entrench provider norms and hierarchical relationships, and that were not supportive of system responsiveness. The implications of largely top-down power dynamics reported in Chapter 6 overlaid on a back-drop of a recently devolved health system with weakly functioning formal feedback mechanisms included the evolution of informal feedback mechanisms. Unfortunately, these informal feedback mechanisms mediated mainly through political actors were insufficient to generate system-wide responsiveness. Further, the combination of formal and informal feedback mechanisms added on to the complexity of building a responsive health system. For example, the middle-level health managers (SCHMTs) and facility managers frequently faced conflicting demands from political actors, the health system bureaucrats and in some instances NGOs, undermining systematic generation of responses to public feedback. Indeed, few systematic feedback management practices were identified in this work, and this limited the construction of a responsive health system.

8.3 Contributions of this study to the existing literature

8.3.1 Contributions to the health system responsiveness literature

This study has contributed to the existing HS responsiveness literature in several ways. First, the current literature on HS responsiveness is limited because of its service-specific nature, lack of focus on responses to feedback [72] and limited consideration of system-wide practices necessary to support responsiveness [13, 72]. This study, therefore, contributes to the responsiveness literature by presenting empirical study findings that focus on the 'response' in health system responsiveness, by exploring whether a change occurred because of public feedback, who implemented any changes, and for whom responses were implemented. This approach to examining responsiveness is in line with the little existing literature that considers both the ability of the health system to respond and the actual response [22, 72, 266]. For example, Joarder refers to responsiveness as a state that involves 'social action' [266], while Lodenstein et al refer to a response as a 'culmination of system factors and processes' [22]. My study findings in relation to the nature of responses included that HFCs and SCHMTs, specifically, drew on a mix of informal and formal interactions to generate responses to public feedback. Responses included mainly local-level changes at the facility level, with a few instances of change across multiple facilities in a sub-county. The responses identified in this study, particularly those generated by HFCs were transient, often limited in longevity by a context of persistent resource scarcity and limitations on authority over financial decisions. A few responses to public feedback resulting from the benevolence (and interests) of politicians benefitted PHC facilities. An example here was the purchase of food supplies for a health facility by a political representative but these were commonly one-off responses that met an immediate need without addressing the underlying problem.

A second contribution of this study to the responsiveness literature is the attention paid to the implications of a significant contextual factor, albeit a highly disruptive one, the COVID-19 pandemic, on responsiveness. The study findings about the practice of responsiveness during the COVID-19 pandemic illustrate how during a period of health system crisis, existing contextual influences can become more pronounced. For example, challenges related to how public feedback was handled once received during the early days of the pandemic appear to have arisen from weak, weakly functioning pre-existing mechanisms for receiving, analysis and documentation of public feedback. Therefore, introduction of an almost new way of handling public feedback (the telephone hotlines) during a period of crisis was difficult to sustain. Further, and consistent with study findings on responsiveness during 'routine times', there was inadequate allocation of resources to support the functioning of feedback mechanisms. For example, CHWs were engaged relatively late on in the COVID-19 response due to the lack of resources to pay their stipends. Even though the national government had mobilised resources to support counties in preparation for the COVID-19 response [267], pre-existing bottlenecks in the flow of these funds when they became available [268]

contributed to challenges in accessing support for feedback mechanisms to function well. Further, in relation to receiving public feedback, the tendency to focus upward and inward within the health system played out in the initial days of the pandemic response, as health managers waited for direction from the national level, with little consideration of public views. When public feedback was eventually considered, this was mainly through newly created mechanisms. Yet, experiences from studies on other health system crises suggest that setting up new feedback mechanisms during a health system crisis is unlikely to be an effective way to learn about public feedback and enhance responsiveness [40, 269]. In my study context, for example, low inclusion of public input was illustrated by how HFC-A members were reportedly unaware of the decision to shut down general PHC services in Facility A and convert it into an isolation centre, though it was discussed in the multi-agency committee formed during the pandemic period.

The third main contribution to the health systems responsiveness literature is that I applied a systems-lens approach to examining responsiveness by considering the influence of the macro-level policy context, the meso-level county and health system organisational context and micro-level actor interactions on health system responsiveness. To do this I explored processes of receiving and responding to public feedback and interactions within two spaces operating at different levels of the health system (HFCs and SCHMTs) and considered how both interacted to support responsiveness. This approach was useful to illustrate the complex nature of responsiveness and that it is the outcome of multiple interacting factors. At macro-level despite inclusion of responsiveness as a broad health system goal, there were few explicit directives relating to responsiveness within health sector policy documents. In the absence of formal guidelines, feedback mechanisms were in practice under-resourced, both in terms of funding and in the human resource required to support their functioning. The study findings on the gaps in the written macro policy context for responsiveness are consistent with findings of a scoping review on health systems responsiveness mechanisms by Sutherns and Olivier, where they found that despite provision for responsiveness within policy documents, feedback mechanisms faced resource and capacity constraints [270]. Similarly, in my study, the problem of low functionality of feedback mechanisms stemmed in part from a lack of clarity at the macro-level context, and from inadequate resourcing at the meso-level. In Kilifi County and in other counties in Kenya problems of resourcing at facility and sub-county levels have been well-documented and continue to persist [98, 99, 271].

Taking a systems view included considering the interplay between software (tangible and intangible) and hardware elements in relation to the practice of responsiveness to better understand 'within system' (organizational) dynamics and influences (see Fig 3.4). The examination of intangible software, specifically power relations, highlighted the power dynamics that permeated across levels of the health system, and between actors at the micro-level, to influence

responsiveness. The novel approach taken in examining power dynamics combined two complementary power frameworks and supported the derivation of a conceptual framework (Fig. 8.1) described in more detail in section 8.4. This approach also addressed calls for a focus on actors and their interactions, which Mirzoev and Kane highlight to be a key component of health system responsiveness [13]. The findings on visible power exercised by higher-level managers over others (CHMT managers over SCHMT managers, and SCHMT managers over facility-in-charges) illustrate the value of a systems lens in examining responsiveness. The study findings on the influence of power on responsiveness have provided deeper knowledge on the social relations and interactions between the public and health systems, including an understanding of both health system organizational and provider, and public side factors that influence responsiveness. These are discussed in more detail below. Together all these considerations demonstrated that the problem of weak responsiveness is not just a product of weaknesses in policy content and framing, or of interactions between actors or of contextual factors. Rather, weak responsiveness is generated by the interaction of all these influences. These findings reveal the complex nature of health systems, in which there are dynamic interactions between different parts of the system including interplay between less visible system software and more visible system hardware [200, 272].

8.3.2 Contributions to the literature on HFCs and DHMTs

The fourth main contribution of this work is to the literature on HFCs and DHMTs specifically, as important governance spaces within health systems across many LMICs. The existing literature on HFCs and DHMTs does not consider their responsiveness roles as is considered in this study. Previous reviews on HFCs have examined the effectiveness of HFCs [113], their role in accountability [10], and the influence of context on HFC functioning [61]. This study extends the knowledge on HFCs and DHMTs by considering their internal functioning in relation to responsiveness specifically and illustrates that both HFCs and SCHMTs could support system-wide responsiveness, with HFCs enhancing facility-wide responses and SCHMTs sub-county wide responses. However, the organisational contexts in which SCHMTs and HFCs carry out their functions could limit their power to enhance responsiveness. These issues are discussed below.

Internal functioning of HFCs and SCHMTs to support responsiveness

In relation to internal functioning to support responsiveness, a cross-cutting theme across the case study HFCs and SCHMTs was the passive approach to learning about public feedback, absence of consistent documentation and lack of integration of feedback from multiple channels. For example, HFCs had no access to formal service feedback mechanisms such as satisfaction surveys and suggestion boxes. This appears to be a missed opportunity, as access to feedback from satisfaction surveys and suggestion boxes might have enhanced integration of various feedback streams to support facility-wide responses. Atela (2013) reported similar findings in his examination of health system accountability and health care delivery in rural Kenya, where despite there being multiple

feedback mechanisms at peripheral facility level, the HFCs were not privy to the feedback received through them [79]. Yet HFCs could be points at the local level where varied forms of feedback such as satisfaction survey results, direct feedback and suggestion box findings are discussed to support facility-wide improvements and change.

Similarly, the passive approach to receiving public feedback at SCHMT-level illustrates a missed opportunity to compare trends across facilities and enable system-wide responses. Another instance where an opportunity for system-wide responses was missed was in the SCHMT's attention to service delivery indicators rather than a combination of multiple sources of information. These findings about greater attention to internal performance targets than to public feedback are consistent with findings about health managers from South Africa and Ghana [145, 273]. In the Ghanaian study by Van Belle and Mayhew, the DHMTs paid more attention not only to the internal health system bureaucracy but also to horizontal accountability requirements by NGOs who provided resources for DHMT activities than to public feedback, which contributed to their being oriented away from public feedback [145].

Connections and linkages between HFCs and SCHMTs sometimes supported responsiveness

Existing literature also rarely considers the linkage between HFCs and SCHMTs. In my study, considering HFCs and the SCHMTs together helped to deepen understanding about responsiveness by drawing out the importance of linkages between health system levels for responsiveness. By including an exploration of the lived experiences of HFC and SCHMT members, it was possible to illustrate the relations between HFCs' and SCHMTs' actions and the organisational structures that they exist in that are relevant for responsiveness. In this study, many HFC responses were limited to the local level, due to limits on what HFCs could influence, a finding also reported in the HFC literature review (section 2.2). This was particularly true for public feedback related to HCW conduct. Without the ability to sanction healthcare workers, HFCs commonly resorted to reporting to SCHMTs, and senior county officials. SCHMTs were not always able to generate responses to feedback on negative HCW conduct; but some responses such as dialogue with the concerned healthcare worker(s) and/or transfers within the sub-county were effective to change HCW behaviour.

As noted above, reporting to higher authorities (such as the SCHMT) was not always effective. This is highlighted in the experiences of HFC-D who reported frustration at the slow pace of change in the conduct of staff in HFC-D, and those of HFC-A who also reported frustration over the slow pace of re-opening their facility for general service delivery following the decision to shut down other service delivery areas and use it for COVID-19 isolation services. These frustrations reflect the limits to HFC power to generate responses for persistent health system issues and illuminate the influence

of contextual factors which cut across system levels in this study, such as resource scarcity, and the prevailing health system focus on COVID-19 at the time.

At SCHMT-level, the dependencies between actors appeared to be distorted by higher-level actors' exercise of power over SCHMTs who worked in conditions of resource shortage and uncertainty, and limited autonomy. This was illustrated for example by the substantial influence of the County Department of Finance who made decisions to prioritise payments to suppliers over payments for SCHMT activities that could strengthen feedback mechanisms such as training HFC members. In relation to responding to some forms of feedback the SCHMT members expressed feelings of disempowerment linked to their narrow authority to enact actions, because of domination by either the CHMT, political representatives or national-level directives. These findings are similar to the experiences of a study on DHMTs' decision-making in Uganda and Malawi who reported that political influence at the district level limited their decision-making authority [274], and another Ugandan study where DHMTs reported restricted ability to manage the district health service delivery due to political influences [275]. Across the two studies, these feelings of disempowerment were made worse by the resource constraints that DHMTs worked in.

Given the resource scarcity context described above, interactions between NGOs and SCHMTs were noted to be important to responsiveness, albeit with mixed effects. On the one hand, SCHMTs collaborated with NGOs to support the functioning of feedback mechanisms, for example NGOs funded training for HFC members and provided support for CHW stipends. The NGOs in turn leveraged the community connections of the HFCs and CHWs to achieve their project objectives. These efforts contributed to well-functioning HFCs and CHWs who could pick up public feedback and transmit to facility-in-charges and SCHMTs. On the other hand, sometimes NGO activities were so many that SCHMT members failed to convene their weekly meetings due to lack of quorum as many SCHMT members were either attending meetings or training sessions planned by NGOs. This weekly meeting was an important platform where SCHMT members shared information including public feedback that had come up during the week, or that were being addressed. During the period when meetings lacked quorum a public feedback issue that required SCHMT-A to visit Facility A remained unaddressed. This highlights the need to balance between the supportive role of NGOs and the possibility that attention to NGO priorities could orient attention away from public feedback, particularly in resource-constrained settings.

Tensions in the representation role of HFC members, including of vulnerable groups

Some of my study findings also highlight the tensions in HFC roles that require balancing the interests of the public and those of the facility. Experiences in HFC-D showed a strained relationship

and contestation between the facility-in-charge, facility staff and HFC members, with a quiet withdrawal of support for the HFC from health providers. In addition, the staff and several SCHMT members perceived that HFC-D members were 'unprepared to do their roles' and appeared to be waiting for their tenure to expire. George et al suggest that if HFCs are seen to only facilitate government targets, which may not align with the interests of the public, the public is unlikely to support them [61]. At the same time, if HFCs serve as a way for the public and elected members to target healthcare workers as scapegoats for wider health system shortcomings then healthcare workers may withdraw their support [61].

As noted earlier, the case study HFCs had a passive approach to learning about public feedback. In my research HFC members reported receiving feedback mainly from people that knew them, including their friends and relatives, suggesting there was limited consultation with the wider public. Similar findings have been reported where the HFCs only received feedback from a fraction of the public [10, 23, 128, 129, 136]. In my study, the HFCs examined had little representation of vulnerable groups, suggesting that these HFCs were not an effective conduit for feedback from the vulnerable groups. This study finding contributes to the discussion on the problem of representation in HFCs. Loewensen et al highlights the tension between the extent to which HFCs are occupied by influential members of the public and representatives of vulnerable groups [276]. On the one hand, representatives of vulnerable groups bring the experience and voice of those with greater health needs to planning and organisation of service delivery. On the other hand, influential members of the public may be better able to address the power differences in the interaction between the public and healthcare workers [276]. In my study, some of the changes resulting from feedback related to HCW conduct (such as late opening of facilities and delays in service delivery) were initiated by such influential members of the public - for example the HFC chairperson who was also a village elder in HFC-A and by the assistant chief who was a representative of the national government at local level in HFC-B. Experiences from a study by Lodenstein et al report similar tensions with the more influential members of the public being able to enact 'local regulation' in response to negative public feedback about drug management by staff [129]. In describing HFC functioning in Nigeria, Abimbola et al argued that HFCs served many of their roles without being representative of marginalised groups, and that in contexts where HFCs receive little support from government or NGOs, elite members can use their resources and influence to achieve HFC goals [130]. The findings from my research suggest that both representation and influence of HFC members are important, and thus HFC membership needs to be carefully balanced to ensure representation of vulnerable groups, while ensuring that there are members influential enough to reduce power asymmetries between the public and healthcare workers.

8.4 Implications for policy, practice, and research

Drawing from the reported findings and contributions to research, I will address the study's fifth objective by making recommendations for policy, practice, and research.

8.4.1 Policy implications

Responsiveness is thought to occur when a health system is designed to incorporate the voices of the people receiving health services into its broader policy-making structures and to respond to issues and needs emerging within the system [13, 89]. The policy content and framing analysis findings in this study suggest that one of the influences on health system responsiveness is weak policy design. Considering the crucial role that policymakers play in shaping practice, it is important for policy makers to adopt policy adjustments that reflect the broad and complex nature of responsiveness. I explain this in more detail below.

Integration of varying responsiveness frames

The predominant focus within health sector policy documents on clinical service delivery draws attention to the different problem definitions addressed by the varying frames elicited from analysis of policy texts. Bacchi argues that policy is often a governance tool intended to redress a problem in society, and therefore policy proposals contain within them representations of what policymakers '*think needs to change'* (pg 8) [262]. Drawing on this argument, the participation, and rights-based frames within legislative, public and a few health sectors documents, present responsiveness as an opportunity to enhance equity. Enhancing equity is implied by these frames' attention to the inclusivity of various segments of the population, particularly the vulnerable whose representation in participatory mechanisms is explicitly expected. In contrast, the policy responses proposed by the 'responsiveness as feedback on clinical service' frame focus on service delivery interactions within most of the health sector policy documents, suggest that responsiveness is viewed as an opportunity to address clinical service delivery problems.

While 'responsiveness as feedback on clinical service' frame might be important to improve patient experiences and ensure service user-specific needs are met, the practice of HS responsiveness could be enhanced if policy makers integrated the various frames identified into a broader framing of responsiveness. Such a framing (that integrates elements from legislative instruments and public sector documents) would re-define the problem of responsiveness to include a focus on the wider public (irrespective of whether they have had a service delivery encounter) and provide more attention to varied population segments, including vulnerable groups. A wider focus (beyond patients and service users) within the health sector policy documents could contribute to health system actors considering data from multiple interactions beyond clinical service delivery interactions and at different phases of the policy process, as suggested in the framing of responsiveness within some of the public sector documents. The Kenyan public participation

guidelines (2016) appear to achieve this kind of integration [88]. This document includes consideration of an environment that enables public feedback; proposes collection of various data forms (both quantitative and qualitative) depending on the issue for which participation is required; recommends communication of findings following data collection back to the public; and suggests incorporation of feedback for service improvement and monitoring of feedback mechanisms. These considerations capture the interlinked framings of participation, accountability, rights-based and feedback on clinical service potentially providing a more holistic approach that might encourage more responsive health systems. These considerations also require re-imagining the functioning of feedback mechanisms including HFCs and SCHMTs. Rather than presenting feedback mechanisms in isolation, a more deliberate effort to integrate varied feedback forms, particularly at SCHMT and HFC level could support a more holistic view of the health system. For example, the HFC could review multiple sources of feedback from suggestion boxes and satisfaction records, including views raised by HFC members themselves [79]. SCHMTs could also be another point of integration where there is closer attention to linkages between HFCs, CHCs and other feedback mechanisms, how well vulnerable groups are represented within HFC membership, and to tracking responses to public feedback.

Development of guidelines to support over-arching strategy for responsiveness

Other findings in this work that have policy implications include the under-developed overarching strategy for responsiveness and a narrow focus in the measurement of responsiveness. The findings related to an under-developed strategy for responsiveness (Chapter 4) included lack of clarity on what happened with feedback once it was received, as well as the absence of guidelines that could provide more detail on the functioning of feedback mechanisms. These weaknesses were apparent from the empirical data (Chapter 5), as SCHMTs operated with low awareness of guidelines on how to manage public feedback, and feedback mechanisms experienced barriers to functionality. These findings are not unique to my study context. Similar findings have been reported in South Africa where policy documents lack clarity on the functioning of feedback mechanisms[270] and public participation is perceived to be 'spectator politics' where the public are merely used to endorse pre-designed programs [277]. Policymakers therefore need to enhance clarity on how feedback is used to generate a response and make provisions for responses to be communicated back to the public. Literature demonstrates that if communities do not feel that their input has value, they stop providing it [278, 279]. Given that there is existing legislated support for the gathering of public feedback, including directives that this feedback should result in service and systems-level response, policymakers can leverage this positive legislative environment to develop guidelines that provide more detail on functioning of feedback mechanisms with greater clarity on how

multiple feedback streams can be integrated, and how the loop between feedback and response is completed.

Broadening the measurement of health system responsiveness

It is important for policymakers to realise that the use of a satisfaction index to assess responsiveness supports an overt focus on service users and service delivery interactions. Further it excludes a significant number of the public who have not used health services. This is important information if health systems are to respond appropriately to segments of the population who have challenges in accessing the health system. Valentine et al (2010), highlighted the lost opportunity to learn about unmet need or inequities in access when they applied the WHO framing that adopts mainly service interaction measures to assess health system responsiveness [280]. More broadly, the use of a single index appears to be reductive for a multi-dimensional health system goal like responsiveness. To improve measurement of responsiveness would require the utilisation of both quantitative and qualitative methodologies, that include an assessment of the experiences of vulnerable groups, and that go beyond satisfaction levels.

Attention to the costs of establishing and maintaining feedback mechanisms and advocacy for resources

This study found immense implementation barriers to mechanism functionality, with resource constraints a cross-cutting factor, identified in Chapters 5, 6 and 7. These resource constraints were expressed in relation to conducting public participation meetings, training of HFCs, formalisation of CHW roles, conducting of satisfaction surveys and maintenance of hotlines. The literature shows that feedback mechanisms require financial support to be implemented and sustained [10, 265]. It is therefore important for policy to be explicit on the resourcing for mechanisms, both in terms of funding and human resource. Specifically, this might include having clear budget lines for activities that enhance the establishment and functioning of feedback mechanism such as training of HFC members and conduct of satisfaction surveys. In relation to human resources, studies from Kenya and India suggest that feedback mechanisms such as HFCs function better when there is a designated focal person to support them [136], and when there is long-term support that endures beyond the initial establishment period [137]. Across all the feedback mechanisms, it is important to know the costs associated with establishing and maintaining the feedback mechanisms for policymakers to advocate for their resourcing.

More broadly, the level of resources directed to the health system, matter. In this study, a context of resource scarcity and uncertainty made it difficult for HFCs and SCHMTs to generate and sustain responses. The study findings therefore emphasise the need for efforts to increase public

expenditure towards the health sector. A study by Robone et al found that public health expenditure is a driver of health system responsiveness [89], while Malhotra and Kyong Do found that countries with a high proportion of public health expenditure had health systems that were more responsive to low-income people irrespective of the GDP of the country [281]. In Kenya, overall allocation to the health sector has had limited growth by 109 percent between FY 2013/14 (following devolution) and FY 2020/21; and health as a proportion of total government budget stood at 11.1% in the FY 2020/21 [282]. Despite the limited growth in allocation at the national level, there have been improvements in the budget allocations to the health sector at county level, but even with these improvements the total budget allocations for health across national and county governments remain below the recommended 15% of the country's annual budget [282, 283]. Given the challenges reported in this study in relation to resource scarcity, advocacy by national and county level policymakers for increased allocations to the health sector are warranted.

Study findings also suggested that resource uncertainty had negative implications for responsiveness. This resource uncertainty was reflected in delays in disbursement from national to county governments and in direct facility funds from donors, NHIF and county government at PHC facility level. At facility level, resource uncertainty was also characterised by variations in the amounts disbursed to facility accounts. These findings are consistent with existing literature [96, 98, 99, 271, 284] and have bearing on how well actors were able to generate and sustain responses. For example, at facility-level a mechanism such as *mama* open days, designed to receive feedback from pregnant and postnatal women, and through which various responses to their feedback were enacted was supported by dedicated *Linda Mama* funds. However, the *mama* open days could not continue between 2019 and 2020 when there were significant delays in the reimbursements to PHC facilities. At SCHMT level, delays in national government disbursements to county level affected planning of SCHMT activities related to the functioning of feedback mechanisms. Even when the funds arrived, the SCHMTs' limited autonomy meant that funds allocated for their activities could be re-allocated by the County Treasury. Therefore, the advocacy efforts of national and county-level policy makers would need to move beyond a specific target for health to include proposals that ensure allocated resources are efficiently used by improving the flow of funds across government levels to health system management units and health facilities.

8.4.2 Implications for practice

By doing an in-depth exploration of the lived experiences of actors, I have generated findings about the social and political nature of health systems [285]. Specifically, study findings from chapter 6 support the idea that actors' decisions and actions in relation to policy implementation are a influenced by the meanings that actors make out of their surrounding realities [202]. For example,

the public's actions of sharing feedback were influenced by their social position relative to health managers, while for managers and policymakers, actions taken in response to public feedback could be linked to their organisational position. In other instances, the observed power struggles were linked to the personal interests of actors, and the worldviews held by actors which contributed to how actors made sense of public feedback. As such these findings related to actor lifeworlds and the exercise of power can be drawn on to strengthen responsiveness. This is in line with other HPSR studies which have demonstrated that that there is potential to leverage on the lived experiences of actors to promote policy implementation [196, 208]. Parashar et al (2021) found that actors drew on their lifeworlds to support implementation of the policy under study, but where policy intent was misaligned with the observed lifeworlds of actors, then delivery of policy benefits to the public was undermined [208]. In this study responsiveness to public feedback appeared to be enhanced by, for example, the exercise of visible power by political representatives underpinned by organisational power relationships and personal concerns about (re)election. Given the influential role of political representatives in my study context, several SCHMT members, particularly in SCHMT-A leveraged this lifeworld to generate responses to public feedback particularly those requiring significant resources. This suggests that building relationships with politicians and leveraging politicians' personal interests could be used to support responsiveness to public feedback.

However, politicians' lifeworlds should be leveraged carefully to ensure equity and a systematic approach to responsiveness, elements that might not always align with politicians' lifeworlds. For example, in my research, despite a few positive experiences with politicians, there were also experiences of 'political interference' and of attempts by politicians to 'promote unfairness'. My study findings regarding experiences with politicians have resonance with existing literature from high-income and LMIC countries which suggest political actors are attracted to the more visible, short-term type of results linked to election cycles [286, 287] and leaving a political legacy [288]. This makes it necessary for health managers to cautiously leverage politicians' actor lifeworlds in a way that balances the support that politicians can give and independence from them [politicians]. To do this requires support that could insulate middle-level health managers against political power in instances where politically motivated responses to public feedback undermine equity and a systematic approach. Such kind of insulation might be provided by senior county health managers who can advocate to politicians the complexity of the health system.

In relation to equity in responsiveness, efforts by the public to access their politicians to leverage responses appeared to be driven by the predominance of invisible and hidden powers that kept the public away from sharing their input with health system actors, and undermined responsiveness. Other studies have reported similar hindrances to the public voicing their concerns related to power asymmetry between the public and health system actors, fear of victimisation, and poorly

functioning feedback mechanisms [23, 24, 289]. Efforts that could off-set invisible power and strengthen the public's capacity to provide feedback include increasing awareness to the public about their right to provide feedback and the mechanisms available to provide feedback and reducing the costs of participation by providing timely information about participatory activities through varied media that can reach a wide range of members of the public. This latter strategy of using varied media is especially relevant given the widespread ownership of mobile phones in Kenya reported at 109%[17] and increasing use of social media, reported to have increased to 11.01 million[18] users in 2021 (25% increase between 2020 and 2021)[290]. These numbers are important because the rapidly increasing numbers of mobile phone ownership and social media users [291, 292] provide an opportunity for health system actors to communicate with the public both about participatory activities where public feedback could be elicited, and actions taken in response to public feedback.

In this study, health managers acknowledged that the public shared feedback through social media but perceived this to be disruptive due to the political pressure it generated. Another concern with the use of social media by the public was the reputational damage to the department of health as managers reported that mainly negative feedback was shared. Managers also reported being constrained in keeping track of social media feedback because they could not always be online. Despite the negative experiences of health managers with instances where the public utilised social media to share feedback, the fact that the public used them at all suggests, as noted above, that they are an important mechanism to pay attention to and incorporate to enhance health system responsiveness. Further, the use of social media could engage more people including vulnerable groups.

In relation to supporting the public to provide input, a practical way to challenge the perception among health managers that public input (particularly for priority-setting and budgeting) is 'incoherent' and focused on individual needs might be the adoption of tools that support deliberative approaches with the public. There are varied mechanisms and processes to get public feedback on priority-setting, but deliberative approaches are viewed to enhance meaningful participation because they encourage debate, dialogue, and allow for consideration of trade-offs [293]. For example, a study from South Africa demonstrated that when members of the public were informed of the resource constraints experienced by the health system, they were able and willing to make trade-offs and to reach a consensus regarding local priorities [294].

[17] Many people have more than one mobile phone thus figures for mobile phone ownership can exceed 100% of the population.

[18] Figures for social media users are not equal to individual social media users

Other actions targeted at hidden power that could be taken by SCHMT members include ensuring that mechanisms within their control such as HFCs, remain truly inclusive especially of vulnerable groups by sharing the rationale for inclusion of these vulnerable groups with facility-in-charges and other public sector administrators involved in HFC election processes. But ensuring their presence may not be enough, as physical presence does not always guarantee meaningful participation [133], and it may be necessary to encourage vulnerable groups to speak and actively participate.

Literature suggests that the willingness of those with hierarchical power to support implementation is an important pre-condition for the success of initiatives [295, 296]. In this study visible power exercised by higher-level managers over others (CHMT managers over SCHMT managers, and SCHMT managers over facility-in-charges) was a pre-dominant influence on the support provided to enable functioning of feedback mechanisms and therefore receiving feedback, and for generation of responses. This suggests that higher-level health system managers (e.g., the CHMT) can leverage their organisational power relationships to formally endorse processes that encourage middle (sub-county) and local-level (facility-level) managers to engage positively with public feedback and feedback mechanisms. One way to do this would be by clarifying within the CDoH where responsibility for receiving and responding to public feedback lies and disseminating information on existing county policy on managing public feedback. This would then be relayed downwards to all health system actors. The CHMT could also hold sub-county and facility managers accountable for weak or no handling of public feedback. However, this hierarchical power would need to be exercised in a way that is supportive, rather than demanding compliance. Literature warns that multiple demands for compliance push managers to prioritize certain courses of action over others and that this could undermine responsiveness to the public [297]. In this study, the case study SCHMTs appeared to experience constraints to their flexibility due to vertical accountability constraints. This was illustrated in the tensions between the CHMT and case study SCHMTs where CHMT members *'dictated'* directions to SCHMT members, resulting in SCHMT reluctance to share feedback upwards. To guard against this, emphasizing responsiveness combined with transparency about actions taken in response to feedback and autonomy in decision-making, is likely to contribute to orienting DHMTs outwards to the public and therefore to building responsiveness.

Another way to strengthen responsiveness could include efforts targeted at SCHMTs and facility-in-charges' worldviews. In this work, health managers' world views sometimes reflected an organisational culture of defensiveness against public feedback. Changing actors' worldviews may be difficult, but literature on strengthening district-level leadership and management suggests that experiential learning and reflective practice focused on personal and professional experiences has the potential to shape mindsets [298, 299]. This could be useful in shaping health system actors' worldviews about the value and legitimacy of public feedback for health system decision-making.

Reflective practice also has the potential to yield improvements in leadership, individual and team behaviours [298, 299]. This is important given the demonstrated linkages between SCHMTs and HFCs. There is therefore potential for the SCHMTs themselves to further shape the mindsets of facility-in-charges to value public feedback, and to improve HFC approaches of engaging with public feedback. However, for reflective practice to have these effects, certain organisational conditions need to be in place that allow individual and group reflective practices to trigger organisational change. This conditions include support from higher system levels [300], and attention to structural barriers that could make it unsustainable to translate managerial efforts into organisational gains.

More broadly, it would also be important to address the contextual factors described in Chapter 7 in relation to provider norms. Campbell and Jovchelovitch (2000) observed that efforts that aim to enhance public voice in health sector decision-making need to be accompanied by a focus on how receptive the health system environment is [301]. The findings in Chapter 7 illustrated that low responsiveness was linked to ingrained provider professional norms (and attitudes) to public feedback which manifested in practices of poor communication to patients and their relatives, and low receptivity to public feedback. These ingrained norms seemed to be linked to underlying factors such as HCWs and managers professional training, weak induction processes into the public sector, and working conditions related to understaffing. Weak communication skills and low receptivity to public feedback are illustrative of weak intangible software. The importance of communication skills for health professionals is increasingly being recognised [302, 303]. Thus, actions that could strengthen communication with the public, and by extension responsiveness include adoption of communication models that promote reduction of the power asymmetries between the public and healthcare providers in pre-service training, and that prepare health providers in training to be more receptive to patients and the public. For the newly employed, allocation of resources to support induction of newly employed staff, where such skills can be re-emphasised could also contribute to greater receptiveness to public feedback. For those already working in the health system, strategies such as short-term training accompanied by longer-term mentorship could be used to build intangible software [299, 304].

Finally, study findings about NGOs and their role in supporting the functioning of feedback mechanisms and responsiveness to the needs of particularly vulnerable groups are consistent with findings in a study from India on the functioning of Village Health Nutrition and Sanitation Committees (VHNSCs) by Scott et al [305]. In the study by Scott et al, NGOs utilised their in-between role as government helper and community advocate to support the establish and functioning of VHNSC [305]. However, and like in this study, the NGO could only provide this support for a limited time. Thus, while leveraging the resources and technical capacity of NGOs can strengthen responsiveness, consideration of the limited grant periods within which the majority of NGOs work is imperative. Therefore, to achieve sustainable support for the functioning of feedback

mechanisms, and to strengthen responsiveness more broadly, NGOs and health managers may also need as part of their strategies to conduct advocacy to county policy makers and legislators to not only set aside resources that can support functioning of feedback mechanisms when a grant period comes to an end, but to ensure that these budgetary allocations are protected.

8.4.3 Study Limitations

One of the limitations of this study is linked to concerns about the generalizability of the study findings. In this work, the focus was only on two SCHMTs and their respective linked HFCs. Thus, the findings cannot be generalised to the population from which the cases are derived -all SCHMTs and HFCs across Kenya- given the complexity and context-specific nature of responsiveness. However, the case study approach does support analytic generalizability, where conclusions about relationships between concepts can be drawn that are transferable to other settings [212, 218]. Therefore, some of the learning about responsiveness to public feedback generated from this work may apply to similar settings and can be used to provoke reflection on responsiveness in other settings.

This study did not include the views of members of the public other than those elected to the Health Facility Committees. Given their exposure to the health system during their tenure, HFC members could be considered atypical members of the public. It could be argued, therefore, that the study did not fully capture the full range of actors involved in the responsiveness pathway. However, the study set out to understand the generation of responses from the health system side, and thus I believe these objectives were addressed even in the absence of views from the broader public.

Finally, I began the first phase of the study during the early days of the COVID-19 pandemic response in Kilifi County, which was among the first counties in Kenya to report a COVID-19 case. Given the attention given to COVID-19, questions might arise about whether the study findings would be applicable in a period devoid of a health system shock such as the COVID-19 pandemic. To minimize the dramatic effects of the COVID-19 pandemic, I collected data in two phases, first during these early days of the pandemic response (three months after the first case was reported), and in a second phase (almost a year later since the first case was reported) as the pandemic continued to unfold. However, health systems are rarely static, and it was important to examine the health system with the understanding that it is dynamic [197].

8.4.4 Areas for further study

This study has highlighted several areas for further investigation. First, the study was conducted in one Kenyan county, focusing on only two ‘processing spaces’ within the county health system. Conducting a similar study in other geographical settings and considering multiple spaces where public feedback is received and responded to within the health system, will deepen understanding of health system responsiveness.

Second, this study focused on HFCs and SCHMTs and drew out interactions with NGOs that contribute to responsiveness. However, the study did not provide an in-depth exploration of NGOs experiences in receiving and responding to public feedback, and how these link back to the health systems that they work in. This is important because NGOs have been highlighted in this study to work with groups that are vulnerable, and investigation of their experiences might reveal unique issues for consideration in relation to HS responsiveness.

Third, this study highlighted that little feedback was picked up from groups identified as vulnerable. The groups considered here were mainly, women, youth and PLWD. However, I recognise that there are other groups that the health system needs to be more inclusive of and responsive to, some of whom were mentioned by study respondents and are identified in literature such as People Who Inject Drugs (PWID), street-connected children and ethnic minorities. In-depth research that considers these groups specifically will be useful to generate information about their participation in feedback mechanisms, experiences in leveraging responses from the health system and the sustainability of these responses.

Fourth, this study explored processes of receiving and responding to public feedback in two spaces within the health system and examined how the connections between these two spaces enhance responsiveness. However, there are many other spaces where public feedback might be received that could shape the health system. In Kenya, these include County Assemblies, public participation fora, and stakeholder fora where NGOs might share feedback that they have picked up in interactions with the public. Exploration of responsiveness practices, including the linkages between mechanisms and on the exercise of power in these spaces could extend the literature on responsiveness further.

Revisiting the study conceptual framework

This study is the first to my knowledge to adopt a power analysis that combines both Gaventa's power cube and Long's actor interface analysis to examine the functioning of a space where public feedback is received and responded to. I found these two power frameworks to be complementary. The power cube supported the examination of the SCHMTs and HFCs as collective spaces, and how these collectives' use of power was supported or constrained by structural factors. I found these structural factors to be related to the power cube's levels of power, and visible and invisible forms of power. Long's actor interface analysis was useful in eliciting where and with whom power lies, and why certain actions were taken (or not) concerning public feedback. Based on these findings,

Figure 8.1 below summarises a few ideas about the influence of power dynamics on actor interactions in receiving and responding to public feedback.

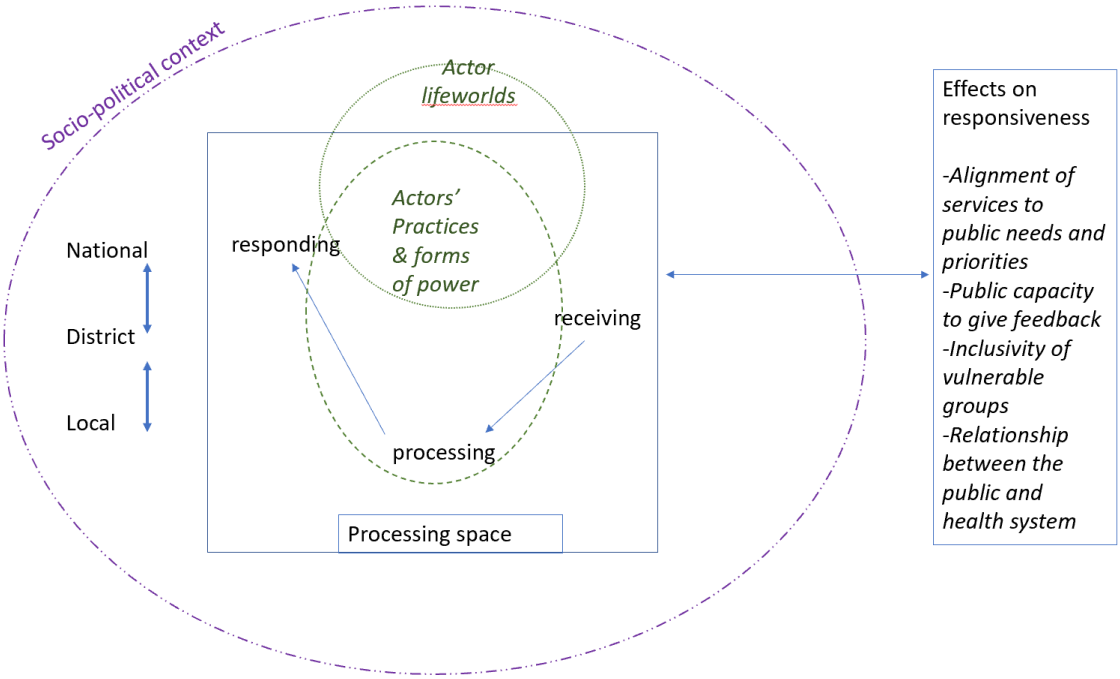

Figure 8.1: A conceptual framework for how power influences the practice of responsiveness in health system processing spaces

This framework illustrates the interplay between structural influences and actors' agency within the spaces where decision-making about public feedback happens. It suggests that actors' lifeworlds are shaped by the contexts in which they find themselves. These in turn shape the actors' power practices and forms of power in receiving and responding to public feedback. Within a processing space for public feedback such as the SCHMT or HFC, power can be wielded in both positive and negative ways. How this power is exercised has a reinforcing effect on the public's sharing of feedback. Positive power practices support the generation of responses and even more feedback from the public. Negative power practices could limit the generation of responses and the public's sharing of feedback or prevent the public from building claimed spaces. However, causation is not linear as actor interfaces form and re-form resulting in power struggles, the effect of which could be to support or undermine the practice of responsiveness, including by excluding the voices of marginalised groups. Further, in these power struggles, power may flow bottom-up, contrasting with the traditional top-down flow, particularly where the public reacts to domination with resistance or contestation.

Having drawn on two power lenses and developed a framework (Figure 8.1) that illustrates the influence of actor interactions and power dynamics on health system responsiveness, there is room for HPSR investigators with an interest in health system responsiveness to test this framework

within further research that considers experiences in other types of spaces where public feedback is received and responded to.

8.5 Chapter Summary

In this chapter, I have presented a synthesis of the overall study findings, which highlight the multi-faceted nature of responsiveness as a health system goal that is influenced by the legislative and policy macro-context, meso-level contextual features, and micro-level actor interactions and power dynamics that cut across multiple health system levels. I have also presented the contributions of this study to existing HPSR literature on responsiveness, and DHMTs and HFCs. I have also considered the implications of these research findings to policy, practice and identified areas for future research. I have presented a framework that explains interactions between actors, their power dynamics and how these might influence the functioning of feedback mechanisms intended to enhance responsiveness. This framework could be tested in future research. I have summarised below recommendations for policymakers, health managers and researchers based on the findings of this study.

<u>Recommendations for national-level policymakers</u>

- National level policy makers need to review the policy content on responsiveness and provide a clearer overarching strategy for health system responsiveness that adopts a systems view rather than a service delivery view of responsiveness. Such a system view would also incorporate integration of feedback from multiple streams of feedback mechanisms to encourage system-wide responses. This system view would also draw on the broader framing of responsiveness adopted in legislative instruments
- It is necessary to develop guidelines with more detail on the functioning of feedback mechanisms such as consideration of the human resource required to support functioning of feedback mechanisms, and clarifications on how feedback from the public is utilised to generate responses.
- The measurement of responsiveness needs to be expanded beyond tracking satisfaction levels and broadened to include both qualitative and not only quantitative methods, as these are likely to tell us more about the experiences of varied populations, and particularly vulnerable groups.
- National level policymakers need to advocate for more resource allocation to the health sector at national and county level to support establishment, functioning and support of feedback mechanisms.

<u>Recommendations for county policy makers, health managers, sub-county health managers and HFCs</u>

- County policy makers and health managers need to clarify where within the County Department of Health, and with whom responsibility for managing public feedback lies.
- County policy makers and health managers need to endorse processes of receiving and responding to public feedback, including what policies and guidelines exist at county level to support responsiveness to public feedback. These can then be used to hold sub-county managers and facility managers accountable for handling of public feedback.
- County policy makers need to advocate for allocation of resources to the County Department of Health to support induction of new health providers, and support functioning of feedback mechanisms such as HFCs beyond establishment.
- County and sub-county health managers can collaborate with NGOs and research institutions to build the intangible software capacity of health managers and frontline providers that could support strengthening of communication skills and engagement of stakeholders particularly political representatives.
- Sub-county health managers can support the inclusion of vulnerable groups in participatory feedback mechanisms by creating awareness to the public of HFC member election procedures through multiple avenues.
- Sub-county health managers need to appreciate that political representatives have a responsibility to the public to be responsive to their demands and personal interests to do so. Such appreciation can help sub-county health managers to leverage their relationships with political representatives to enhance responsiveness.
- County, sub-county health managers and HFCs who have received public feedback need to disseminate information back to the public regarding responses generated, including providing opportunities for the public to provide input into the processes of how their feedback is managed.

Areas for further research

- Empirical research needs to explore the experiences of vulnerable groups who participate in feedback mechanisms and draw connections between their participation and ability to leverage responses for the groups they represent.
- More empirical work is needed on how NGOs and other spaces within health systems such as public participation fora and stakeholders' fora contribute to enhancing health system responsiveness. This empirical work can test the power framework introduced in this study.

8.6 Personal reflections on recent policy proposals with potential to strengthen responsiveness to public feedback

The current Kenya health sector strategic plan (2018-2022) recognises that there are weaknesses in the governance of the Kenyan health system characterised by inadequate inclusion of all stakeholders in the public health sector, weak accountability to the public and weakly functioning

governance structures. This recognition has contributed to proposals to, review guidelines for the functioning of health facility committees [250]; develop an accountability framework to assess Community Health Committee functionality [251]; finalise and disseminate a social accountability manual [251]; establish new public accountability mechanisms such as community score cards [306]; and conduct capacity building for counties on social accountability [306]. The references to both patients and the *public* and focus on participatory methods for receiving public feedback in the recent proposals suggest an improvement that could address the breadth of responsiveness. However, these changes are still not fully in line with systems-thinking, and therefore may not be a substantive shift in the conceptualisation of responsiveness by policymakers. For example, there is still much focus on the process of receiving, and much less on the generation of responses to public feedback, and a strong focus on formal feedback mechanisms, yet as illustrated in this thesis, informal feedback mechanisms are important to consider.

Notably, much emphasis has been placed on social accountability as an important outcome. As noted in the introduction chapter of this work, accountability is a means to responsiveness [51]. Drawing from this thesis, I understand responsiveness to be linked to but distinct from social and outward accountability. Social accountability provides a way for scrutiny of the public health sector to be achieved, and in some instances (though few), sanctions could be applied. However, responsiveness reflects the imperative to build a people-centred health system, by incorporating people's views into shaping health systems, which has political and social justice elements. In this study's conceptualisation of responsiveness, accountability mechanisms are acknowledged as possible feedback mechanisms through which public views reach health system actors. Some mechanisms (particularly 'voice'[19] mechanisms where the public seek redress for negative experiences with the health system) can involve accountability procedures. Here these accountability procedures would be working to facilitate responsiveness. However, in other instances the public could 'exit' by failing to utilise a public health service or a feedback mechanism which is more reflective of weak responsiveness, rather than weak accountability. Social accountability therefore presents one component among many required for a responsive health system. Responsiveness refers to the changes made to the health system because of views or concerns raised by and with the public through both formal and informal feedback mechanisms. It is the result of a combination of various elements such as the broader governance context, health system characteristics including health provider, manager and policymaker perceptions on public feedback, and the features of feedback mechanisms.

[19] The terms exit and voice are borrowed from Exit, Voice and Loyalty (Hirschman, 1970). It's been adapted here such that, the public use their 'voice' through channels available to them to express views/concerns about the public health sector, 'Exit' occurs by the public moving across providers (public or private) to seek a health service.
(Hirschman, A. O. (1970). *Exit, voice, and loyalty: Responses to decline in firms, organizations, and states* (Vol. 25). Harvard university press.)

The focus on social accountability in the current health sector strategic plan if carried over to the next health sector five-year strategic plan (2023-2028) can begin to shape how public feedback is valued. This is a step towards strengthening responsiveness. In addition, several of the proposals in the documents referred to above are steps towards changing organisational practices and norms, which have been shown in this thesis to influence health system responsiveness. Efforts at changing organisational practices can be impactful and could lead to culture-change when there is provision for long term and deepened engagement with health system actors and the public. In top-down hierarchies such as the Kilifi County health system, and indeed the Kenyan public health sector, where it goes against the grain to be inclusive of local priorities and thinking, the spirit of culture-change could be lost given the difficulties inherent in implementing such interventions. Having conducted this study on health system responsiveness to public feedback, and identified both positive and negative exercises of power, and influences of context, it is important that these are considered in the conceptualisation of responsiveness and proposed practices towards building a more responsive health system.

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Appendices

Appendix 1: Summary of articles included in HFC literature review

Authors	Title	Region/country/Study design	Study objective	Key findings
Hamal, M., et al. , 2019	Social Accountability in Maternal Health Services in the Far-Western Development Region in Nepal: An Exploratory Study.	Nepal;Qualitative	Describe and discuss social accountability mechanisms that exist for maternal health services	Functioning of Mother's Groups & CHVs limited to information sharing. Social audits & Community Health scoreboards implemented in limited sites with poor participation. Local level responses
Lodenstein, et al 2019	"We come as friends": Approaches to social accountability by health committees in Northern Malawi	Malawi;Qualitative	Explores how HFCs monitor the quality of health services and how they demand accountability from health workers	HFCs addressed health worker performance mainly using informal approaches
Gurung, G., et al. 2018	Nepal's Health Facility Operation and Management Committees: exploring community participation and influence in the Dang district's primary care clinics.	Nepal; Qualitative	Describe community representation in HFCs and influence of community representatives in HFC decision-making	High representation of women & marginalised cases. Selection processes were influenced by powerful elites. Participation was mainly 'Manipulation & Information
Topp, et al, 2018	The health system accountability impact of prison health committees in Zambia	Zambia; Qualitative	Examine impact of newly established prison health committees	Improved access to care among inmates, improved relations between inmates& corrections officers
Feruglio, F., Nisbett, N, 2018	The challenges of institutionalizing community-level social accountability mechanisms for health and nutrition: A qualitative study in Odisha, India	India;Qualitative	Examine community level social accountability mechanisms and how they are perceived by community members & frontline workers	Weak community participation, committees largely controlled by frontline workers; Self-help groups had more collective power & were better able to advocate for members' needs
Ogbuabor, D.C., Onwujekwe, O.E., 2018	The community is just a small circle: citizen participation in the free maternal and child healthcare programme of Enugu State, Nigeria	Nigeria;Qualitative	Examine the influence of social accountability initiatives on revenue generation, pooling and fund management, purchasing and capacity of health facilities in a free maternal child health programme	HFCs were constrained by weak legal framework, ineffectual committees higher up the system, restricted financial disclosure, mistrust & weak complaints systems
Oguntunde,et al, 2018	Overcoming barriers to access and utilization of maternal, newborn and child health services in northern Nigeria:	Nigeria; Mixed methods	Assess stakeholders' perspectives on HFC contribution to quality of care with a focus on maternal child health services	HFCs had positive impact on MCH services, they mobilised the community & increased demand for MCH services

	An evaluation of facility health committees			
Danhoundo et al, 2018	Improving social accountability processes in the health sector in sub-Saharan Africa: A systematic review	Sub-Saharan Africa;Systematic review	To identify the conditions that facilitate effective social accountability	Facilitative conditions: leveraging partnerships, context-appropriate, intergrated data collection, cleary defined roles; Constraining conditions: corruption, community fear of reprisal, and limited funding
Madon, S., Krishna, S.2017	Challenges of accountability in resource-poor contexts: lessons about invited spaces from Karnataka's village health committees	India;Qualitative longitudinal study	To examine influence of VSHNCs on inter-actor accountability	Increase in frequency & quality of interactions within the VHSNC
Passi, R., et al. 2017	Assessment of village health sanitation and nutrition committees of Chandigarh, India.	India; Mixed methods	Assess implementation status of VHSNCs & analyse implementation challenges	Most VHSNC members were trained, had opened bank accounts, and received the 'untied' grant which was mostly used for administration leaving little for health and nutrition-related activities.
Scott, K., et al. 2017	Beyond form and functioning: Understanding how contextual factors influence village health committees in northern India.	India; Qualitative longitudinal study	Examine how VHSNCs navigated their contextual environment and how this influenced VHSNC functioning	Women & marginalised groups navigated social hierarchies that hindered their ability to be assertive in the presence of men & powerful local families; non-responsiveness of higher system level bred mistrust of government institutions
Gurung, et al, 2017	Why service users do not complain or have 'voice': A mixed-methods study from Nepal's rural primary health care system	Nepal; Mixed methods	Explore the relevance of the concept of patients' complaints as a management tool	Infrequent complaints by service users linked to perception of non-responsiveness among providers, little knowledge of service entitlements, low awareness of complaint mechanisms
Lodenstein, et al 2017	Social accountability in primary health care in West and Central Africa: Exploring the role of health facility committees	Benin, Guinea, DRC; Qualitative	Explore the social accountability practices facilitated by HFCs	HFCs facilitated social accountability by engaging with health providers in person or through meetings to discuss service failures, leading to changes in quality of services
McMahon,et al, 2017	"We and the nurses are now working with one voice": How community leaders and health committee members describe their role in Sierra Leone's Ebola response	Sierra Leone; Qualitative	Examine community volunteers and HFC members' roles during the Ebola outbreak	HFC members (& other community volunteers) built community trust and support for Ebola prevention and treatment & enabled formal health workers to better understand and address people's fears and needs

Scott, K.,et al, 2016	Negotiating power relations, gender equality, and collective agency: Are village health committees transformative social spaces in northern India?	India;Qualitative longitudinal study	Examine how VHSNCs enable/hinder the renegotiation of power	VHSNCs supported some re-negotiation of intra-community inequalities but this did not extend outside the VHSNC; powerful outside stakeholders emphasized community responsibility for improving health without acknowledging barriers to effective VHSNC action
Abimbola, et al, 2016	'The government cannot do it all alone': Realist analysis of the minutes of community health committee meetings in Nigeria	Nigeria; Qualitative	Examine how and under what circumstances committees influence the demand and supply of PHC services	Committees demonstrated 5 modes of functioning: villages square, community connectors, government botherers, general overseers& back-up government
Srivastava, et al, 2016	Are village health sanitation and nutrition committees fulfilling their roles for decentralised health planning and action? A mixed methods study from rural eastern India	India; Mixed methods	Examine structure & functioning of VHSNCs for decentralised health planning and community action in health, nutrition and sanitation	Equitable representation from vulnerable groups. VHNSCs focused on health promotion activities. Constraints: irregular meetings, members' limited understanding of their roles & responsibilities, restrictions on planning and fund utilisation, and weak linkages with the broader health system
George et al, 2017	Anchoring contextual analysis in health policy and systems research: A narrative review of contextual factors influencing health committees in low and middle income countries	LMICs; Narrative review	Examine the contextual features relevant to HFC	Demonstrated that contextual elements are dynamic and porous in nature, influencing HFCs but also being influenced by them. Identified contextual elements that are well understood and those that are not e.g. markets and media
Kilewo, E. G. and G. Frumence , 2013	Factors that hinder community participation in developing and implementing comprehensive council health plans in Manyoni District, Tanzania	Tanzania; Qualitative	Examined factors that hinder community participation in developing and implementing Comprehensive Council Health Plan (CCHP).	Low participation of HFCs in planning. Participation hindered by poor communication, resource constraints, lack of role clarity & low management capacity among HFCs
Gurung, G. and S. Tuladhar, 2013	Fostering good governance at peripheral public health facilities: an experience from Nepal.	Nepal; Mixed methods	Examine how good governance at the peripheral public health facilities in Nepal can be fostered	HFC meetings increased, membership expanded to include marginalised castes & women, enhanced resource mobilisation, increase in health facility opening days because of continuous engagement & capacity building of HFCs by NGO partner

Waweru et al, 2012	Are Health Facility Management Committees in Kenya ready to implement financial management tasks Findings from a nationally representative survey	Kenya; Mixed methods	Assess how prepared HFCs were to undertake a new financial management role	Most facilities had bank accounts and HFCs which met regularly. HFC members and in-charges generally had positive relationships, HFC members expressed high levels of motivation and job satisfaction. Challenges included users' low awareness of HFMCs, lack of training and clarity in roles & some indications of strained relations with in-charges
McCoy, D. C., et al. 2012	A systematic review of the literature for evidence on health facility committees in low-and middle-income countries.	LMICs; Systematic review	Examine HFC effectiveness in achieving community participation & factors that influence HFC perfomance & effectiveness	HFCs had varying roles in different contexts and hence were influenced by different factors
Molyneux, S., Atela, M., Angwenyi, V., Goodman, C.	Community accountability at peripheral health facilities: A review of the empirical literature and development of a conceptual framework	LMICs; Systematic review	Review empirical literature on accountability mechanisms in peripheral facilities & to present a conceptual framework	Little empirical work on accountability mechanisms linked to peripheral facilities; Available literature suggested accountability initiatives may face constraints related to how communities are defined, support at community, facility, and higher system levels
Falisse, J. B., et al. 2011	Community participation and voice mechanisms under performance-based financing schemes in Burundi.	Burundi;Quantitative	Analyse 2 community accountability mechanisms, CBOs & HFCs in a Performance Based Financing programme	HFCs focused on supporting medical staff & not on representing the population. CBOs conveyed information about population concerns to the health authorities; but represented few users and lacked the ability to enforce change.
O'Meara, et al, 2011	Community and facility-level engagement in planning and budgeting for the government health sector – A district perspective from Kenya	Kenya;Qualitative	Examine the experience implementing annual health sector planning guidelines that included community participation	Community engagement was conducted through HFCs. There was overlap in some priorities raised by staff, communities and those included in national indicators. Majority of the community priorities were not included in the final plan as national indicators took precedence
Zambon and Ogatam 2011	Municipal health council compositions in the state of Sao Paulo	Brazil; Qualitative	Discuss the legal structure of the municipal Health Councils in a Health County in a state with six municipalities.	Some council regulations had evolved & disagreed with local and federal laws. Authors recommended correction and improvement of regulations to facilitate performance of the health councils

Goodman, et al. 2007	Health facility committees and facility management - exploring the nature and depth of their roles in Coast Province, Kenya.	Kenya; Mixed methods	explore the nature and depth of managerial engagement of HFCs & how this has contributed to community accountability	Breadth & depth of HFC activities increased after introduction of direct facility funding. Good relationships with facility staff, but some mistrust was expressed between HFC members and health workers, & between HFC members and broader community, partially reflecting a lack of clarity in HFC roles. Women & uneducated were likely to have low awareness about HFCs
Mubyazi, G. M., et al. 2005	Community views on health sector reform and their participation in health priority setting: case of Lushoto and Muheza districts,	Sub-Saharan Africa, Tanzania; Qualitative	explore and describe community views on HSR and their participation in setting health priorities.	Community members were dissatisfied with services at facility level & with the Community Health Fund; user fees were a burden to community members; low engagement between communities and their respective VDCs and WDCs
Golooba-Mutebi, F., 2005	When popular participation won't improve service provision: primary health care in Uganda.	Sub-saharan Africa, Uganda; Qualitative	Analyse the inlfuence of decentralisation & community participation in improving quality of care	HFCs did not meet regularly, complaints by service users rarely received a response; A history of dictatorship and civil war coupled with resource constraints & political patronage within the health system discouraged community participation
Few, R., et al, 2003	Urban primary health care in Africa: a comparative analysis of city-wide public sector projects in Lusaka and Dar es Salaam.	Sub-Saharan Africa, Zambia & Tanzania; Mixed methods	assesses urban and rural contexts of health care in LMICs with reference to 3 issues: by-passing of primary services, community participation and inter-sectoral action	Health committee role in monitoring, planning and management strengthened throughout project; however, low awareness of HFCs and perception that HFCs existed to serve facility needs rather than community needs
Iwami, M. and R. Petchey, 2001	A CLAS act? Community-based organizations, health service decentralization and primary care development in Peru. Local Committees for Health Administration	Peru; Qualitative	evaluate the achievements of the CLAS & analyse the relationship between health and economic policy	High participation among women in CLAS activities, CLAS was effective in identifying unmet needs and developing a payment system that protected the poorest
Ramiro, L. S., et al, 2003	Community participation in local health boards in a decentralized setting: cases from the Philippines.	Phillipines Mixed methods	to analyze the role of the LHB as the government's intended mechanism for broader community participation in health decision-making	More consultations with the community & higher per capita health expenditure in units with functioning local health boards. Only mayors and municipal health officers felt empowered by devolution; low awareness of devolution and their roles in health decision-making among community members.

Jacobs & Price, 2005	Community participation in externally funded projects in Cambodia	Cambodia Mixed methods	examine the effectiveness of an innovative equity fund approach to improving access to public sector health services for the poor	Community participation structured around *pagodas* was more effective & sustainable than newly (and externally) established community structures with formally elected representatives.
Jacobs & Price, 2004	Improving access for the poorest to public sector health services: insights from Kirivong Operational Health District in Cambodia	Cambodia Quantitative	explore the appropriateness of utilizing community members to identify the poorest for an equity fund aimed at increasing access to health services for the poor	Identification by community members (pagoda volunteers) of those eligible for equity funds was feasible, accrued minimal direct costs, and was effective in attracting the poorest to the public sector
Loewensen et al, 2008	Assessing the impact of health centre committees on health system performance and health resource allocation	Zimbabwe; Mixed methods	analyse & understand the relationship between HFCs as a mechanism of participation and specific health system outcomes	HFCs identified community needs, mobilized community action and support for primary health care programmes, but their role in decision-making and holding service providers to account was contested.
Boulle et al, 2008.	Promoting Partnership between Communities and Frontline Health Workers: Strengthening Community Health Committees in South Africa.	South Africa; Mixed methods	explore different dimensions of participatory approaches (focused on HFCs) to people-centred health systems	Establishing a focal person to support Community health committees was instrumental in re-establishing & supporting HCCs in their roles
Mubyazi et al, 2007	Local primary health care committees and community-based health workers in Mkuranga District, Tanzania: does the public recognise and appreciate them?	Tanzania; Qualitative	explore villagers' views on existence and functioning of local PH committees, village health workers, health facility staff & responsiveness to community needs	Low awareness of VHWs & HFCs among community; dissatisfaction with health providers; Health providers were unhappy with villagers' complaints as they felt villagers were aware of resource constraints within the health system
Ngulube et al, 2011	Governance, participatory mechanisms, and structures in Zambia's health system: an assessment of the impact of Health Centre Committees (HCCs) on equity and health care	Zambia & Tanzania; Mixed methods	assess impact of Health Centre Committees (HCCs) on equity in health and health care	Generally low awareness of HCC members among community members; Some HCCs had authority to make own decisions on certain things. Better performing HCCs kept their user fees lower and provided for other alternatives to cash payments
Macha et al, 2011	Examining the links between accountability, trust, and performance in health service delivery in Tanzania	Sub-saharan Africa, Tanzania Mixed methods	examine pre-conditions for effective functioning of the committees to represent community voice & improve health worker performance & resource mobilisation	Most HCCs had at least one female member, & all members were voted in. 2 HCCs selected for in-depth study, one committee was more active due to its engagement in facility construction activities which focused committee's energies. Reported mistrust between HCCs & existing local structures

Niyongabo et al, 2018	"Ways and channels for voice regarding perceptions of maternal health care services within the communities of the Makamba and Kayanza provinces in the Republic of Burundi: An exploratory study"	Sub-Saharan Africa, Burundi; Qualitative	examine experiences of women & men with maternal health services including channels used to express these experiences, and providers' reactions to views	HFCs & suggestion boxes were not used for channelling complaints, community preferred using CHWs. Fear of expressing oneself linked to the post-war context of Burundi, social and gender & religious norms limit the expression of community members' views, especially those of women.

Appendix 2: Summary of articles included in DHMT literature review

Author	Study objective	Geographical coverage	Mechanism/Channel through which public feedback can be/is conveyed	Content of feedback received	Details on processing feedback	Details on responding to feedback
Studies describing health system functioning						
Razavi DS., Kapiriri L., Abelson J., Wilson M, 2019	To examine district-level decision-makers' perspectives on the participation of different stakeholders, including challenges related to their participation	Three districts in Uganda	-Representation by political, cultural, traditional leaders	Feedback not specified	No details on processing feedback	No mention of response to feedback
Henriksson D.K., Peterson S.S., Waiswa P., Fredriksson M., 2019	to investigate to what extent district-specific evidence informed prioritisation of child survival activities in the annual district work plans and how stakeholders in the planning process perceived the use of evidence.	Two districts in Uganda	-Community dialogue with caregivers of children under 5, Health providers and Village Health Teams	Feedback not specified	No details on processing feedback	No mention of response to feedback
Van Belle S., Mayhew S.H., 2016	To assess governance arrangements and accountability practices of key health actors in a Ghanaian health district to understand to what extent public accountability is achieved	Rural district in Ghana	-District health committee; sub-district health committee, and Community Health Planning Service committee; NGOs interacted with vulnerable groups (adolescents, women)	Public feedback was not specified		

Tuba M, Sandoy IF, Bloch P, Byskov J., 2010	To assess local perceptions of fairness and legitimacy of decision making related to the delivery of malaria services at district level	Kapiri-Mposhi District, Zambia	Suggestion boxes, meetings between district health managers and community members, Community Health Workers, Neighbourhood Committees	-Uncaring and harsh attitudes by health providers, -Long waiting time at the facilities, -lack of responses to complaints made by the community members, -Inadequate malaria medicines at health facilities and inadequacy of subsidized Insecticide Treated Nets, (including being required to pay more than the subsidized amounts by healthcare workers), -Health worker absenteeism	-Some feedback was not acknowledged by district health managers for example complaints about health provider behaviour towards health service users at facility level and complaints about waiting time	-In response to other feedback for example over-pricing of subsidized ITNs, district health managers in collaboration with NGOs supplying the ITNS set up a monitoring system to track number and price of ITNs
O'Meara WP, Tsofa B, Molyneux S, Goodman C, 2011	To examine implementation of national planning guidelines including the engagement of communities in health sector priority setting	Kilifi District, Kenya	As per guidelines, community dialogue in which community priorities would be collected by CORPs but these were instead shared by HFC members (community representatives) in practice	Community priorities included filariasis, skin infections, bilharzias, and chronic conditions such as hypertension, diabetes and arthritis, health issues affecting adults and the elderly, and substance abuse among the local youth	Identification of local priorities happened as a separate process from target setting and activity planning and budgeting. Due to the parallel nature of the two processes, only local priorities consistent with national indicators were included in district plans and budgets.	This resulted in service delivery activities that mainly matched national level priorities and not local priorities
Maluka S, 2011	To analyse health care organisation and management systems, and explore the potential and challenges of implementing Accountability for Reasonableness (A4R) approach to	Mbarali District, Tanzania	According to priority setting guidelines, health boards and health facility committees provide information on community priorities but this did not occur in practice,	No specific public feedback reported on		

	priority setting in Tanzania.					
Mukinda F.K., Van Belle S., George A., Schneider H., 2020		Gert Sibande District, Mpumalanga Province, South Africa	District Health Council (includes political representatives), clinic health committees, National Advocacy organisation, Treatment Action Campaign; informal mechanisms through meetings. Majority of the accountability mechanisms emphasised performance accountability	No specific public feedback reported on		
Kapiriri L, Norheim OF, & Heggenhougen K,	To assess leaders' & the public's experiences with public participation in health planning and priority setting at different levels within a decentralized framework.	Nama Sub-county, Mukono district, Uganda: Included respondents from national, district, sub-county, parish, and village levels (village leaders & community members)	Health Unit Management Committees, local councils, hospital boards, public health committees, but these were reported not to be functioning well	No specific public feedback reported on		
Jacobs E & Camargo BC, 2020		RRP, GBAO districts in Tajikstan, Central Asia	No formal voice mechanisms in either of the two study districts; but neighbour committees & NGO	Informal payments at district hospitals -General public distrust in the health system, but more trust reported in the lower peripheral facility levels		

			supported CBOs were the main channels for feedback, but these did not link back to the district health system; community members evolved informal mechanisms with health providers at facility level			
Parashar et al, 2020	To analyse the role of actor relationships and power in the implementation of a free entitlement health policy	Himachal Pradesh, India	Specific community feedback mechanisms not identified			
Nyikuri et al, 2017	To describe how district managers experienced and interpreted this change within a context of a rapidly devolving health system in Kenya	Coastal county in Kenya	Views of the community were to be collected through the community unit and shared upwards to the facility and health system levels	Public feedback not described		
McCollum et al, 2018	To provide a power analysis of priority-setting at county level in Kenya, following devolution	Multiple counties, Kenya	Public participation forums but these are poorly attended	Public feedback not reported		
Tsofa et al, 2017	To examine the early effects of devolution in Kenya on health sector planning, budgeting and financial management.	Kilifi County, Kenya	Public participation initiated by County Treasury	Public feedback not reported		
Cleary et al, 2014		South Africa	Local Action Groups, Health Facility Committees,			
Intervention studies						

Butler et al, 2020	To contribute to the evidence base by providing lessons from a strategic, multitool, multi-level social accountability project	5 districts, Malawi	CSOs, bwalo forum (community dialogue) at community and district level, radio listening clubs	-poor referral systems and lack of emergency transport equipment and systems; inadequate staff and attendance at health centers and negligent or unfriendly workers; lack of 'youth friendly' health services, clinics for children under five, and functional maternity wards; shortages of drugs and supplies and the suspicion that health workers divert or sell 'free' drugs; lack of electricity or adequate space in health centers; poor water and sanitation in health facilities; issues related to traditional customs and beliefs (e.g. child marriage, home deliveries); gender-based violence and lack of male involvement in RMNCAH; and, lack of health budget experience and training for newly appointed councillors.	Most structural issues were passed on to the national level for action. These required district health managers to travel to the capital	-Authors suggest some community level action was taken but not clear what responses were implemented at community level. However structural issues (e.g. staff shortages, drug thefts and stockouts, a weak referral system and inadequate infrastructure) reportedly took time to be fixed.
Blake et al, 2016	To assess the effectiveness of engaging multiple health and non-health sector stakeholders to improve MNH services at facility level	Ashanti and Volta regions, Ghana	Facility score-cards. A multi-disciplinary team scored facilities by assessing the health facilities' environment to provide emergency obstetric services, assessing client satisfaction with services	Staffing shortages, availability of drugs, availability of equipment, accessibility challenges to health facilities	Analysis of score-card results shared at district, health facility & community level meetings	Community leaders identified actions that could be taken at community level, e.g. fund-raising to improve roads, to buy an ambulance. Between two assessments, five facilities obtained an emergency vehicles/ambulance—either through the purchase of a new vehicle or through an improved referral system using the existing district hospital vehicle.

Boydell et al, 2018	To examine how changes are produced in a social accountability project (The Health Accountability Project) and what happens in the implementation process	Three districts in Central Uganda	CSOs undertook budget analyses of FP/RH spending and prepared a brief on local performance, mapped the district decision-making, created community groups, and facilitated dialogues with decision-makers. The CSOs worked with Village Health Teams comprising Community Health Workers and in one district with the charitable arm of the Buganda Kingdom (traditional kingdom) which provides social services	-Requests for outreach services for FP -Threat of violence from male partners because of contraceptive use	No specific mention of specific processing of feedback data, rather for some feedback action was taken as implementation was ongoing	increased budget allocations for FP/RH services in two districts, increased staffing levels, and the development of an operating theatre in one district. Increased number of delivery beds in participating villages and included, and increased mobile services and blood donations, consultations with communities on health matters during district planning -Increased uptake & demand for FP services
George et al, 2018	To examine how community action can improve care seeking and service delivery of maternity services for marginalized communities,	Gujarat, India	-Community report cards from 2395 women's self-reported receipt of information on entitlements and use of services over 3 years of implementation monitored prospectively through household visits); Women were engaged through their community	-Request for resumption of services suspended in several facilities -Few outreach clinics in hard-to-reach areas -low care seeking among women from vulnerable groups (e.g., higher numbers of home deliveries) -higher use of private facilities among vulnerable women	Data collected by volunteers were sent to the supporting NGO staff who collated data from the monitoring tool into the report cards. A color-coded system was developed to denote whether levels of service receipt were poor (red), average (yellow) or good (green). -NGO staff would then lead the dialogue with	-Increased awareness among marginalized women about health entitlements related to their health needs and rights, Restarting of services (increasing the number of outreach clinics in hard-to-reach areas; Initiating deliveries in a previously defunct facility), repairs that improved the quality of the service environment (fixing leaks and toilets), better relationships between community members and government providers (health trainings by government providers for women's collectives, invitation to NGO partners to attend block

			platforms-women's collectives, self-help groups, village development committees and dairy co-operatives to create awareness on entitlement, and later collect feedback; hotline for women to call in case of obstetric emergencies		health providers and health managers	level maternal death review meetings), and addressing inappropriate practices (kickbacks) between female community level providers and private providers, private hospital not providing services as per the public-private insurance scheme)
Zulu J.M., Michelo C., Msoni C., Hurtig A.-K., Byskov J., Blystad A., 2014	To examine local perceptions and practices related to what was perceived as 'fair' priority setting (baseline study) and the potential evolvement of such perceptions and practices over time as a result of an AFR based intervention (evaluation study)	Kapiri-Mposhi District in Zambia	Neighbourhood Committees	No content of feedback specified, but notes that there was little input by the community during priority setting		
Byskov et al, 2014	To assess knowledge about the relevance and usefulness of the (Accountability for Reasonableness) AFR concept as well as about the implementation process and potential outcomes from diverse contexts.	Malindi district in Kenya, Kapiri-Mposhi district in Zambia, Mbarali district in Tanzania	In Tanzania-Meetings at community level between district health managers and community members -In Kapiri-Mposhi, Zambia-neighbourhood health committees	Identified community priorities in Tanzania included-requestsfor construction of new health facilities, solving problems with procurement of drugs, supplies, and equipment, and shortage of health staff. -Content of community feedback from Kenya & Zambia not identified	- After priorities across the health system (starting from the community level) were consolidated at district level, they were disseminated again to the public to provide opportunity for appeal prior to approval and on-ward submission to regional level	-The AFR intervention was most fully implemented in Zambia, where outcomes included improvements in identification of local priorities, and greater involvement of stakeholders in priority setting. However, the project duration in all three countries was too short to demonstrate effects in terms of changes in the ultimate outcomes of AFR for quality, equity, and trust and for health outcomes

			community meetings, suggestion boxes, and development committees		-In Malindi, Kenya, priorities were publicized through a newsletter and posting of adopted district priorities at in facility notice boards -In Kapiri Mposhi, Zambia, the DHMT increased its use of existing ways to make decisions and reasons public to the community. This included the use of drama groups, neighbourhood health committees, traditional birth attendants, posters, community meetings, information sessions at the clinics, and the development committees.	
Maluka et al, 2011	To evaluate the experiences of implementing the AFR approach in Mbarali District, Tanzania, to find out how the innovation was shaped, enabled, and constrained by the interaction between contexts, mechanisms and outcomes	Mbarali District, Tanzania	CHMT members travelled twelve villages in the district to solicit priorities from the community	Content of public feedback not described	Priorities collated at the district level were disseminated to the public and facilities prior to submission to regional level to provide an opportunity for appeal. These priorities were pinned on the notice board at the district hospital, district council offices, village council offices, ward executive offices, health centres, and dispensaries	No specific responses were identified

Appendix 3: Informed consent form for interview respondents

Formal title: Examining and strengthening health system responsiveness to public feedback

Lay title: Examining how health systems respond to citizen feedback

Who is carrying out this study and what does it involve?

This study is being carried out by KEMRI. KEMRI is a government organization that carries out health research to find better ways of preventing and treating illness in the future for everybody's benefit.

Our work involves primarily talking, observing, and working with a range of people at county and sub-county level and in hospitals, health centres and dispensaries. Specifically, for this study, we are working together with health managers at county level to better understand:

- How the health system responds to different forms of citizen feedback.
- This includes learning about the different channels of feedback used by various citizens, or groups of citizens to give feedback to the health system, how feedback given to the system is integrated, processed and what system responses exist to various forms of feedback and the ways in which this influence health system outcomes
- We know that involvement of citizens can be particularly important, but also challenging in times of crisis, such as health worker strikes or emerging epidemics (for example COVID-19)

Why do you want to talk to me and what does it involve?

We would like to hold discussions with you as a manager(s) working at county/sub-county/facility levels and who is familiar with various ways that citizens feedback information into the health system.

- The discussion will be guided by myself. We will ask questions about channels for giving feedback to the health system used by citizens or groups of citizens that you are aware of, how information from these feedback channels reaches decision-makers and how this information is processed and what system responses there have been.
- You do not need to discuss any information you are not comfortable sharing.
- I would like to ask you several questions about channels for giving feedback to the health system used by citizens or groups of citizens that you are aware of, how information from these feedback channels reaches decision-makers and how this information is processed and what system responses there have been. The discussion will take place wherever you are most comfortable. No-one else but the interviewer will be present unless you would like someone else there.
- We would like to record the interview to assist later in fully writing up the information, but you can still participate if you do not agree for the interview to be recorded.
- [*Where recordings made*]: The discussion will be recorded to assist later in fully writing up the information. No-one and no facility will be identified by name in the write up.

Are there any risks or disadvantages to me taking part?

- The discussions should take approximately 45 minutes. If you have had to travel to the interview place, you will be provided with a cash reimbursement to cover your transport in line with KWTRP policy.

Are there any advantages to me taking part?

There are no direct individual benefits to taking part in this work. But in being involved, you will contribute to improving knowledge about strengthening health systems that may help you, other individuals, and facilities and counties in Kenya and elsewhere in future. This may be for example through developing new health interventions and policies. Throughout the work we will feed back what we are learning – without revealing individual or facility identities - to local and national leaders and health care managers for further discussion and reflection. At the end our policy and practice impact is assisted through developing materials such as this to support discussions.

Who will have access to the information I give?

- The recordings will be done using an encrypted recorder. All our documents/ recordings are stored in securely in locked cabinets and on password protected computers. The knowledge gained from this research will be shared in summary form, without revealing individuals' identities. Only those closely involved in the study will have access to the data

- Tape recordings of interviews and notes taken during the interview will be destroyed at the end of this study.

Who has allowed this research to take place?

All research at KEMRI must be approved before it begins by several national and international committees who look carefully at planned work. They must agree that the research is important, relevant to Kenya and follows nationally and internationally agreed research guidelines. This includes ensuring that the rights of all potential participants are respected.

What will happen if I refuse to participate?
All participation in research is voluntary. You are free to decide if you want to take part or not. If you do agree you can change your mind at any time without any consequences.

What if I have any questions?
You are free to ask me any question about this research. If you have any further questions about the study, you are free to contact the research team using the contacts below:

Nancy Kagwanja, KEMRI Wellcome Trust Research Programme, P.O. Box 230, Kilifi. Telephone: [Insert mobile] or 0722 203417, 0733 522063, 041 7522063

If you want to ask someone independent anything about this research, please contact:
Community Liaison Manager, KEMRI Wellcome Trust Research Programme, P.O. Box 230, Kilifi. Telephone: 041 7522 063, Mobile 0723 342 780 or 0705 154 386

And

The Head, KEMRI Scientific and Ethics Review Unit, P. O. Box 54840-00200, Nairobi; Telephone numbers: 0717 719477; 0776 399979 Email address: seru@kemri.org

KEMRI-Wellcome Trust Research Programme consent form for [How the health system responds to citizen feedback)

I have had the study explained to me. I have understood all that has been read/explained and had my questions answered satisfactorily. I understand that I can change my mind at any stage and it will not affect me in any way. I agree to take part in this research.

I agree for the interview/discussion to be recorded □ Yes □ No

Signature: _____ **Date:** _____

Respondent Name: _____ **Time:** _____

Signature: _____ **Date:** _____

Researcher Name: _____ **Time:** _____

THE RESPONDENT SHOULD NOW BE GIVEN A COPY TO KEEP

Appendix 4: Interview guide used in Phase 1 data collection

Introduction

I would like to have a discussion with you as a manager(s) working at county/sub county/hospital/facility level and who is familiar with various ways that citizens feedback information into the health system. I would like to ask you questions about channels for giving feedback to the health system used by citizens or groups of citizens that you are aware of, how information from these feedback channels reaches decision-makers and how this information is processed and what system responses there have been. I would also like to learn about the Covid-19 response in Kilifi County and how the threat of Covid-19 (and other challenges e.g. the prolonged health worker strikes of 2017) have influenced how the health system responds to feedback/concerns/needs voiced by the community.

1. What are the different channels of receiving citizen feedback into the health system at the meso (facility/sub-county) level?
2. What kind of feedback from citizens have you been getting? Who have been providing the most feedback? Are there some groups of citizens from whom you do not receive feedback? Why do you think this is the case?
3. How is the information from various feedback channels processed? Is information from various feedback channels aggregated? Who are the actors involved in processing it?
4. Is there some feedback information that you sometimes deem inappropriate/not legitimate? How do you determine this?
5. Is there feedback that is received but you cannot respond to it? What are some of the reasons that you would be unable to respond to certain forms of feedback?
6. From the various feedback channels, are there some responses that are provided at facility level/subcounty to the public?
7. Is there some feedback that goes directly to the (county/national) level? What feedback is this and why does it go directly to the county/national level? Does the county/national level then share the feedback at your level?
8. Which groups do you consider vulnerable who might have challenges in giving feedback to the health system? How do you try to engage these groups for their feedback? (E.g., are there specific feedback channels for these groups? Do you aggregate their feedback with that of other groups? Is there a way for these groups to get a response from the health system regarding the feedback that they have given to the health system?
9. What have been the key new issues/concerns for the public, health system users and health providers in the context of crises, including health worker strikes and emerging epidemics (especially COVID-19)? How have these concerns shifted over time, how have they been voiced (both directly and indirectly, to HCWs and up the health system). what has been the response? How has this epidemic affected responsiveness more widely in the short term, and how will it continue to do so in the future? What are your views on if and how the system can better respond to the needs of the public and facility users in future?
10. What choices have been considered in responding to the Covid-19 crisis? Which of these competing choices have been taken and what guided the discussion? *Probe for e.g. selection of health facilities to serve as isolation centres. What was considered, what and who decide? Were public views or feedback considered? How did they provide this feedback?*

Appendix 5: Interview guide for SCHMT members

Introduction	-Can you tell me about your current position/role in the (sub-county) health system? *Probes: For how long have you been in that position? Who do you report to? Probe for when was your SCHMT was formed? Was it formerly a sub-district prior to devolution? Or is it among the more recent ones?*
Broad questions about the functioning of the SCHMT and related to receiving public feedback	-What is the structure of the SCHMT? And what roles does the SCHMT play within the health system? What are the ways/channels through which the SCHMT receives feedback (views, concerns, complaints) from the public? (*Probe for routine collection of public and users' views or more random, ad hoc. Probe also for formal-e.g., health sector stakeholder forum; multiple sector stakeholder forum, health committees etc /informal mechanisms)* Is there a person/team designated within the SCHMT to handle community/public views, priorities, complaints, suggestions? *Who does this team comprise of? How was this team selected, by whom?* *-For any of the mechanisms for receiving feedback mentioned probe for how they are resourced (e.g. the participatory mechanisms such as HFCs, CHSF), who is assigned to access information collected (e.g. for hotlines, suggestion boxes, surveys)* -Are there any instances where you have received information about public views/concerns from actors higher up in the health system/outside the health system but within the public sector/elsewhere e.g. from CSOS/NGOs? *(Probe for when this has happened, how frequently)* -Which sources of information about public views/priorities do you prioritise, why? What are some of the key issues/concerns that have been raised by the public and health system users recently? Would you say there are some forms of information/views/concerns that are prioritised over others? Why is this so? -What challenges do you experience in accessing information to public feedback?
Processing public feedback	-What happens to these public/community views, priorities, or concerns when they are received by a member of the SCHMT/SCHMT? How do you integrate the feedback from a) multiple channels b) multiple facilities Probe *for other processing e.g. analysis, consolidation, prioritization. If any of these happens, is there a designated person/team for it? If yes, who comprises the team? Is there support for analysis, consolidation, from elsewhere e.g., from NGOs/CSOs (if yes, to what extent are they involved?)* -Is there feedback that is escalated upwards to other health system actors, or re-directed elsewhere? How is the decision to do this made? *Are there any guidelines/framework that the SCHMT uses to determine how to handle public feedback?*
Responding to public feedback	-As part of the SCHMT, were you able to respond to the concerns/issues/priorities you mentioned. If yes, what kinds of responses have you been able to enact? Were the public made aware of how their concerns were addressed/if their views were taken up? How? Other than the SCHMT were there instances where other actors were engaged to generate a response? Which actors were these? *(Probe for a critical incident, and attempt to track back to a response or inaction from the health system)* -For issues that get escalated upwards for action to the health system, how do you learn about whether any action has been taken?
- **Enablers** - **Barriers**	-How well would you say the mechanisms/channels through which you receive public views/concerns/complaints/compliments function. Why do you think they function so well (or not?)

	-What would you say enables/limits you as a SCHMT member/or SCHMT to receive and respond to community concerns/views
-Vulnerable groups	-There are groups within the population that are considered vulnerable. Which groups are these in your sub-county? How would you say their voices are included in the information you receive from the public? *Probe for groups within the community that the respondent thinks are vulnerable, but their voices are not included in feedback channels currently in use.* Is there any concern/compliment/view that you learnt about concerning experiences of vulnerable groups with the health system that comes to mind? How was this responded to?
Health system shocks (e.g. COVID-19/HCW strikes)	-To what extent would you say the public's views and concerns were/have been integrated in the COVID-19 response (from the early days to date? for example in selection of COVID-19 isolation facilities, to learn about community challenges in accessing care) *Probe for what mechanisms were used to learn about public concerns and views? Were there mechanisms for feedback that you expected would be used but were not used? Why do you think this is so? Who were the main decision-makers regarding what actions would be taken in response to public feedback/or in determining what information was released to the public? Were there any new mechanisms introduced? Who were the main actors involved in the introduction of these mechanisms? What was the SCHMT's role (if any) during the introduction of these mechanisms? Have newly introduced mechanisms continued to function well (or not) to date?* -There was a HCWs strike towards the end of 2020 and beginning of 2021. Were there any views, concerns, feedback that you recall receiving /your team received from the public at this time?
Overall value of public feedback	To what extent would say information (concerns, complaints, compliments, priorities) from the public is incorporated into health sector plans, projects, service delivery? What opportunities exist for the public to learn about what happened with feedback they received? Who do you think are the important people when it comes to making decisions about feedback from the public? Please explain why you think so?

Appendix 6: Informed consent form for HFC FGDs

Formal title: Examining and strengthening health system responsiveness to citizen feedback

Lay title: Examining how health systems respond to citizen feedback

Who is carrying out this study and what does it involve?

This study is being carried out by KEMRI. KEMRI is a government organization that carries out health research to find better ways of preventing and treating illness in the future for everybody's benefit. Our work involves primarily talking, observing, and working with a range of people at county and sub-county level and in hospitals, health centres and dispensaries. Specifically, for this study, we would like to better understand how the health system responds to different forms of citizen feedback. This includes learning about the different channels of feedback used by various citizens, or groups of citizens to give feedback to the health system, how that feedback is processed and what system responses exist to various forms of feedback and the ways in which this influence health system outcomes. We know that involvement of citizens can be particularly important, but also challenging in times of crisis, such as health worker strikes or emerging epidemics (*for example COVID-19)*

Why do you want to talk to me and what does it involve?

We would like to hold discussions with you as members of the community who use the health system to hear more about their experience of the health system. You were selected because you participate (as a HFC member) in one of the channels of feedback to the health system. Specifically, we want to learn about

- Which channels you use to receive public feedback about the health system
- How the feedback is processed
- If and how you generate responses on the feedback that you receive

- We would like you to take part in a group discussion with [7-8] other persons who also have a close link to one of the channels to give feedback to the health system.
- The discussion will be guided by myself/colleague in person. The discussion will take place at the health facility. Only the people involved in the discussion, the person asking the questions, and a note-taker will be present.
- If you do not want to answer any of the questions you may say so and the interviewer will move on to the next question.
- The discussion will be recorded to assist later in fully writing up the information. No-one will be identified by name in the recording but if you do not agree to be recorded, we will proceed without it and take notes.

Are there any advantages/disadvantages to me taking part?

- The discussions should take approximately one and a half hours. There are no direct individual benefits to taking part in this work. But in being involved, you will contribute to improving knowledge about strengthening health systems that may help you, other individuals, and facilities and counties in Kenya and elsewhere in future. This may be for example through developing new health interventions and policies. Occasionally we share what we are learning – without revealing individual or facility identities - to local and national leaders and health care managers for further discussion and reflection. Our policy and practice impact is assisted through developing materials such as this to support discussions.
- We will reimburse your travel costs incurred while coming to participate in this Focus Group Discussion. We will also compensate for out-of-pocket expenses as per our organization guidelines.

Who will have access to the information I give?

- All our documents/ recordings are stored securely in locked cabinets and on password protected computers. The knowledge gained from this research will be shared in summary form, without revealing individuals' identities. Only those closely involved in the study will have access to the data
- Tape recordings of interviews and field notes written in our books will be destroyed at the end of this study.

Who has allowed this research to take place?

All research at KEMRI must be approved before it begins by several national and international committees who look carefully at planned work. They must agree that the research is important, relevant to Kenya and follows nationally and internationally agreed research guidelines. This includes ensuring that the rights of all potential participants are respected.

What will happen if I refuse for my county/facility to participate?

All participation in research is voluntary. You are free to decide if you want to take part or not. If you do agree you can change your mind at any time without any consequences.

What if I have any questions?

You are free to ask me any question about this research. If you have any further questions about the study, you are free to contact the research team using the contacts below:

Nancy Kagwanja KEMRI Wellcome Trust Research Programme, P.O. Box 230, Kilifi. Telephone: [0722698642] or 0722 203417, 0733 522063, 041 7522063

If you want to ask someone independent anything about this research please contact:

Community Liaison Manager, KEMRI Wellcome Trust Research Programme, P.O. Box 230, Kilifi. Telephone: 041 7522 063, Mobile 0723 342 780 or 0705 154 386

And

The Head, KEMRI Scientific and Ethics Review Unit, P. O. Box 54840-00200, Nairobi; Telephone numbers: 0717 719477; 0776 399979 Email address: seru@kemri.org

We have had the study explained to us. We have understood all that has been read/explained and had our questions answered satisfactorily. We understand that I can change our mind at any stage and it will not affect us in any way. We agree to take part in this research.

We agree for the interview/discussion to be recorded □ Yes □ No

Signature: _____ **Date** _____

Group representative: _____ **Time:** _____

Signature: _____ **Date** _____

Researcher: _____ **Time:** _____

EVERY FGD PARTICIPANT SHOULD BE GIVEN A COPY OF THE CONSENT FORM TO KEEP

Appendix 7: FGD topic guide

<table>
<tr><td colspan="2">Introduction
I would like to hold discussions with you as a facility-in-charge and a member of the HFC. Specifically, I'd like to learn about
• Which channels you use to receive and give feedback to the health system
• How the feedback you give is processed
• If and how you get any responses on the feedback that you give
• We would like you to take part in a discussion that takes about 40minutes to 1hour
• If you do not want to answer any of the questions you may say so and the interviewer will move on to the next question.
The discussion will be recorded to assist later in fully writing up the information. No-one will be identified by name in the recordi
ng but if you do not agree to be recorded, we will proceed without it and take notes</td></tr>
<tr><td>Back-ground questions</td><td>-Please tell me about your current position/role in this health facility? How long have you been in that role/position?
Probes: What are your day-to-day responsibilities? How long have you been in this position? Who do you consider yourself accountable to?</td></tr>
<tr><td>Broad questions about the functioning of the HFC and related to receiving public feedback</td><td>-In your role as facility-in-charge, what are the ways/channels through which you receive feedback (views, concerns, complaints) from the public? (Probe for routine collection of public and users' views or more random, ad hoc. Probe also for formal-e.g. suggestion boxes, HFC, NGOs etc /informal mechanisms) Is there a person/team designated within the facility to handle community/public views, priorities, complaints, suggestions? How was this person selected, by whom?

-Is there any effort by the health facility to obtain community views on how to allocate the budget or set priorities in the AWP/or any other program plans and budgets? In what ways, if it happens, are community views incorporated in the facility planning process?

-Are there any instances where you have received information about public views/concerns from actors higher up in the health system/outside the health system but within the public sector/elsewhere e.g. from CSOs/NGOs, MCAs, the SCHMT, CHMT, other senior county official? (Probe for when this has happened, how frequently)

-Which sources of information about public views/priorities do you prioritise, why? What are some of the key issues/concerns that have been raised by the public and health system users recently? Would you say there are some forms of information/views/concerns that are prioritised over others? Why is this so?

What challenges do you experience in accessing information to public feedback?</td></tr>
<tr><td>HFC formation, representation and embeddedness in the community</td><td>-As the facility-in-charge, what are your roles in relation to the HFC? What is the structure of the HFC? What roles does the HFC play within the health system? How were the current members of the HFC selected/elected? What happens when a HFC member is unable to continue his duties? (Probe for whether another member is appointed/or not?). Who is most active on the HFC? Who is least active? What are some reasons for this?
- Does anyone from the health system (other than you) go to HFC meetings or activities? Who? What do they do/say?
-If the HFC wants to change something about the health system, what can they do? How would the health system respond? Why?
- Can you/any member tell me about a time when the HFC tried to solve a problem?</td></tr>
</table>

	Can you/ any member tell me about a time when someone came to the HFC for help? • What issues do you think the HFC should work on? • What things do you think the HFC can do/respond to? • Has the HFC or any HFC member spoken with community members about health? Has the HFC taught people about the health system? How? • Has the HFC monitored any services (, quality of care or availability of care at health centers, immunization, WASH) How did this monitoring works? What were some challenges? What was done with this monitoring data? How do you (and other health providers) feel about this monitoring activity? Record keeping Does the HFC maintain any registers? Keep minutes? Who does this? What is the relationship between the general community and the HFC? • To what extent are HFC members aware of the issues facing the community? • What do you think the community expects from the HFC? Do you think the HFC is meeting the expectations of community members?
Changes over time related to HFC	-Have you seen any changes in health system functioning or facility service delivery arise because of the HFC? Examples: The extent to which very marginalized people are accessing health services? People's awareness of the HFC? Of their health rights? The availability of care and quality of care from the health centers? Availability of drugs? Staff absenteeism? Whether people use public health services versus private health services? *Probe for why they think this change has occurred/ or if no change why the think this is the case?*
HFC challenges from HFC in-charge perspective	- What are the challenges facing the HFC? What would help the HFC overcome these challenges? What do you think needs to change to make the HFC more functional? Probe on: How would different aspects (other members, resources, training, health system, other stakeholders) need to change?
Processing public feedback	-What happens to these public/community views, priorities or concerns when you receive them? How do you integrate the feedback from multiple channels and or sources *(e.g. from multiple community units linked to this facility?) Probe for other processing e.g. analysis, consolidation, prioritization. If any of these happens, is there a designated person/team for it? If yes, who comprises the team? Is there support for analysis, consolidation, from elsewhere e.g. from NGOs/CSOs (if yes, to what extent are they involved?)* -Is there feedback that is escalated upwards to other health system actors, e.g. to the SCHMT or re-directed elsewhere? How is the decision to do this made? *Are there any guidelines/framework that you/the HFC use to determine how to handle public feedback?*
Responding to public feedback	-What kinds of responses have you been able to enact to some of the issues that you have mentioned as feedback raised by the public? Were the public made aware of how their concerns were addressed/if their views were taken up? How? Are there instances where you have engaged other actors to generate a response? Which actors were these? *(Probe for a critical incident, and attempt to track back to a response or inaction from the health system)* -For issues that get escalated upwards for action to the health system, how do you learn about whether any action has been taken?
- **Enablers** - **Barriers**	-How well would you say the mechanisms/channels through which you receive public views/concerns/complaints/compliments function. Why do you think they function so well (or not?) -What would you say enables/limits you as a HF-in-charge to receive and respond to community concerns/views?

-Vulnerable groups	- Which people find it difficult to seek health services in the community you work in? (e.*g. minority groups)* (Or which groups of people need health services, but you face challenges in providing them with community health services) *-Probe for: Would you say that the HFC is representative of the public that seeks care in this facility? Why do you think so?* - How would you say their voices are included in the information you receive from the public? *Probe for groups within the community that the respondent thinks are vulnerable, but their voices are not included in feedback channels currently in use.* Is there any concern/compliment/view that you learnt about concerning experiences of these groups with the health system that comes to mind? How was this responded to? -Are there any local initiatives that you are aware of which have been successful for ensuring that everyone in the community gets the services that they need?
Health system shocks (e.g. COVID-19/HCW strikes)	-To what extent would you say the public's views and concerns were/have been integrated in the COVID-19 response (from the early days to date? -for example in selection of COVID-19 isolation facilities, to learn about community challenges in accessing care) *Probe for what mechanisms were used to learn about public concerns and views? Were there mechanisms for feedback that you expected would be used but were not used? Why do you think this is so? Who were the main decision-makers regarding what actions would be taken in response to public feedback/or in determining what information was released to the public? Were there any new mechanisms introduced? Who were the main actors involved in the introduction of these mechanisms? What was the SCHMT's role (if any) during the introduction of these mechanisms? Have newly introduced mechanisms continued to function well (or not) to date?* -There was a HCWs strike towards the end of 2020, and beginning, what public feedback about health services/health system did you receive during this time? Were you able to respond to this feedback? How?
Overall value of public feedback, Additional qns related to power	-To what extent would say information (concerns, complaints, compliments, priorities) from the public is incorporated into health sector plans, projects, service delivery? -What opportunities exist for the public to learn about what happened with feedback they received? Who do you think are the critical when it comes to making decisions about feedback from the public? Please explain why you think so? - Do you have any ideas or suggestions about what would help ensure that feedback mechanisms function well, and the public receives the feedback they need? What about ideas for making system wide changes based on public feedback? What is the HFMC network? How did it come about? What forms of feedback did it raise and how were these responded to? Is it operational, if not, why?

Appendix 8: Observation guide for SCHMT meetings and activities

Observation checklist	
1. **Setting**	What is the physical environment like? How is the SCHMT room organised? Physical objects related to broad county health policy-E.g. posters, mission, vision statement of the County Department of Health, any posters/notices related to policy around receiving and responding to public feedback?
2. **Participants**	Who are the members of the SCHMT? How many people and their roles?
3. **Activities and interactions**	Who initiates the meeting? Who speaks most frequently? Are there interruptions to when a team member talking? How are these responded to by the one who is speaking? By other team members? Do all SCHMT members actively participate in discussions? Are there members who are quiet during most of the meetings? Are the meetings documented? Who is responsible for documentation (One specific person/rotational? Is there a structure to the documentation? Does there seem to be a 'core' SCHMT team? What makes them 'core' (e.g. control over/ access to resources, professional back-ground etc). If present, how does this core team interact with the rest of the team? (E.g. are they inclusive in decision-making about SCHMT activities)
4. **Content of discussion**	Is there a standing agenda? Is public feedback among the items on the standing agenda? If not, how frequently has public feedback come up in discussions? When public feedback was discussed, how much time was spent on it, were there specific, actionable resolutions? -Are there sub-committees within the SCHMT that discuss public feedback? Which members of the SCHMT are involved in this sub-committee? How were they selected?
5. **Frequency and duration**	How frequently do the SCHMT meetings occur? How long on average do they last? When SCHMT meetings are not held, what are the reasons for not holding them?
6. **Other activities outside of meetings**	What other activities are carried out apart from support supervision activities and vaccine campaigns? How frequent if any are unplanned activities? What is the reaction to these unplanned activities?
7. **(Common Language)**	Are symbolic and connotative meanings of words; non-verbal communication (e.g. dress, space)Are there any negative labels or identities assigned to other actors (e.g. patients, community members, general public, senior health managers, political representatives) or physical spaces (e.g. specific health centres, county health managers' offices) Instances of humour camouflaged as dissent/disagreement?

Appendix 9: Coding Framework

Open coding (step 1)	Categories	Initial themes
1. Handling of public feedback at health facility level • Policy and guidelines for handling public feedback available at facility level • Formal public feedback channels a. Participatory channels providing public feedback at facility level-comprising community representatives i. Membership of participatory channel o Membership representativeness (including of vulnerable groups) ii. Process of selection of members o Who is involved in selection o Roles of different actors in selection process iii. Roles of members once selected iv. Functioning of channel o Frequency of meetings o Who calls for meetings o Documentation of feedback o Is public feedback a standing agenda o Where/to whom is the feedback relayed once received -Within health facility -Within health system but outside health facility -Outside health system but within ward, sub-county, county o Functioning during early days of COVID-19 and continuing change in functioning -Frequency of meetings -Public feedback received over time -Actions taken in response to this feedback v. Content of feedback o Complaints o Requests for introduction of new services, infrastructure o Compliments • Who shares feedback o Vulnerable groups o General public • Responses to feedback b. Non-participatory channel i. Functioning of channel	-Existing feedback channels at different levels of the health system -Formal -Informal -Participatory	-Range of feedback channels
	- Feedback Complaints • Range of complaints -HCW conduct -General	Range of feedback collected
	Compliments	
	Service infrastructure and equipment requests	
	Who are the actors	-<u>Range of actors</u> • Actor interface • Power practice at actor interface • Effects of power practice o Strengthening receiving feedback o Supporting generation of responses • <u>Actor lifeworlds</u> o Power relationships -Social positions or status, authority, organisational/ institutional hierarchy, technical/ professional expertise, resourcefulness, gender, caste, class relations o personal characteristics -Individual interests, motivation, identity, image, recognition, previous experiences, cognitive and behavioral traits,
	Roles of actors	
	Participation of actors in receiving, processing (prioritizing/integrating) and responding to public feedback -support for receiving feedback -Constraints to receiving feedback -Considerations in prioritizing varied feedback for response -Support for generating responses to feedback -Constraints/actions hindering response to feedback -Integration of feedback -Prioritization of feedback -Case-by-case approach to response generation -System-level responses vs Individualised responses -Feedback that resulted in change • Across multiple departments within a facility • Across multiple facilities within a sub-county	

1. Frequency of utilisation 2. Utilised by whom (specific populations, general populations) 3. Dedicated person/individual to support functioning of the feedback channel 4. Documentation of feedback ii. Content of feedback received 1. Complaints 2. Requests for introduction of new services, infrastructure 3. Compliments iii. Who shares feedback 1. Vulnerable groups 2. General public iv. Responses to feedback -Feedback prioritised for response -Not responded to -Who generated response c. Presence of these organisations (NGOs/CSOs) o Whether/how these organisations link back to HFC/health facility when they learn about public views d. Communication back to the public e. Informal channel o Type of informal channel o Public buzz o Social media o Informal one-on-one conversations o Who utilises informal channel o When/instances of use of informal channel o Where/to whom is the feedback relayed once received o Responses to feedback from informal channel o Communication back to the public f. Functioning during early days of COVID-19 and continuing changes over time g. Public feedback received during this time h. Actions taken in response to COVID-19 and response related feedback i. Views about value of feedback 2. Handling of public feedback at sub-county level/within SCHMT -Policy and/guidelines for handling public feedback at sub-county level -Membership/composition of SCHMT -SCHMT functioning • Frequency of meeting • Roles related to handling of public feedback • Dedicated team/focal person handling feedback within SCHMT • Documentation of feedback • Public feedback as standing agenda in SCHMT meeting	• Change in a process across the county health system	situations in personal lives, understanding o worldviews of actors -Values, norms, beliefs, moral standing, religious views, organisational/ institutional norms and culture Power in flows and processes of handling public feedback across health system levels and spaces • Levels of power • National • Local o County o Sub-county o Facility level o Community • Spaces of power o Invited: -Membership (citizens, service users -inviting authority (NGOs, government) -form of engagement (transient, on-going(regularised); one-off o Closed: Membership(bureacrats, elected representatives, experts o Claimed • Forms of power -Visible power (formal rules, structures, authorities, institutions, and procedures of decision-making) -Hidden power (excluded categories of people, control of what feedback can

• Changes to SCHMT roles during early days of COVID-19 • Formal channels of public feedback to SCHMT a. Participatory channels-functioning i. Membership of participatory channels o SCHMT involvement in selection process of community representatives ii. SCHMT role in supporting functioning of participatory channels iii. Content of feedback from participatory channels o Complaints o Requests for introduction of services, infrastructure o Compliments iv. Responses generated o Feedback relayed up-wards to county level o Who has generated responses v. Functioning during early days of COVID-19 and continuing changes over time o Public feedback received during this time o Actions taken in response to this feedback b. Non-participatory channels-functioning i. Functioning of channel o Frequency of utilisation o Utilised by whom (specific populations, general populations) o Dedicated person/individual to support functioning of the feedback channel o Documentation of feedback		be shared/discussed) -Invisible power (values, beliefs, acceptance of status quo)

ii. Content of feedback received o Complaints o Requests for introduction of new services, infrastructure o Compliments iii. Who shares feedback o Vulnerable groups o General public iv. Where is feedback relayed once received o Stays within SCHMT Relayed to CHMT/County senior managers o Shared with decision-makers outside health system but within county government v. Responses to feedback c. Stakeholder organisations sharing public feedback/ supporting sharing of public feedback i. Presence of these organisations (NGOs/CSOs) ii. Whether/how these organisations link back to HFC/health facility when they learn about public views • Informal channels to SCHMT a. Who commonly utilises informal channels b. When/instance of use of informal feedback channel c. Content of feedback i. Complaints ii. Requests for introduction of new services iii. Compliments d. Where is feedback relayed once received i. Stays within SCHMT ii. Relayed to CHMT/County senior managers iii. Shared with decision-makers outside health system but within county government iv. Responses generated		
4. Cross-cutting open codes • Attitudes to complaints, suggestions brought by the public • Structures that support response generation • Links across health system levels		

Appendix 10: Policy brief-Receiving and responding to public feedback in the early days of the COVID-19 pandemic

KEMRI | Wellcome Trust

POLICY BRIEF
DECEMBER 2020

Receiving and Responding to Community Feedback During Health System Crises: Lessons from Early days of the COVID-19 Pandemic Response in Kilifi County

Key messages

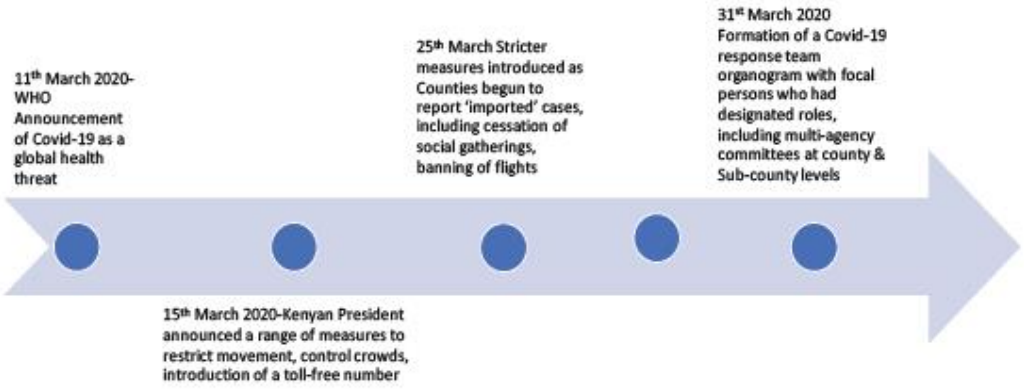
1. During crises, health systems have an opportunity to leverage community ideas, needs and support through pre-existing public and community engagement mechanisms, especially those that allow direct interaction such as health facility committees and meetings with community health volunteers.
2. In Kilifi, the use of multiple feedback mechanisms and approaches allowed for a range of issues and concerns to be picked up and responded to in the early days of the COVID-19 outbreak response. The approaches used have varied with the evolution of the pandemic.
3. Where new feedback mechanisms are introduced during a crisis, there needs to be adequate resource allocation, coordination and monitoring of these mechanisms to ensure responsiveness to community concerns and needs.
4. Careful co-ordination and planning at various health system levels and with wider stakeholders is critical when implementing public health interventions during health system crises to ensure that communication and co-ordination challenges do not undermine community input into, trust and support for health system interventions.

Introduction

Health system responsiveness, defined as how the health system reacts to input from the public or citizens is one of the goals of the health system alongside fairness in financing and health service outcomes. Listening to and responding to public inputs and feedback can lead to a health system that is stronger and fairer to all segments of the population, where policy and practice is more appropriate for and accessible to citizens. Responsiveness is closely tied to the broader idea of citizen, public, or community participation in health systems. However, responsiveness is likely to be undermined, especially for vulnerable and marginal populations in periods of unexpected shocks and crises to the health system such as disease outbreaks or health worker strikes. In the current COVID-19 crisis, there has been more focus globally on health system control interventions; with minimal consideration of community views about these interventions. In this brief, we report early findings on health system responsiveness to community feedback in implementation of the COVID-19 crisis response in Kilifi County, drawing on publicly available national and county level documents, press briefings, in-depth interviews and observations of County Health Management Team (CHMT) COVID-19 briefings in the Kilifi learning site. We consider what community engagement and citizens feedback channels were utilised, what concerns were raised by the public, how they were handled by health system actors and highlight lessons learned.

Context

Fig 1 below summarises some of the global and national events in the early days of the COVID-19 response.



Soon after the first case was announced in Kilifi, the CHMT developed an organogram (Fig 2) with focal persons responsible for different aspects of the COVID-19 response. The organogram evolved over time and had links to other stakeholders through multi-agency committees at county and sub-county levels. The County multi-agency committee was co-chaired by the Governor and County Commissioner and included stakeholders such as other county government departments, business groups representatives, religious leaders and Non-Governmental Organisations (NGOs). The sub-county multi-agency committee included the Sub-County Medical Officer of Health (SCMoH), the Sub-county Commissioner and sub-county level stakeholders.

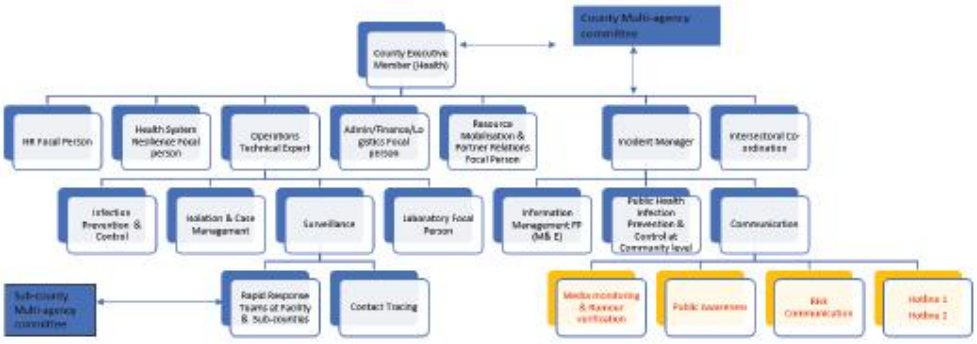


Figure 2: Organogram of the Kilifi Covid-19 response team showing links to county and sub-county multi-agency committees (as at March 2020)

Findings

Mechanisms for receiving and responding to community concerns and feedback

During the early days of the response in Kilifi County, 'information provision' by County Department of Health (CDoH) officials was the most heavily utilised way of engaging the community. Messages were passed through public address systems by public health and health promotion officers, who traversed all the 35 electoral wards in Kilifi county. Radio -mostly local FM stations- was also utilised. Periodically, the County Governor (joined by other senior county officials) issued press briefings on the status of the response in the county and encouraged the public to adhere to prevention measures. The decision to involve the senior county leadership in conducting messaging around COVID-19 was informed by a perception that their involvement would signal to the community the importance of the control measures that were being put in place. Messages that were shared with community members included:

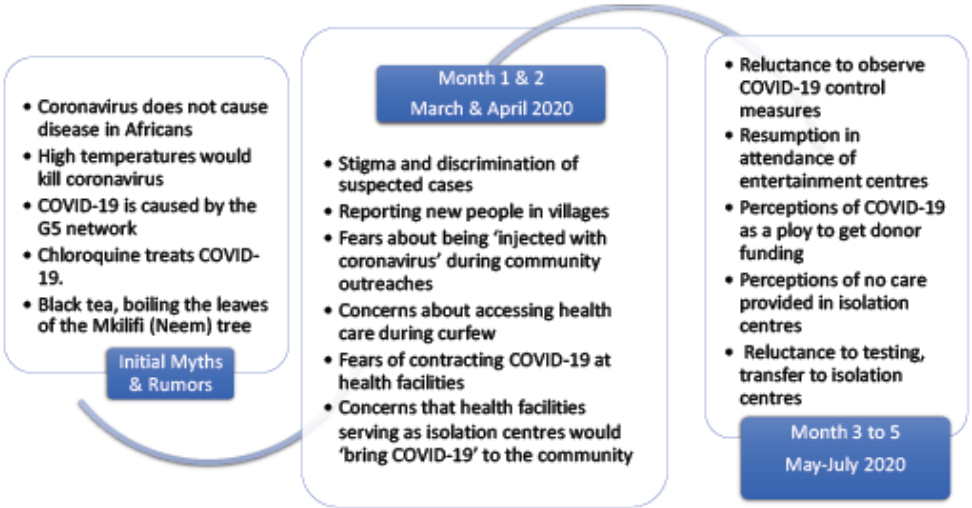
- The signs and symptoms of COVID-19 and what to do if one had such symptoms
- Advice to stay at home, wash hands, wear face masks and practice physical distancing as measures to control the spread of COVID-19
- Importance of quarantine and isolation as a part of the supportive management for COVID-19 and a prevention strategy to reduce transmission
- Providing hotline numbers where members of the public could call to report concerns and ask questions

The county response team used pre-existing channels (such as county Facebook pages, existing Whatsapp groups), and a newly introduced channel (two hotline numbers) to keep track of community concerns and rumours. A CHMT member was tasked to scour media outlets including social media to keep track of rumours and myths. Some rumours were shared directly with the county response team through personal interaction with community members and healthcare workers close to community level such as ward public health officers. A register was maintained in which identified community issues were documented including the source, details of the rumour or community concern and action taken in response.

Early community sensitization efforts were generalised with little specific messaging strategies and packaging for different groups. Youth for example, continued to sit in groups without observing physical distancing measures. There was little mention of engagement with other marginalized groups such as people living with disability (PLWD). However, at the time of data collection, there were ongoing efforts to develop a proposal for engagement with PLWD and youth groups.

Community concerns and feedback

Community concerns and feedback changed over time as shown in Fig. 3 below



In the early days of the COVID-19 response, there was significant fear, which reportedly resulted in community compliance with the COVID-19 transmission measures. Community members frequently called the hotline numbers to report new entrants to their villages and request testing for COVID-19. One manager observed:

"During the first wave of infection, the three hotline numbers would receive up to 200 calls in 24 hours but now, calls have reduced to about 20 to 50 calls across all the hotline numbers." County Health Manager

Unfortunately, this fear also resulted in stigmatization of community members who were suspected cases. For example, a person suspected of having COVID-19 was denied use of water points and shops in one village. In another village, community members almost burned down the home of a COVID-19 suspect. Communities also raised concerns about the use of their health facilities as isolation centres, with perceptions that they were 'being brought COVID'.

Concerns about contracting the virus reportedly contributed to a decline in service delivery in across health facilities. One respondent observed:

"They [community members] are calling our health facilities a hub of COVID, so we have experienced a decline in service delivery. This doesn't mean we don't have clients who are suffering from other illnesses but they are afraid of catching the virus in our facilities". County Health Manager

There were also reports from the community of mothers delivering at home due to difficulties in getting transport to the health facility. The majority of respondents linked poor outcomes among pregnant women to transport challenges due to restrictions on travel as part of the control measures.

As the pandemic evolved, there were reports of community fatigue with adherence to control measures illustrated by resumption of public gatherings such as funerals, repopulation of entertainment centres, reduced observance of physical distancing and wearing of face-masks. There were also cases of resistance to testing, transfer to isolation centres, closure of business premises and reports of community members hiding people who had tested positive with the belief that positive results were made up.

One factor attributed to the reported community fatigue and emerging resistance was scepticism about the continued existence of COVID-19. This scepticism was linked to a press briefing that announced the discharge of the last COVID-19 patient in the county in the 'first wave' (lasting between 26th March 2020 when the index case was reported and 29th April 2020, when the last contact was discharged). Following the briefing, community members adopted the view that *'Kilifi County has no Coronavirus'.*

The characteristics of the outbreak in Kilifi may also have contributed to this scepticism. For example, the majority of COVID-19 cases reported in the County were asymptomatic and at the time of data collection, some parts of Kilifi County had not reported a single case. Where there were reported cases, often they remained unknown to the public. These characteristics coupled with the economic impact of staying at home, meant that many community members reportedly opted to *'take the risk of contracting COVID-19, rather than die of hunger in their homes'.*

Actions in response to community concerns and feedback

Various actions were taken by CDOH officials in response to community concerns and feedback, ranging from increased information provision, through organising community consultations, to ensuring modifications to support access to care during curfew hours.

In response to fears about COVID-19 being brought to the community, CHMT members engaged directly with community leaders in specially organised meetings , observing social distancing, to get their buy-in for use of identified facilities as isolation centres. These community leaders included village elders, sub-county and ward administrators, chiefs, community health committees and health facility committees. Concerns and feedback raised through the hotline numbers were handled by designated CHMT members (Fig 2). In response to reports of new entrants to community reports of suspected cases, the hotline handlers notified respective sub-county response teams to visit the affected households. Rumours, myths and calls seeking information about COVID-19 were mapped to identify regions where they originated. These were shared with the communication team (Fig 2) who engaged community members through their local leaders. The risk communication team was

comprised of people who spoke the local languages. Often, they spoke in vernacular when explaining the importance of COVID-19 transmission prevention measures to community members. While on the ground, the communication team responded to myths and rumours by acknowledging the beliefs of the community members (because some were not harmful practices) but provided additional explanation of why prevention measures were important and emphasized that no cure for COVID-19 had been found yet.

In some cases, community concerns resulted in multiple responses at various health system levels. In response to concerns about accessing care during curfew hours, some Sub-county Health Management Teams (SCHMTs) identified together with community members, transporters who were given passes by the police that would allow them to transport a patient. To supplement these efforts, at county level, the hotline numbers (initially set up for the COVID-19 response) were shared again through radio and social media for community members to call and request pick-up by ambulance during curfew hours.

Challenges related to community engagement and citizen feedback processes

Trust and governance are considered essential components of good pandemic response. Over time there appeared to be high levels of mistrust within communities, with perceptions that *'COVID-19 is a creation of government to attract donor funding'* and allegations of extortion of money from business owners. There was also a perception among community members of selective application of enforcement measures, particularly of business closure. For example, a manager at a private health facility for which a closure directive had been issued noted that no public health facilities were closed for reporting a COVID-19 positive case, and threatened to stop reporting COVID-19 cases. Eventually, the closure directive for the private health facility was retracted. The county COVID-19 response team then adopted a strategy to conduct risk assessment rather than effecting outright closure when a private health facility reported a COVID-19 case.

Challenges in co-ordination and communication were observed between departments and within the multi-agency committees responsible for enforcement. For example, a team of enforcement officers would go out with the CDoH staff to ensure adherence to transmission measures (these included closure of business premises in some cases), but questions about who gave the directive for closure of premises would later arise. This contributed to a perception of unfair treatment among business owners and reluctance among enforcement officers to accompany CDoH staff during inspection of facilities and business premises, leading to loss of sustained enforcement efforts.

Hotline numbers were a newly introduced channel for receiving community concerns. While the hotlines provided important feedback, challenges related to their use might have undermined responsiveness to community needs and concerns. For example, the hotline phones could not make outgoing calls and were inconsistently loaded with airtime. The persons handling them sometimes used their own phones to respond to community members' calls or messages. It is therefore likely that some community members without airtime, might have lost an opportunity to raise their concerns.

There were also challenges in 'closing the feedback loop' to ensure that community members who needed an ambulance were reached in good time. First, there was reluctance among a few facility managers to release ambulances to pick mothers and community members from their homes. Second, even when ambulances were released, there were delays, and in one case a woman who needed transport to the hospital delivered on the way. Third, there were no measures to track implementation of the directive that ambulances could pick community members from their homes such as expected turn-around time to deliver the labouring mother to a health facility. Finally, there were was no mapping of ambulances to determine which were nearest to which facilities to enable efficient deployment based on need. The hotline handlers often stayed on the phone for hours trying to find an ambulance for a community member who had called in.

Use of community participatory structures such as Community Health Volunteers (CHVs and health facility committees for COVID-19 community engagement happened later rather than earlier in the pandemic response. Community members frequently had follow-up questions, which they mainly asked CHVs, but CHVs were not any better informed than other community members as they were sensitized on COVID-19 later. The low and late utilisation of CHVs was linked to the low coverage

of community units (community health service delivery structures within which CHVs work). At the time of the COVID-19 outbreak in Kilifi, community unit coverage was approximately at 30%, and therefore CHVs could not be used in all parts of the county. In addition, a challenge of working with CHVs was the inability to support their daily stipend due to budgetary constraints. Furthermore, there was inadequate Personal Protective Equipment (PPE) to ensure the protection of CHVs when they went out to households. This may all have begun to change, because with support from the national government the coverage of community units has recently increased to 78%, with 1500 CHVs trained on both general CHV roles and COVID-19.

Conclusion and Recommendations

Overall, in Kilifi County, multiple mechanisms and approaches were used to receive and respond to community concerns and feedback during the COVID-19 outbreak response. The approaches used have varied with the evolution of the pandemic, and some of the challenges experienced provide an opportunity for learning. Although, the pandemic continues to unfold, some recommendations based on learning from recent experiences include:

1. While one-sided information sharing may reach large audiences, the use of more interactive mechanisms (such as health facility committees and meetings with CHVs) that allow interrogation by community members about what is happening should be strengthened as these have greater potential to build and maintain public support for health system actions.
2. Consistency in messaging and application of measures across all levels of the community is important to build community trust and to overcome resistance to response efforts. This can be achieved by strengthening communication and co-ordination at higher health system levels, including with stakeholders.
3. Introduction of new mechanisms for receiving community concerns and feedback during a health system crisis requires adequate support and close monitoring to ensure that responsiveness to community feedback is not undermined.
4. Public health responses and interventions during times of health system crises may have un-intended consequences. Care is therefore needed in planning and implementing them including anticipation of short term and longer term implications and mitigation measures for any negative consequences.

This brief was developed as part of ongoing work on health system responsiveness with input from Nancy Kagwanja, Alex Hinga, Benjamin Tsofa and Sassy Molyneux. We thank the health managers of Kilifi County for their participation in this work.

KEMRI | Wellcome Trust

Appendix 11: Ethics Approval

KENYA MEDICAL RESEARCH INSTITUTE

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Email: director@kemri.org, info@kemri.org, Website. www.kemri.org

KEMRI/RES/7/3/1 **December 11, 2019**

TO: **NANCY KAGWANJA**
PRINCIPAL INVESTIGATOR

THROUGH: **THE DIRECTOR, CGMR-C**
KILIFI

Forwarded 6.12.19
DIRECTOR
CENTRE FOR GEOGRAPHIC MEDICINE RESEARCH, COAST

Dear Madam,

Re: **PROTOCOL NO. KEMRI/SERU/CGMR-C/171/3920 *(RESUBMISSION III OF INITIAL SUBMISSION)*: EXAMINING AND STRENGTHENING HEALTH SYSTEM RESPONSIVENESS TO CITIZEN FEEDBACK IN KENYA. *(VERSION 1.3 DATED NOVEMBER 26, 2019)***

Reference is made to your letter dated November 28, 2019. The KEMRI Scientific and Ethics Review Unit (SERU) acknowledges receipt of the revised study documents on December 02, 2019.

This is to inform you that the issues raised during the 290th Committee C meeting of the KEMRI Scientific and Ethics Review Unit (SERU) held on **August 29, 2019** have been adequately addressed.

Consequently, the study is granted approval for implementation effective this day, **December 11, 2019** for a period of **one (1) year**. Please note that authorization to conduct this study will automatically expire on **December 10, 2020.** If you plan to continue with data collection or analysis beyond this date, please submit an application for continuation approval to SERU by **October 29, 2020**.

You are required to submit any proposed changes to this study to SERU for review and the changes should not be initiated until written approval from SERU is received. Please note that any unanticipated problems resulting from the implementation of this study should be brought to the attention of SERU and you should advise SERU when the study is completed or discontinued. You may embark on the study.

Yours faithfully,

ENOCK KEBENEI
THE ACTING HEAD
KEMRI SCIENTIFIC AND ETHICS REVIEW UNIT

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KEMRI/RES/7/3/1 **May 28, 2020**

TO: **NANCY KAGWANJA,**
PRINCIPAL INVESTIGATOR

THROUGH: **THE DEPUTY DIRECTOR, CGMR-C**
KILIFI

Dear Madam,

RE: **KEMRI/SERU/CGMR-C/171/3920 *(REQUEST FOR AMENDMENT 1)*: EXAMINING AND STRENGTHENING HEALTH SYSTEM RESPONSIVENESS TO CITIZEN FEEDBACK IN KENYA.**

This is to inform you that at the 299th Committee C meeting of the KEMRI Scientific and Ethics Review Unit (SERU) held on **May 28, 2020**, the request for amendment for the above referenced research proposal was discussed.

The Committee noted the following amendments:

1. Addition of a specific objective
   a. To explore the implications of local and national sudden shocks (such as health worker strikes and COVID-19), on health system responsiveness. (pg 13)
   b. Addition of detail in the data collection section and informed consent forms to include phone and online interviews;
      - Addition in the background about the importance of examining the response to shocks like Covid-19- (pgs, 8, 10)
      - Addition of specific objective-(pgs 13)
      - -Addition of physical distancing considerations during data collection-(pgs 19, 20, 21)
      - Addition of ethical considerations around informed consent and eventual dissemination of study findings in light of current Covid-19 pandemic (pgs 25, 26)
      - Addition on the informed consent forms (pgs 37,40, 43, 46, 49)
   C. Changes in ICF and data collection tools as a result of addition of the objective above
      - ICF documents-(pgs 37, 40, 43, 46, 49)
      - Data collection tools-(pgs 52, 53, 54, 55).

The Committee concluded that the amendments are justified and do not alter the risk/benefit status of the study and are therefore **granted approval** for implementation.

Please note that you are required to submit any further request for changes to the approved protocol to SERU for review and approval prior to implementing any additional changes.

Yours faithfully,

ENOCK KEBENEI,
THE ACTING HEAD,
KEMRI SCIENTIFIC AND ETHICS REVIEW UNIT.