

POLITICAL PRIORITISATION FOR PERFORMANCE-BASED FINANCING AT THE COUNTY LEVEL IN KENYA: 2016 TO 2019

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ABSTRACT

Background: Performance based financing was introduced to Kilifi county actors in Kenya in 2015. Kilifi was identified by the Kenyan national government as one of the 20 arid and semi-arid counties (out of 47 counties) mandated to start the implementation of the scheme and potentially inform the development of a nation-wide PBF policy. This study investigates how political and bureaucratic actors at the local level in Kilifi county have subsequently influenced the extent to which PBF has been politically prioritised at the sub-national level.

Methods: The study employed a single-case study design. The Shiffman and Smith (2007) political priority setting framework with adaptations proposed by Walt and Gilson (2014) was used. Data was collected through document review (n=19) and in-depth interviews (n=8). Framework analysis was used to analyse data and generate findings.

Results: Throughout the study period (2015-2018), national policy elites gave sustained attention to PBF as a priority issue for implementation, this sustained attention was however not present at the sub national level in Kilifi county and funding for PBF was not prioritised post donor funding. Key factors that contributed to this in Kilifi county included: redistribution of power from national actors to sub-national actors following devolution, this affected the national Ministry of Health's ability to lead and be an effective guiding organisation; misalignment between the globally advocated idea of 'pay for performance' and the local pre-existing centralised and rigid approaches to public financial management; and actors at the sub national level who contested the PBF intervention design features and its framing as 'additional funding'. As a consequence, the implementation of PBF in Kilifi was for a short time only using donor resources and did not last beyond donor timelines and funding.

Conclusion: This research shows that for health reforms to gain political priority in highly devolved contexts, there is need to recognise the formal and informal institutions existing at the devolved level of governance and for adequate early involvement and leadership from sub-national bureaucratic and political actors, in health and beyond the health sector. In addition, advocacy for the health reforms should embody frames that align with the political context to increase the chances of gaining political traction. Finally, the political context including political and bureaucratic power at different levels of government are crucial features that will also influence the acceptability of reform and ultimately political prioritisation.

Keywords: performance-based financing, politics, political prioritisation, agenda setting, policy analysis, policy introduction, power, devolution, sub-national, Kilifi county, Kenya.

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DECLARATION

I, **Dennis Wambiri Waithaka**, hereby declare that the work on which this thesis is based is my original work (except where acknowledgements indicate otherwise) and that neither the whole work nor any part of it has been, is being, or is to be submitted for another degree in this or any other university.

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Date: 3rd March 2021

DEDICATION

This thesis is dedicated to my mother, Susan Njeri. Her endless love, support and belief in me has seen me through great tribulations.

ABBREVIATIONS

PBF	Performance Based Financing
RBF	Results Based Financing
GoK	Government of Kenya
MoH	Ministry of Health
CDoH	County Department of Health
CEC	County Executive Committee
MCA	Member of County Assembly
NGO	Non-Governmental Organisation
WHO	World Health Organisation
LMICs	Low- and Middle-Income Countries
PHC	Primary Healthcare
ToT	Trainer of Trainees
KHSSP	Kenya Health Sector Support Project
HSSF	Health Sector Service Fund
MDGs	Millennium Development Goals
HRITF	Health Results Innovation Trust Fund
MCH	Maternal and Child Health
HIV	Human Immunodeficiency Virus
AIDs	Acquired immunodeficiency syndrome
ASAL	Arid and Semi-Arid Land
NHIS	National Health Insurance Scheme

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PART A: PROTOCOL

1.1 Introduction

Results based financing (RBF) is an umbrella term for any arrangements that link payments (in the form of money or material goods) to healthcare providers (to the facility or directly to the healthcare worker) when they achieve predetermined targets, or to healthcare recipients when they take health related actions or behaviours (WHO, 2019, World Bank Group, 2014, Morgan, 2014, Renmans et al., 2016, Soucat et al., 2017). Although, the terms performance based financing (PBF) and pay for performance (P4P) have been used interchangeably with RBF, the World Health Organisation (WHO) has distinguished PBF as where “incentives are purely financial, directed only to providers not beneficiaries, and explicitly dependent on the degree to which providers achieve certain pre-established verified performance indicators” (WHO, 2019, para 1). The link of payments on pre-defined process or output indicators contrasts with the input-based approach (the funding of inputs such as salaries and drugs) and user fee regimes (Eichler et al., 2007, Meessen et al., 2011, WHO, 2019). In this protocol, the term PBF is used to refer to incentives that target healthcare providers (supply-side) with the aim of improving health service delivery at the facility level, under the umbrella term of RBF.

PBF was introduced in Kenya as a pilot project in Samburu district in 2011, technically and financially supported by the World Bank (MoH, 2014). The Samburu pilot, which was considered a success, ran for two years and was evaluated in 2013; the year in which the country went through devolution (MoH, 2014). Devolution restructured the government into two administrative levels: the national government and 47 county governments (GoK, 2010). After devolution, a decision was made at the national level to scale up PBF in 20 Arid and Semi-Arid Land (ASAL) counties, with the financial and technical support of the World Bank (MoH, 2014). The PBF experiences in the 20 ASAL counties would potentially inform nation-wide implementation of the PBF scheme in Kenya. Since the AHPSR (2015) report which focused on implementation of the PBF scheme in Kenya from 2011 to 2015 when the scaling up process had just began in seven ASAL counties, no study has examined further implementation of PBF at the county level, and in particular, whether PBF is a political priority at this local level.

Political priority refers to the “degree to which political leaders actively give attention to an issue, and back that attention with the provision of financial, technical and human resources that are commensurate with the severity of the issue” (Shiffman and Smith, 2007, p.1370). Political prioritisation at the county level is important because the 2010 Kenyan constitution empowers the county governments to determine whether any legislative actions and/or resource allocation for PBF will take place at this level (GoK, 2010) – ultimately determining the successful implementation or not of the scheme. Thus, analysing the political prioritisation of PBF at the county level will entail examining the processes of decision-making by local political and bureaucratic actors who are responsible for

legislation and resource allocation at the county level. These decision-making processes are influenced by the levels and sources of power of different actors, existing framing and ideologies, and key features of the political context that shape actor power and actions (Gilson et al., 2018, Bambra et al., 2005). The aim of this study is to explore and explain the evolution of the political prioritisation (or not) of PBF in Kilifi county in Kenya from 2016 to 2019 from a political and bureaucratic perspective.

1.2 Background

1.2.1 Global context and PBF experiences in Low- and Middle-Income Countries (LMICs)

The launch of the Millennium Development Goals (MDGs) in 2000 put health at the centre of the development agenda globally (Shroff et al., 2017a, Shroff et al., 2017b). There was a recognition that health indicators particularly those related to maternal and child health were performing poorly in LMICs despite donors' substantial allocation of funds in their health systems (Meessen et al., 2011, Morgan, 2014, Shroff et al., 2017a). Governments and international partner payments for inputs rather than high quality outputs was argued to be inefficient due to 'resource leakage', lack of accountability and staff absenteeism, which greatly contributed to the prioritization of the need for mechanisms that could improve the effectiveness of development aid and health spending (Eichler et al., 2007, WHO, 2007, Meessen et al., 2011, Morgan, 2014, Shroff et al., 2017a). This led to the global development and growth of innovative financing mechanisms such as; PBF, advance market commitment of funds for vaccines, international finance facility for immunization and the international drug purchase facility, health financing was thus seen as one of the entry points for strengthening the performance of health systems (WHO, 2007). PBF was the approach advocated for by international development agencies including the World Bank, USAID, and the Norwegian government for achieving health goals including the MDGs (Oxman and Fretheim, 2009, Chimhutu et al., 2015, Petrosyan et al., 2017, Shroff et al., 2017a). These agencies were particularly crucial in diffusing the ideas to LMICs through various strategies such as organising workshops and tours (to 'successful countries') to introduce and showcase the PBF concept to senior government officials, and offering financial and technical support for the implementation of the schemes (Petrosyan et al., 2017, Shroff et al., 2017a, Kiendrébéogo et al., 2017, Sieleunou et al., 2017). Notably, the PBF drive gained momentum with the creation of the World Bank Health Results Innovation Trust Fund (HRITF) in 2007, supported by the Norwegian and United Kingdom governments. This is because through the trust fund, the World Bank promoted and supported low-income countries to at least partially pay healthcare providers based on performance linked to maternal and child health outcomes (World Bank Group, 2014, Shroff et al., 2017a, Shroff et al., 2017b). Through the trust fund, about US\$390 million had been committed for PBF projects in 29 countries as of 2016 (World Bank Group, 2014). The HRITF is however under evaluation and is expected to be terminated in 2022 (Paul et al., 2018).

Despite the widespread introduction and implementation of PBF in LMICs, evidence on the effectiveness of PBF in LMICs is understood to be weak and contradictory (Oxman and Fretheim, 2009, Witter et al., 2012, Renmans et al., 2016). Oxman and Fretheim (2009)'s review of systematic reviews on the effectiveness of all types of results-based schemes found that although giving financial incentives to healthcare providers and healthcare recipients was effective in the short-term for simple and well-articulated behavioural goals, there was little evidence on longer-term sustained changes and very limited evidence on their effectiveness in LMICs. Further, the result-based schemes resulted in unintended effects, such as healthcare recipients cheating on health-related actions and healthcare providers manipulation of data and displacement of efforts away from un-incentivized services, which have been less well studied (Oxman and Fretheim, 2009). Witter et al. (2012)'s systematic review of the effectiveness of PBF in improving service delivery in LMICs was inconclusive due to the low quality of evidence and wide variations in PBF approaches and settings - and therefore highlighted the need for more robust studies (Witter et al., 2012). In addition, the review revealed that it was not clear how the design features of PBF (such as the choice of performance indicators, performance targets, and level and structure of financial incentives) and ancillary components (such as increased funding, training and formative supervision) interact with different contexts to affect its effectiveness (Witter et al., 2012).

The uncertainties about the effectiveness of PBF contributed to a shift in focus towards understanding how best to design and implement PBF (opening the 'black box') by studying if and how it works, its interaction with the broader health system and how it is perceived by stakeholders (Ssengooba et al., 2012, Witter et al., 2012, Paul et al., 2017, Shroff et al., 2017b). To this end, Witter et al. (2013) proposed a framework for studying and monitoring the interactions between PBF and the health system centred around the following five domains; 1) the context and its influences on PBF 2) PBF emergence 3) design 4) implementation and 5) effects of PBF on health system. A more recent review conducted by Renmans et al. (2016) aimed at opening the 'black box' of PBF through analysing findings on interactions between the various actors and the effects of PBF schemes on service delivery in LMICs. It highlighted that the political ideologies ("implicit assumptions about what is just and according to which philosophical vision(s) society should be structured") and the environment (including existing purchasing and payment mechanisms, socio-cultural practices, economic situation, capacity and structure of the health system) in which PBF is implemented are important to designing policies that are relevant and sustainable in the local context (Renmans et al., 2016, pp.1297–1309). The review thus heavily suggested the need for more research particularly on the influence of ideas, design and context on acceptability and effectiveness of PBF schemes (Renmans et al., 2016).

While there is uncertainty on the effectiveness of PBF and there is a need to open the 'black box' of PBF, the approach has been rolled out and is in various stages of scaling up across LMICs. A multi-national study of PBF scaling up processes in 11 LMICs found that in countries such as Rwanda, Burundi

and Cameroon it had progressed to a national policy, while, in other countries such as Chad and Uganda, it had failed to progress beyond the pilot project and was discontinued (Shroff et al., 2017a). The differences in evolution of PBF schemes were attributed to the role of various international and national policy entrepreneurs including their ideas and power, contextual factors and national level buy-in. For example, in Rwanda and Cameroon, the evolution from pilots to national policies was enabled by the promotion of the idea that PBF would enhance results and transparency respectively which were key issues in the political agenda at the time (Shroff et al., 2017a). Meanwhile, PBF's failure to progress to a national program in Uganda was partly attributed to local perceptions that it was donor driven hence there were doubts on health facilities operational capacity and PBFs long-term financial sustainability (Shroff et al., 2017a). The authors conclude by highlighting the need for more empirical research to enhance the understanding of the policy evolution of PBF schemes from an idea that originated globally, transferred to the national level and eventually became local level policies (Shroff et al., 2017a). Furthermore, the only literature available that has analysed the political economy and politics of PBF policy processes has focused at global/continental (Gautier, 2019), regional (Barnes et al., 2015) and/or national levels (Kiendrébéogo et al., 2017, Chimhutu et al., 2015, Sieleunou et al., 2017, Gautier, 2019).

1.2.2 PBF in Kenya

In 2010, an international training organized and sponsored by the World Bank and the Dutch government was held in Mombasa, and among others, global evidence on PBF was shared (AHPSR, 2015). This training was reportedly useful in passing the ideas and knowledge and, setting the agenda for PBF in Kenya (AHPSR, 2015). Following this, in October 2011, the government of Kenya (GoK) through the ministry of health (MoH) and with financial and technical support from the World Bank's HRITF, established a PBF pilot in 26 primary healthcare facilities (dispensaries and health centres) in Samburu district to implement and examine the impact of PBF on the following six MCH indicators; antenatal consultations, facility deliveries, family planning, growth monitoring for children under-five years, full vaccination of children, HIV testing and counselling (AHPSR, 2015, Obare and Bellows, 2014). These indicators were identified as critical in addressing the stagnating maternal and neonatal mortality rates, the high fertility rates and the high prevalence of stunting among under-five children in Kenya (MoH, 2014).

The pilot phase ended in October 2013 (three months after devolution) with the evaluation reports revealing improvements in staff motivation, collaboration with community health units, facility infrastructure and, utilization of growth monitoring services (Obare and Bellows, 2014, Population Council, 2013). However, there were no significant increase in five out of the six service utilization indicators that were targeted by the PBF pilot (i.e. antenatal consultations, facility deliveries, family

planning, vaccination and HIV testing and counselling services) (Obare and Bellows, 2014) and, external verification by the community and local Non-governmental organisations (NGO) were not conducted as stipulated in the pilot design (AHPSR, 2015). There were also reports of loss of confidence and motivation due to delayed disbursement of PBF funds associated with delayed verifications, slow processing of PBF reports and bureaucracies in accessing the newly devolved county government's general bank account (Population Council, 2013, AHPSR, 2015). In addition, in some of the facilities, funds were used to incentivise mothers to deliver in the facilities by for example, offering them soaps and 'lesos' (African garment) to take home after delivery (AHPSR, 2015, Population Council, 2013), which may have overestimated the effects of PBF. Respondents also noted that it was not clear whether the improvements in the health indicators were only due to the PBF pilot or other policies and programmes targeting similar MCH indicators - such as the abolition of user fees in primary healthcare facilities, the free maternity services policy (which requires that all public health facilities offer maternity services for free) and the Beyond Zero campaign (campaign led by the Kenyan first lady to promote safe delivery) - which led to concerns on its cost-effectiveness (AHPSR, 2015).

Despite the PBF pilot's lack of significant increases in most of the targeted service utilization indicators, difficulties in external verifications and concerns over cost-effectiveness, the scheme was to be scaled up to include 20 Arid and Semi-Arid Land (ASAL) counties. By the end of 2015, only seven Northern counties had set up the required structures and started the implementation of PBF (AHPSR, 2015). In addition, although the World Bank had financially supported PBF from conception to setting aside USD \$ 20 million for the scale up in Kenya, as of 2015, there was no evidence that either the national or county governments had allocated any funds towards the scaling up of PBF (AHPSR, 2015). Allocation of public funds is an important indicator of government commitment and buy-in, and a step towards sustainable integration of PBF schemes into health systems (Shroff et al., 2017a). Further, the AHPSR (2015) report highlighted that there were different actors (politicians and civil servants) with different orientation and interests in health services at the county level. Specifically, while the political actors were supposed to push the political agenda for the institutionalisation of PBF into the county planning and financing system, the civil servants were expected to implement PBF (AHPSR, 2015). As such, it would be important to analyse how the two different interests (political and bureaucratic) influence the scaling up of PBF in Kenya (AHPSR, 2015). Since the scaling up of PBF in the ASAL counties began in 2015, no study has examined further evolution of the PBF policy process in Kenya in these counties. This study therefore seeks to build on the AHPSR (2015) report on PBF in Kenya and contribute to the knowledge base on the on the politics of policy processes by exploring and explaining the political prioritization of PBF at the county level from 2016 to 2019.

I.3 Problem statement and rationale

As of 2015 when PBF (which, as of 2019, is still not a legislated nationwide policy) started being scaled up at the county level in Kenya, it was reliant on technical and financial support from the World Bank's HRITF funding, which is scheduled for termination in 2022 (Paul et al., 2018). Termination of this funding without investment by the county governments has the potential to negatively affect health workers motivation and performance and ultimately service delivery. As such, it is important to examine the evolution of the political priority for PBF particularly at the county level as it will determine whether county resources are allocated to the scheme even after the withdrawal of the HRITF funding. Further, since 2015, the county governments are likely to have various competing issues in their agendas and, the policy environment is likely to have shifted, "transforming the relations between actors and between institutions" (Walt and Gilson, 1994, p. 366). Thus, examining the evolution of the political priority for PBF at the county level will also help us to understand the context for further implementation of PBF in Kenya and; to build the knowledge base on the emergence of PBF at the local level. This will provide useful insights on how and why some policies do or do not gain traction at the local level, which may ultimately inform whether PBF becomes a nationwide policy. More broadly, the study will respond to calls on the need for more empirical research to enhance the understanding on the influence of context, politics and power on the policy evolution of PBF schemes from an idea that originated globally and was transferred and transformed to national and local levels policies (Shroff et al., 2017a, Renmans et al., 2016, Witter et al., 2013, Witter et al., 2012).

The study will be conducted primarily at the county level where the actors have had more exposure and experience with the evolution of the PBF scheme since 2015. More specifically, the study will be done in Kilifi county, one of the 20 ASAL counties that were mandated to implement PBF.

I.4 Research Aim

To explore and explain the evolution of the political prioritisation (or not) of PBF in Kilifi county in Kenya from 2016 to 2019 from a political and bureaucratic perspective.

The purpose of this study is both exploratory and explanatory as it seeks to explore and explain a relatively unknown situation (Robson, 2002, Gilson, 2012). More specifically, it seeks to explore whether PBF has evolved into a political priority (or not) in Kilifi county and, explain what factors have influenced the evolution of the political prioritisation (or not) of PBF.

1.5 Research question

How did political and bureaucratic actors in Kilifi county make meaning of global and national ideas on PBF and which factors and actors influenced the extent to which PBF has been prioritised?

1.6 Conceptual framework

This study will apply the adopted the Shiffman and Smith (2007) political priority setting framework, which included adaptations proposed by Walt and Gilson (2014) to explore the factors influencing the evolution of political priority for PBF in Kilifi county. Although the Shiffman and Smith (2007) political priority setting framework has been used to examine why some global health issues are more (or less) successful in generating political priority at the global (Shiffman and Smith, 2007, Tomlinson and Lund, 2012, Shavar et al., 2015) and national (Prata and Summer, 2015, Daire et al., 2018) level, this study will test the framework's utility at a sub-national level. Table I below shows the components of the Shiffman and Smith (2007) political priority setting framework with the adaptations proposed by Walt and Gilson (2014).

Table I: The adapted Shiffman and Smith (2007) political priority setting framework proposed by Walt and Gilson (2014); additions or changes made by Walt and Gilson (2014) highlighted in red

Categories	Description	Factors shaping political priority
Actor power	The strength of the individuals and organisations concerned with the issue	1. Policy community cohesion 2. Leadership 3. Effective guiding 'organisations' (rather than 'institutions') 4. Civil society mobilisation
Ideas	The ways in which those individuals with the issue understand and portray it	5. Internal frame 6. External frame
Issue characteristics	Features of the problem	7. Credible indicators 8. Severity 9. Effective interventions 10. Contestations or conflicts
Political contexts	The environment in which actors operate	11. Policy windows 12. Global governance structures (formal and informal institutions) 13. Historical dimension

Outcome

Assessment of whether the issue is being taken seriously by policymakers

12. Presence of an authoritative decision or resources allocated to issue

Actors and their collective power are central to the prioritization of the concerned issue (Shiffman and Smith, 2007). Generating political priority is easier when the actors who are centrally concerned with the issue have power to influence the policy process, and when they agree on basic issues such as the definition and solution of the problem (Shiffman and Smith, 2007). To further unpack the various aspects of power and how they interact with each other, the Gaventa (2006) 'power cube' will be adopted. The power cube is a tool for analysing the *levels*, *spaces* and *forms* of power and their interconnectedness. The levels dimension of the power cube refers to the different layers of decision making which include; local, national and global (Gaventa, 2006). The spaces dimension of the power cube refers to the potential arenas for participation in decision-making which includes; closed spaces ('decisions made by actors behind closed spaces'), invited spaces ('people are invited to participate in the decision-making') and claimed/created spaces ('less powerful actors powerful claim/create spaces from or against powerholders') (Gaventa, 2006). The forms dimension of the power cube refers to the ways in which power manifests itself which entails; visible power (the observable and definable aspects of political power, for example, authorities and institutions), hidden power (that which influences 'what gets into the decision-making table or political agenda') and, invisible power (as that which 'shapes meaning and what is acceptable') (Gaventa, 2006). Data collection and analysis will entail identifying the actors who have influenced the PBF policy processes and their sources, levels and forms of power in Kilifi county between 2016 and 2019.

Ideas are "the ways in which those involved with the issue understand and portray it" (Shiffman and Smith, 2007, p. 1371). There are two types of frames: 1) internal frame, is the extent to which the framing of the issue is agreeable within the policy community in terms of the definition of the problem, its causes and solutions; and 2) external frame, is the extent to which the framing of the issue appeals to key actors such that they respond by for example, allocating resources (Shiffman and Smith, 2007). An idea used to describe the issue is likely to get attention if framed in a manner that is agreeable within the policy community [internal frame] and, portrayed externally in a manner that appeals with the political actors [external frame] (Shiffman and Smith, 2007, Shavar et al., 2015). Here, data collection and analysis will entail identifying the key ideas behind the actors' articulations of the nature of the problem that PBF was intended to address and, how PBF is framed as a solution, at the county level.

The characteristics of the issue refers to the "features of the problem" (Shiffman and Smith, 2007, p. 1371). Different issues attract different levels of political support due to certain features that the issue

has. In this study, the main 'issue' under investigation is 'PBF'. Thus, data collection and analysis will entail identifying any features of PBF that may be influencing its ability to gain political support at the county level. It will also involve identifying any conflicts and contestations that may arise due to particular features of PBF (Walt and Gilson, 2014).

The political context refers to the "environment in which actors operate" (Shiffman and Smith, 2007, p. 1371). It includes factors such as policy windows, formal and informal institutions, due to their ability to influence political support levels (Shiffman and Smith, 2007). During data collection and analysis, factors that influenced the evolution of political prioritisation in Kilifi county between 2016 and 2019 will be identified. In addition, historical events or processes that may have influenced the evolution of political prioritisation for PBF in the county will also be included.

Finally, the outcome component was added by Walt and Gilson (2014, p. iii 14) "to see whether the issue under discussion was being taken seriously by policymakers as indicated by the presence of an authoritative decision or allocation of resources". In this study, an assessment of political prioritisation for PBF in Kilifi county between 2016 and 2019 will also entail finding evidence, or lack thereof, of authoritative decisions such as development of local PBF policy documents, or PBF related resource allocation during this period (Walt and Gilson, 2014).

1.7 Research design and strategy

This study will adopt a flexible single-case study design. A flexible study design is adopted because the study aims to investigate an issue [the political prioritisation of PBF at the county level in Kenya between 2016 and 2019] for which the researcher 'has no control over events' and there is 'limited knowledge' on the issue under investigation (Gilson, 2012, Robson, 2002). The limited knowledge of the issue makes 'tight pre-specifications' prior to data collection, as is the case in fixed study designs, infeasible (Gilson, 2012, Robson, 2002).

Within the flexible study design, a case study strategy was adopted. This is because, according to Yin (2014, pp. 27-45), a case study strategy is appropriate in situations when (1) the main research questions are "how" or "why" questions; (2) a researcher has little or no control over the events; and (3) the focus of study is empirically explaining a contemporary phenomenon ('the case') in-depth and within its real-life context. As such, a case study strategy is an appropriate mode of inquiry for this study because "how" the political priority for PBF in Kilifi county has evolved between 2016 and 2019 is a contemporary phenomenon ['as opposed to historical'] influenced by, and embedded within a broader socio-political context (Yin, 2014).

A single case with embedded units of analysis (figure 1) was adopted to capture the common local contextual realities, politics and actor power that are central to implementing and scaling up reforms

['common case'] in Kenya (Yin, 2014). Further, according to Yin (2014), single-case studies can contribute significant knowledge on the subject under study and test the applicability of theory (such as the study's conceptual framework). 'The case' to be examined is *the political prioritisation of PBF in Kilifi county between 2016 and 2019*. Yin (2014, p. 217) refers to the 'case' or unit of analysis as 'the main subject of study in a case study' and is usually a 'concrete entity' such as an individual, organisation, process, policy, or an occurrence such as a decision. Bounding the case by focusing on specific time periods (such as between 2016 and 2019) and geographical location (such as Kilifi county) is important in defining the scope of the data collection and distinguishing data about the subject under investigation ('the case') and the context (things that fall outside of the case). The specific site for the data collection (Kilifi county) was selected based on the following two criteria: i) county where PBF was implemented and ii) easy accessibility to political and bureaucratic actors and government documents due to the longstanding relationship between the county managers and the research institution (KEMRI-Wellcome Trust Research Programme-KWTRP) to which the student researcher works in.

An embedded unit of analysis refers to a "unit lesser than the main unit of analysis, from which the case study data are also collected" (Yin, 2014, p. 218). In this study, the following two embedded units of analysis will be selected:

1. The management and distribution of funds for PBF in Kilifi county (financing lens)
2. A policy development process that included input from the health service managers (health providers lens)

Figure 1 below shows the single-case study with two embedded units of analysis.

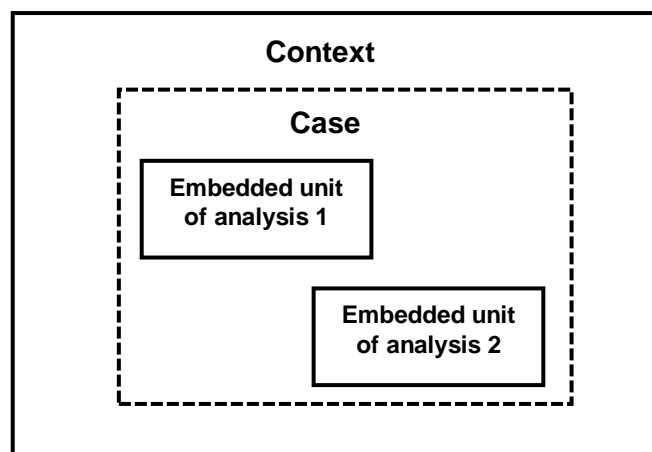


Figure 1: Single-case study with two embedded units of analysis. Source: (Yin, 2014).

The embedded units of analysis will provide a lens that will enable us to explore and explain if PBF evolved into a political priority (or not) in Kilifi county. Financing as a lens was selected because the

PBF scheme is an alternative mechanism of financing the health sector thus the management and distribution of funds has the potential to provide insights on the initiative. Given that it is likely that actors involved in the management and distribution of the PBF funds share a certain financing perspective, a policy development process that included input from health service managers was selected to gain insights into health providers perspective. These units of analyses have the potential to unearth key processes, ideas, exercises of power and any authoritative decisions that may have been taken for PBF in Kilifi.

In line with a case study methodology, multiple sources of evidence will be used, and the data triangulated to enhance rigour (Yin, 2014). Specifically, data will be collected through review of a range of documents and in-depth interviews of a range of actors as discussed below. The Shiffman and Smith (2007) political priority setting framework with the adaptations proposed by Walt and Gilson (2014), will guide the development of the data collection tools and the analysis and thus, supporting analytical generalisability and enhancing the rigour of the case study (Yin, 2014).

I.8 Data collection

The data will be collected through the following two methods of data collection:

I.8.1 Document review

Documents will be reviewed if they contain any information related to the PBF scheme in Kenya and in particular, the introduction and implementation of the PBF scheme in Kilifi county. Examples of such documents include: PBF scaling-up manual, Kilifi PBF policy documents, memorandums, minutes, media articles and letters. The inclusion criteria for documents is those that:

- Communicate the introduction of the PBF scheme in Kilifi county between the national government, the World Bank (or any external actors), and the Kilifi county government on matters related to the PBF scheme,
- Communicate guidelines for the implementation of the PBF scheme in Kilifi county, specifically related to the financing of PBF and the selected policy development process.
- Involve communications by actors and departments within Kilifi county government on matters related to the PBF scheme
- Policy documents stating any goals and / or decision taken with regards to PBF.

The relevant documents will be sought from the interviewees, county offices and online searches. The online searches for documents will be done on google, Kilifi county government website, Kenya RBF website and the World Bank RBF website, which are all publicly accessible. The search terms that will

be used are: 'performance-based financing' OR 'Results based financing' OR 'pay for performance' OR 'PBF' OR 'P4P' OR 'RBF' OR 'health financing' OR 'provider payment' AND 'Kenya' OR 'Kilifi'. In addition, any information found in these websites that matches the above inclusion criteria will be extracted. The reference lists for the documents will also be checked for any relevant citations. The exclusion criteria for documents will be those that:

- Do not contain information related to the PBF scheme in Kenya
- Focus only on the implementation of the scheme in other counties except Kilifi

1.8.2 In-depth interviews

The in-depth interviews will entail an online conversation between the student researcher and the study participants, guided by a semi-structured interview guide (see appendix I). Briefly, in a semi-structured interview guide, the questions are open-ended thus not limiting the responses of the respondents (Srivastava and Thomson, 2009), however the questions have been designed to answer the research question and have been informed by the use of the political priority setting framework with the adaptations proposed by Walt and Gilson (2014), and Gaventa (2006) power cube concepts. In addition, during the interview, the interviewer can make use of prompts to help and direct the respondent into the research topic issues which enables the gathering of more detailed and in-depth data (Srivastava and Thomson, 2009).

The study will target both bureaucratic and political actors who meet the following inclusion criteria:

- Were involved in the introduction of the PBF scheme in Kilifi county in the period under study
- Are/were involved in the implementation of the PBF scheme in Kilifi county, specifically related to the financing of PBF and a selected policy development process.

In the first instance, the potential participants will be identified in the first round of documents reviewed, after which, additional participants will be identified through snowballing, whereby, interviewees will be asked to identify whom they consider to be centrally involved in the introduction of PBF; financing of PBF and; the development of local PBF policies, in Kilifi county. This will mostly include: 1) bureaucratic actors from the Kilifi county department of health (CDoH) and Kilifi county department of finance (CDoF) and 2) political actors such as the county executive officer (CEC) in-charge of health services and members of the county assembly health committee which is responsible for all matters related to health. In addition, to triangulate the findings, a few interviews will be conducted with representatives from the World Bank and the MoH who were involved in either the introduction of PBF in Kilifi county, the financing of PBF funds or the development of local PBF policies in Kilifi county. The final number of participants will depend on data saturation, in which case, selection of participants will stop when no new information is forthcoming.

To request for the interviews, telephone calls and/or e-mails will be made to the potential participants by the student researcher and if interested and willing, a suitable time and place will be organized to conduct the online interviews. The participants will first be taken through the information sheet and consent form (see appendix II and III) before initiating the interviews. The interview is expected to last between 45 minutes and 60 minutes. An audio recorder will be used to record the interviews, however, if the interviewee does not want to be audio recorded, extensive notes will be taken. Following each interview, the participants will be requested to share any key documents to review in cases where there is need to supplement the information that they will have provided; which should not take more than 10 to 20 minutes of their time (but is not part of the interview). Further, permission will be sought to contact the interviewee for any clarification or additional information, if necessary.

I.9 Data management and safety

As described earlier, data will be collected using document review and in-depth interviews. Data from the interviews will be captured using encrypted audio recorders and field notes in 'real-time' to ensure 'confirmability' (Yin, 2014), whereas, relevant data from document review will be captured using an excel template. To ensure data safety, the audio recordings, excel templates and any soft copy documents (obtained for document review) will be stored in a password protected Dropbox folder available only to the student researcher and his supervisors. This data will also be backed up in KWTRP online platforms. On the other hand, the audio recorder, field notes and hardcopy documents (obtained for document review) will be safely stored in a locked draw, only accessible by key in the KWTRP offices in Kilifi.

The audio recordings, transcripts, field notes and reviewed documents will be available for two years after completion of data collection to allow the writing up of a publication, after which they will be destroyed.

I.10 Data analysis

Framework analysis will be adopted to provide findings and interpretations that are relevant for policy and practice (Green, 2014, Bryman, 1993). Framework analysis is an analytical process that involves sifting, charting and sorting the collected data according to the key issues and themes (Green, 2014, Bryman, 1993). The following five steps will be followed: familiarization, thematic analysis, indexing, charting and, mapping and interpretation (Green, 2014). Notably, despite the identification of the five steps, they are not 'strictly sequential and mutually exclusive' (Gale et al., 2013)

1.10.1 Familiarization

In this stage, the student researcher will immerse himself into the data by listening to the audio-recording and reading the transcripts and documents to capture and make note of any emerging key ideas and concepts (Srivastava and Thomson, 2009, Gale et al., 2013, Bryman, 1993, Green, 2014). Given the potentially large volumes of data usually collected in qualitative methods, in this stage, the student researcher will purposively select a few transcripts for review in the first instance, to represent the diversity of views and sources (Srivastava and Thomson, 2009, Bryman, 1993). Specifically, the student researcher will select and review one transcript from the CDoH, CDoF, MoH and World Bank, to get an initial awareness of the emerging key ideas and concepts.

1.10.2 Thematic analysis

In this stage, the analyst aims at developing a coding scheme by drawing upon a-priori issues (such as those from the research questions and conceptual framework) and/or emerging issues from the familiarization stage (Green, 2014). In this particular analysis, the main categories of the study's conceptual framework will form the themes for the coding scheme. In addition, to ensure that the data is not forced to fit into the a-priori themes, the student researcher will keep an open mind to identify any emerging themes.

1.10.3 Indexing

This stage will entail linking the textual data from each transcript and reviewed document to the themes derived from the study's conceptual framework (Green, 2014).

1.10.4 Charting

In this stage, the indexed data will be lifted from each transcript and placed in a chart with the thematic headings derived from the study's conceptual framework (Green, 2014). The chart will contain summaries of the data within themes so that the researcher can compare within and across the interviews and documents reviewed (Green, 2014).

1.10.5 Mapping and interpretation

Mapping and interpretation is about critical examination of the data presented in the charts (Ritchie and Spencer, 1994, Srivastava and Thomson, 2009, Green, 2014). It will involve identifying and defining the key concepts and explaining the relationships between the concepts (Ritchie and Spencer, 1994, Srivastava and Thomson, 2009, Green, 2014). In addition, it will also entail interrogating theoretical concepts (either from the study's framework or emerging from the data) and 'going beyond' the content of the data collected to generate additional concepts or understanding of the data (Thomas and Harden, 2008, Gale et al., 2013). As such, this stage is highly dependent on the judgement and insights of the analysts (Thomas and Harden, 2008). Therefore, the interpretations made by the

student researcher along with the analytical process described above, will be shared with the supervisors (experienced qualitative researchers) for review thus enhancing rigour during the analysis.

1.11 Ensuring rigour in the data collection and analysis

The following four tests are commonly used to establish the trustworthiness of any empirical social research: reliability, confirmability, credibility and transferability (Yin, 2014, Gilson, 2012). Thus, Yin (2014) recommends several case study tactics that can be adopted in each of the four tests above to ensure rigour in using the case study strategy (see table 2). In this study, several actions will be taken in line with the four tests and case study tactics, as described below.

To ensure reliability, a case study protocol will be developed and followed during the data collection and analysis (Yin, 2014, Gilson, 2012). The case study protocol will ensure that all the decisions (and justifications) taken in developing the study are explicitly stated (Gilson, 2012). To further ensure that the study is reliable, an online case study database [Dropbox] will be created and used for storing all the audio recordings, interview transcripts and documents for review. This online case study database will be accessible to the supervisors for review.

To ensure confirmability of the study findings, three key steps will be taken during the data collection and composition. First, as described earlier, multiple sources of evidence will be used to address the study aims. Specifically, data will be collected through a review of a wide range of documents and, in-depth interviews of different actors which ensures that a wide range of perspectives are captured. Second, a chain of evidence will be established by keeping a detailed record of the data collection and analysis procedures (Gilson, 2012). In addition, the interview data will be recorded and transcribed in real-time (Yin, 2014). Third, the draft case study findings will be shared with key informants to check for 'accuracy and resonance' with their experiences (Yin, 2014).

To ensure credibility of the study findings, data triangulation, critical reflection and explanation building will take place (Yin, 2014, Gilson, 2012). The data triangulation will entail comparisons of the data across the respondents and data sources (Yin, 2014, Gilson, 2012). Meanwhile for critical reflection, the student researcher will keep a reflexive diary in which he will record reflexive notes, impressions of the data and thoughts about analysis throughout the research endeavor (Pezalla et al., 2012, Gale et al., 2013). Critical reflection is important in studies [such as this] that adopt qualitative methods because the researcher is the primary tool of the inquiry, and thus, his 'individual characteristics, experiences and disciplinary paradigms' are likely to influence the research process particularly the analysis (Pezalla et al., 2012, Gale et al., 2013). As such, the student researcher's reflections will be shared and discussed with the supervisors who have more exposure and experience with the use of

the single case study strategy. Finally, there will be considerations of explanations for the experiences analysed which will enhance the credibility of the case study (Yin, 2014).

To ensure transferability of the study findings, theory will be used to guide the data collection and analysis (Yin, 2014, Gilson, 2012). Specifically, the Shiffman and Smith (2007) political priority setting framework with the adaptations proposed by Walt and Gilson (2014) will be used and tested at the county level in Kenya. Table 2 below summarizes the approaches that will be adopted to ensure rigour in this case study.

Table 2: Approaches to ensuring case study rigour. Sources: (Yin, 2014, Gilson, 2012)

Tests	Case study tactic	Stage of case study research where tactic will be used	Action taken in this study
Reliability	Use case study protocol	Data collection and analysis	Data collection and analysis procedures indicated in the protocol will be followed.
	Develop case study database	Data collection	The audio recordings, interview transcripts and documents for review will be entered into a Dropbox folder accessible to the student researcher and supervisors.
Confirmability	Use multiple sources of evidence	Data collection	Use of document review (wide range of documents) and in-depth interviews of a wide range of actors.
	Establish a chain of evidence	Data collection	A detailed record of the data collection and analysis procedures will be kept. In addition, the interview data will be recorded and transcribed in real-time.
	Have key informants review the case study report	Composition	The draft case study findings will be shared with key informants to check for 'accuracy and resonance' with their experiences.
Credibility	Data triangulation	Data analysis	There will be comparison of the data across respondents and data sources.
	Critical reflection	Data analysis	A reflexive diary will be used to record reflexive notes, impressions of the data and thoughts about analysis. The reflections alongside the analysis will be shared with the supervisors who have more exposure and experience with the single case study strategy.
	Explanation building	Data analysis	There will be considerations of explanations for the experiences analysed.
Transferability	Use theory in single case studies	Research design	The Shiffman and Smith (2007) political priority setting framework with adaptations proposed by Walt and Gilson (2014) will be used to guide data collection and analysis.

1.12 Ethical considerations

With regards to the standard risks associated with research involving human participants, this study poses minimal risk. This is because, the probability and magnitude of harm from the study is not expected to be greater than that encountered during day-to-day activities and, none of the potential study participants represent vulnerable populations. Nonetheless, a number of ethical considerations will be made including paying particular attention to the influence of the study on the relationships between the researcher, study participants and other health systems actors. Ensuring that the study does not negatively impact on the relationships between the researcher, study participants and other health system actors is important: (1) to not create or exacerbate tensions between health system actors in Kenya and, (2) in ensuring that the opportunities for others to do research in that setting in the future are maintained (Molyneux et al., 2009)

First, this study will be conducted under a larger study entitled "A critical analysis of health care purchasing arrangements in Kenya", which has already received ethical approval from the KEMRI Scientific and Ethics Review Unit (SERU) in Nairobi, Kenya (see appendix IV and appendix V). A principal investigators (PI) of the larger study has reviewed this protocol to ensure alignment to the larger study. Second, before initiating any data collection, informed consent will be sought from the study participants (see appendix II and III). Within the consent form, it will be emphasized that participation is voluntary and that they can decline or withdraw at any point in time without suffering any repercussions. Third, it is possible that the study may elicit sensitive information that may potentially damage an actor's reputation. Hence, methods will be used by the student researcher to ensure anonymity and confidentiality including codes that will be used to replace participant names in the transcripts and research outputs. However, due to the rich descriptions that are usually part of a case study strategy, it may still be possible for individuals to be recognised especially by those working in the same environment. As such, sensitive information will not be: (1) discussed openly and (2) directly attributed to specific individuals. Fourth, although this study is not expected to cause any harm, enquiring about the flow of PBF funding may cause slight discomfort among study participants, for example if there was any mismanagement of the PBF funding or high contestation over management of funds. The student researcher will thus ensure that participants understand their right to not answer questions they are not comfortable with. To this end, it is important to note that given the flexible nature of the study design, other unforeseen risks may emerge in the course of the research endeavour. Thus, the student researcher will continuously engage in reflective practice with the larger study PI in Kenya and with his supervisors to identify and address emerging risks (Molyneux et al., 2009, Hyder et al., 2014). Finally, as part of ethical mindfulness, it is important that the benefits of a study outweigh any potential risks associated with it. A key benefit from this study is that it will provide useful insights on the politics of health financing (PBF in particular) at the local level, local contextual realities and actor power; which are central to implementing and scaling up reforms. This health policy

analysis seeks to contribute to our understanding of context and politics and ultimately the potential implications for any future health financing reforms in Kenya. This work will also serve as an input into ongoing deliberations on the future of PBF in Kenya and any future evaluations of the effectiveness of PBF in Kenya. Since this study poses relatively low risk and is relevant to the ongoing deliberations on the future of PBF in Kenya and more broadly in LMIC settings, the benefits are considered to outweigh the risks.

1.13 Dissemination and communication

Two reviews by Edwards et al. (2019) and Olivier et al. (2017) highlighted that among others, poor quality studies, use of technical language in research outputs and lack of timely access to relevant studies, are key barriers to the translation of research findings to policy and practice in LMICS. As such, to promote the uptake of study findings, two deliberate strategies aimed at preventing the three barriers highlighted above will be adopted. In the first instance, the rigorous use of a single case study will enhance the quality of the research output which may promote uptake of the findings. Second, the findings will be summarised in simple language [with no jargons] and shared with policy makers at the county and national levels through dissemination meetings and quarterly stakeholders' forums to ensure timely access to 'non-technical' research outputs. Further, some of the policy makers are potential participants in this study thus they will be asked for permission for the student researcher to get in touch with them through a phone or by email to share and discuss the findings, which will also enhance timely access to the study findings. Finally, to ensure uptake of the study findings internationally, the findings will be published in an Open Access Journal and presented in international conferences such as the Health Systems Global international conference.

1.14 Timeline

The research is scheduled to be conducted between January 2020 and June 2020. However, the timeline is flexible depending on when the ethical approval will be obtained and thus can be extended to November 2020. Table 3 below is a timeline of the key research activities.

Table 3: Timeline of key research activities

Activity	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Ethical approval						
Document review and interviews at national and county level						
Data analysis and writing up the thesis						
Writing up the thesis						
Thesis submission						

1.15 Budget

All research expenses will be covered by Wellcome Trust's International Masters Fellowship grant awarded to the student researcher (Dennis Waithaka), grant award reference WCT-WDM01. This grant is meant to not only pay his tuition fees and monthly stipend, but also, any research costs related to his Masters in Public Health dissertation. The expenses will include: travelling costs, accommodation, telephone calls, printing and photocopying services. Table 4 below shows a breakdown of the costs in British Pounds, which is the currency in which the funds are received. The finance department of KWTRP have been consulted on the units and unit cost of each item.

Table 4: Budget

Item	Units	Unit cost	Total amount in British Pounds (£)
Airfare Cape Town to Kilifi (return ticket)	1	£ 200.00	£ 200.00
Ground transport (Kilifi mileage)	800	£ 0.60	£ 480.00
Accommodation (days)	30	£ 50.00	£ 150.00
Telephone calls (hours)	20	£ 30.00	£ 600.00
Printing and photocopying services	100	£ 10.00	£ 1000.00
			£ 2430.00

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PART B: JOURNAL MANUSCRIPT

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Title

**Political prioritisation for performance-based financing at the county level in
Kenya:2015 to 2018[‡]**

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[‡] The date used in the dissertation (2015 to 2019) differs from the one given here in the manuscript (2015 to 2018). This is because, the initial date (2015 – 2019) for the dissertation was decided upon during the protocol development phase, this date was based on the initial review of the literature for the protocol. However, while doing the empirical research, I found that the findings were relevant for the period from 2015 (when PBF was introduced in the study county) to 2018 (as that is when funding for PBF ceased at both national and sub national levels in the country). As such, for the manuscript, we used the time frame that was relevant based on our empirical findings.

Abstract

Background: Performance based financing was introduced to Kilifi county actors in Kenya in 2015. Kilifi was identified by the Kenyan national government as one of the 20 arid and semi-arid counties (out of 47 counties) mandated to start the implementation of the scheme and potentially inform the development of a nation-wide PBF policy. This study investigates how political and bureaucratic actors at the local level in Kilifi county have subsequently influenced the extent to which PBF has been politically prioritised at the sub-national level.

Methods: The study employed a single-case study design. The Shiffman and Smith [1] political priority setting framework with adaptations proposed by Walt and Gilson [2] was used. Data was collected through document review (n=19) and in-depth interviews (n=8). Framework analysis was used to analyse data and generate findings.

Results: Throughout the study period (2015-2018), national policy elites gave sustained attention to PBF as a priority issue for implementation, this sustained attention was however not present at the sub national level in Kilifi county and funding for PBF was not prioritised post donor funding. Key factors that contributed to this in Kilifi county included: redistribution of power from national actors to sub-national actors following devolution, this affected the national Ministry of Health's ability to lead and be an effective guiding organisation; misalignment between the globally advocated idea of 'pay for performance' and the local pre-existing centralised and rigid approaches to public financial management; and actors at the sub national level who contested the PBF intervention design features and its framing as 'additional funding'. As a consequence, the implementation of PBF in Kilifi was for a short time only using donor resources and did not last beyond donor timelines and funding.

Conclusion: This research shows that for health reforms to gain political priority at sub-national level in a highly devolved contexts, there is need to recognise the formal and informal institutions existing at the devolved level of governance, not only national level, and for adequate, early involvement and leadership from both bureaucratic and political actors across levels (national and sub-national) in health and other key sectors (such as treasury and legal). Further, advocacy for the health reforms should embody ideas and frames that align with the particular political context, to increase the chances of gaining political traction.

Keywords: performance-based financing, politics, political prioritisation, agenda setting, power, sub-national, Kenya.

2.1 Introduction

2.1.1 PBF introduction in LMICs

Performance based financing (PBF) is “a form of service provider payment where financial incentives are directed to healthcare providers (not beneficiaries) when they achieve pre-determined process or output indicators, adjusted by some measure of quality” [3, para. 1]. It represents an attempt to move away from the traditional payment for inputs (such as staff salaries and drugs), which has been argued to be inefficient due to, for example, resource leakage, lack of accountability and staff absenteeism [4 5 6 7 8 9].

PBF has been contested both on ideological and practical grounds [9]. For instance, some have criticized PBF for attempting to quantify (and price) complex health system processes into single indicators. Others have claimed that it leads to inequitable access to healthcare services as health workers are more likely to focus on the incentivised indicators and services whilst reducing quantity and/or quality of services delivered for the non-incentivised indicators [9]. Critics have also argued that the rapid and widespread introduction of PBF in low- and middle-income countries (LMICs) is a result of strong advocacy from international consultants and organisations, ignoring the contradictory evidence on its effectiveness and efficiency in these settings [10] [11]. In practice, the widespread introduction of PBF in LMICs, including Sub-Saharan Africa (SSA), has rarely been accompanied by its successful evolution into national public policies [8]. While there is growing evidence about the technical challenges of implementing PBF schemes in SSA (e.g. Antony, et al. [12], Ridde, et al. [13], Zitti, et al. [14]), there is a limited body of literature about the political economy and politics of PBF policy processes in these settings. Available studies have focused at global/continental [15], regional [16] and/or national levels [15 17 18 19]. This study seeks, therefore, to contribute to this limited literature by examining the experience of PBF political prioritisation at the sub-national, or county, level in Kenya [20]. We use the term political prioritisation or agenda setting to refer to the process through which an issue gains sustained attention by political leaders who then allocate resources that match the severity of the issue [1].

2.1.2 Background: The introduction of PBF in Kenya: the political and policy environment

PBF was introduced in Kenya through a larger project, the Kenya Health Sector Support Project (KHSSP), agreed between the World Bank and the National Treasury of Kenya - as the representative of the government of Kenya (GoK) – and which identified the Ministry of Health (MoH) as responsible for project implementation [21]. One of the key aims of the KHSSP was to improve the delivery and utilisation of quality essential health services to women and children, especially among poor and drought-affected populations [21]. This was to be achieved through increasing the operational funds reaching primary healthcare (PHC) facilities by transferring funding directly from the national treasury

to PHC facility accounts, rather than through sub-national (then districts) treasuries [22]. This mechanism of direct cash transfer sought to address the historical challenges faced by PHC facilities, of very limited and delayed funding due to “bureaucratic reasons, leakages in financial flows or diversion to other priorities” [23, p. 416]. Initially intended to run from 2010 to 2016, KHSSP was eventually extended to 2018 to enable, among other things, the implementation of PBF in selected counties. PBF was planned as a performance-based component of the Health Sector Service Fund (HSSF) that would use existing HSSF structures including the arrangements for transferring funds directly from the national treasury to the PHC facility accounts [21 24]. It was thought that the provision of PBF’s financial incentives to PHC facilities would motivate health workers to improve their performance and thereby “accelerate” the achievement of the Millennium Development Goals (MDGs) four and five [24, pp. 1-4].

In the same year that implementation of the KHSSP began (2010), a new constitution was adopted in Kenya. The new constitution provided for the creation of a devolved system of governance comprising a national government and 47 semi-autonomous county governments [20]. Table I below shows the county level government structures and responsibilities post-devolution. This new governance system strongly influenced how political and bureaucratic actors in Kilifi county, where this study was conducted, made meaning of global and national ideas on PBF, as well as over which factors and actors influenced the extent to which PBF was prioritised at the county level.

Table 1: County level government structures and responsibilities post-devolution, source: GoK [20]

County government structures	Actors within the county structures	Key responsibilities
County legislature	-Elected members of the county assembly (MCAs).	<ol style="list-style-type: none"> 1. Make any county legislation necessary for the effective functioning of the county government. 2. Oversight over the county executive. 3. Receive and approve plans, budgets and policies, for the management and utilisation of county resources and institutions.
County executive	<p>-Elected county governor and deputy governor.</p> <p>-County executive committee (CEC) officials for each county department (are individuals with the knowledge and experience relevant to manage their department and are appointed by the governor and approved by the county assembly). Notably, working under the CEC official is a Chief Officer, also appointed by the governor and is responsible for the day-to-day functioning of the department.</p>	<ol style="list-style-type: none"> 1. Implement national and county legislation. 2. Manage and coordinate the functions of the county administration and departments. 3. Provide the county assembly with full and regular reports on matters related to the county. 4. Prepare proposed legislation for consideration by the county assembly.

Under devolution, the national MoH is assigned the roles of policy and standards formulation, management of national referral services, and pre-service training for health workers, whereas the county governments are assigned all health service delivery functions including the management of human resources for all facilities within a county (this excludes national referral hospitals) [20]. Although the national MoH, thus, held responsibility for the formulation of the PBF policy, the county governments had the legislative power to determine whether any legislative actions and/or resource allocation for PBF would occur at the county level [20] – ultimately determining the successful implementation or not of the scheme.

The devolved system of governance was adopted after the March 2013 national and county government elections, with the initial intention to transfer functions progressively from the national government to counties with guidance from a transition authority [25]. However, soon after the elections, the newly elected governors pushed for the immediate transfer of all county functions [25]. In June 2013, the President reportedly “succumbed” to this political pressure and “directed” the immediate transfer of all devolved functions to the counties despite their lack of capacity and

structures to undertake the functions at the time [25, p. 169]. This resulted in lack of clarity and contestation over the “specific” responsibilities of the national and county government and their entities/departments (e.g. for procurement of health commodities, management of intercounty transfers for health workers, in-service training and career progression) [25, p. 169]. Most notable was the country-wide contestation between the MoH and county governments over their roles in the management and channelling of the HSSF funds [26]. On the one hand, the MoH, with support from the World Bank, preferred the pre-devolution system of direct transfers of the HSSF funds from the national treasury to PHC facility accounts. On the other hand, the county governments wanted control over the management and use of the HSSF funds and therefore proposed that they were sent to the county revenue fund rather than directly to facility accounts. The county revenue fund is a pooled account that was established post-devolution where “all money raised or received by or on behalf of the county government” (PFM Act of 2012 section 109) is deposited and managed by the county treasury. In this study, we will focus on the key events unfolding from early 2015 when PBF was introduced in Kilifi county by the national MoH, including the short four months period of implementation in 2018 in Kilifi, up until the end of 2018. This was the point that donor funding for PBF ceased and the implementation of PBF ended in Kilifi county.

2.1.3 Research question

How did sub national actors in Kilifi county influence the political prioritisation of PBF at the local level?

2.2 Methods

2.2.1 Conceptual framework

The study adopted the Shiffman and Smith [1] political priority setting framework, with adaptations by Walt and Gilson [2] (see Table 2 below). It has previously been used to examine why some global health issues are more (or less) successful in generating political priority at the global [1 27 28] and national [29 30] level. Global political priority is the “degree to which international and national political leaders actively give attention to an issue, and back up that attention with the provision of financial, technical, and human resources that are commensurate with the severity of the issue. Political priority is present when: (1) international and national political leaders publicly and privately express sustained concern for the issue; (2) the organisations and political systems they lead enact policies to address the problem; and (3) these organisations and political systems provide levels of resources to the problem that are commensurate with its severity” [1 p. 1370].

Table 2: The adapted Shiffman and Smith [1] political priority setting framework proposed by Walt and Gilson [2]; additions or changes made by Walt and Gilson [2] highlighted in red

Categories	Description	Factors shaping political priority
Actor power	The strength of the individuals and organisations concerned with the issue	1. Policy community cohesion 2. Leadership 3. Effective guiding 'organisations' (rather than 'institutions') 4. Civil society mobilisation
Ideas	The ways in which those individuals with the issue understand and portray it	5. Internal frame 6. External frame
Issue characteristics	Features of the problem	7. Credible indicators 8. Severity 9. Effective interventions 10. Contestations or conflicts
Political contexts	The environment in which actors operate	11. Policy windows 12. Global and national governance structures (formal and informal institutions) 13. Historical dimension
Outcome	Assessment of whether the issue is being taken seriously by policymakers	12. Presence of an authoritative decision or resources allocated to issue

Regarding actor power, generating political priority is easier when the actors who are mainly concerned with the issue have power to influence the policy process, and when they agree on basic issue characteristics such as the definition and solution of the problem. In terms of ideas, an issue is likely to get attention if: described in a manner that is acceptable within the policy community [internal frame] which is typically made up of a variety of actors who can have similar or competing interests around the issue of focus; and is portrayed externally in a manner that appeals to the policymakers (leading them to, for example, allocate resources to the policy) [external frame]. Political support levels are also influenced by key features of the problem, the issue characteristics, such as: severity of the problem, the ease with which the problem can be measured and monitored, contestation around the problem, and whether there are inexpensive and evidence-based interventions available as

solutions. In addition, political support levels are influenced by the events and conditions surrounding the policy process, that is, the political context, which include policy windows (e.g. elections and global agendas), as well as formal and informal institutions. The term “institutions” was added by Walt and Gilson [2, p. iii6] to include the “formal and informal norms and rules that that make up judicial and legal institutions” at the global and national governance level, and they also recognised the influence of historical factors. Finally, the outcome component was added by Walt and Gilson [2] to examine whether an issue has been prioritised i.e. is being taken seriously by national policy makers as evidenced by authoritative decisions (such as making appropriate legislation and policies) and/ or allocation of domestic resources.

2.2.2 Study design

The study adopted a single-case study design as the aim was to explain empirically a “contemporary phenomenon” (‘the case’) in-depth and within its real-life setting, where the distinction between the phenomenon and its surrounding context is unclear [31, p. 32]. Further, a case study design was deemed appropriate as we sought to answer the ‘how’ and ‘why’ of a process over which the researchers had little control and about which there was limited knowledge [31]. The case is ‘a policy process’ and specifically, *the process of political prioritisation of PBF in Kilifi county between 2015 and 2018*. 2015 – 2018 is the time period from when PBF was introduced to the county managers in Kilifi (2015), to the point that donor funding for PBF ceased and the implementation of PBF stopped in Kilifi county (2018). The specific site for data collection (Kilifi county) was selected based on the following two criteria: i) a county where PBF was to be implemented and ii) ease of accessibility to county managers and government documents. Finally, to ensure rigorous analysis in flexible study designs, we adopted the following three approaches in accordance with Gilson [32] recommendations. First, we used a conceptual framework to support the transferability of the findings to other settings. Second, to enhance the validity of the descriptions and explanations of findings, we used more than one method of data collection (interviews and document reviews) and looked for patterns of convergence in the findings by comparing the data across interviewees, and between the interviews and documents. Third, the preliminary findings from the interviews and documents were reviewed by other research team members to enhance credibility by, for example, thinking through analytic points, checking and testing assumptions being made in analysis and deepening descriptions and explanations. The work was also discussed periodically with two in-country health financing and governance experts to reflect on the ideas emerging from the data and to identify relevant actors.

2.2.3 Data collection procedures

Data collection included a review of 19 documents and 8 in-depth interviews as shown in table 3. The in-depth interviews were conducted between April and September 2020. The interviews were broadly guided by a semi-structured interview guide (see appendix I) informed by the conceptual framework. This entailed online audio-recorded conversations lasting about an hour with purposively selected study participants. The decision to conduct online interviews (rather than face-to-face) was due to the outbreak of the COVID-19 pandemic just as the data collection was about to begin. Participants were selected on the following basis: (1) that they were either knowledgeable about PBF's introduction and implementation in Kilifi and/or (2) were directly involved in PBF's introduction and implementation process to Kilifi county. In the first instance, the study participants were selected based on an initial review of the documents described later; after which, the snowballing technique (i.e. interviewees asked to suggest others who were involved) was used to identify additional study participants. The study participants were recruited through telephone calls and email invitations. However, six interview invitations were refused for unknown reasons or because the respondents felt that they were not adequately involved with PBF. Nevertheless, we were able to capture the perspectives of various county bureaucrats with relevant knowledge and triangulated the findings with two interviews with actors from the national level and the documents reviewed. Table 3 below is an overview of the in-depth interviews conducted.

Table 3: Overview of the In-depth interviews

Actors	Interviews
County bureaucrats	6
National level actors	2
Total	8

The criteria for documents included in the study were those from both national and county levels that contained information that was pertinent to the introduction and/or implementation of PBF in Kilifi county. These documents, named in table 4 below, were identified from the interviewees, and from targeted internet searches in google, government websites and the World Bank's results-based financing (RBF) websites.

Table 4: Overview of documents included in the case study (n= 19)

Document description	Type of document
1. The Public Financial Management Act, 2012. Author: Government of Kenya	Legislation
2. County Allocation of Revenue Act (CARA) of 2015. Author: National treasury	Legislation
3. Financing agreement between International Development Agency and the republic of Kenya	Financing agreement
4. PBF scale up 2014 – 2016, September 2014. Author: MoH	Operational manual- early version
5. PBF scale up 2015-2018, April 2017. Author: MoH	Operational manual- final version
6. National guidelines on the transfer of conditional grants (such as PBF) to county governments, August 2015. Author: National treasury	National operational guidelines
7. Kilifi county financial guidelines on disbursement, use and reporting PBF, published in 2017. Author: MoH	County operational guidelines
8. Capacity building for PBF scale up: invitation to facilitate as PBF master trainer of trainees (TOT), August 2015. Author: MoH	Memo
9. Capacity building for PBF scale up: Nominees for PBF trainer of trainees (TOT) workshop 14th-18th September at the Kenya School of Government, Nairobi, August 2015. Author: MoH	Memo
10.Capacity building for PBF scale up: Cascading PBF training in the counties, January 2016. Author: MoH	Memo
11.PBF progress update for the financial year 2015/2016. August 2016. Author: MoH	Memo
12.PBF procurement guidelines for essential equipment. Author: MoH	Memo
13.Kilifi sub-county health managers appointment letters to the Joint verification Team. Author: Kilifi CEC-Health	Letter
14.The piloting and scaling up Performance-Based Financing (PBF) in Healthcare in a Devolved Governance System: Experiences from Kenya between July 2011 and May 2015. Author: Alliance for Health Policy and Systems Research (AHPSR).	Implementation report
15.Implementation completion and results report: The Kenya Health Sector Support Project (KHSSP), 2019. Author: World Bank	KHSSP evaluation report
16.Technical assessment of the PBF pilot project in Samburu county, Kenya ^[33]	PBF pilot quantitative evaluation report
17.Evaluation of PBF pilot project in Samburu county, Kenya ^[34]	PBF pilot qualitative evaluation report
18.RBF Health Kenya,2014. Author: World Bank Group	Website
19.Kenya receives 2.5 billion Kenyan Shillings to improve healthcare, October 2016. Author: The Standard- Health	Website

2.2.4 Data analysis

The data were transcribed verbatim and the coding done manually. A framework analysis approach was adopted to provide findings and interpretations that are relevant for policy and practice [35 36]. This involved the following five iterative steps: (1) familiarization by listening to the audio-recordings and reading the transcripts and documents for review; (2) developing a coding scheme by drawing upon the study's conceptual framework; (3) reading through the transcripts and documents thoroughly and manually linking the relevant findings to the coding scheme; (4) sorting and charting the data according to the coding scheme and; (5) critical examination and interpretation of the charted data across respondents and themes to generate explanations and in-depth understanding of the data.

2.3 Results

In this section we first present a summary statement of the results, and then a summary table of the key themes of the findings using the adapted Shiffman and Smith [1,2] framework (Table 5). We then narrate the results, using a timeline of events (figure 2) and discussing key interacting factors that influenced the nuanced political prioritisation of PBF in Kilifi county.

2.3.1 Summary statement

National policy elites gave sustained attention to PBF as a priority issue for implementation in the period 2015 – 2018. However, this attention was not sustained as a high priority issue by key policy elites in Kilifi county, and the limits on 'political prioritisation' at the sub-national level are shown by the fact that funding for PBF was not prioritised in the county. On the one hand, national actors had: availed donor funding to implement PBF in the county; developed some PBF policy documents (specifically, operational manuals and guidelines); and led PBF sensitisation and training in the county. On the other hand, the Kilifi county governor greatly delayed (by almost three years) the signing of a performance agreement with the national MoH thereby limiting PBF implementation in Kilifi county. As a result, PBF implementation in the county eventually took place in a short period of four months only in 2018 and implementation stopped once donor funding ended in 2018. Post donor funding, no domestic funding had been allocated to PBF by either the MoH or the county; and no legislative actions had been taken by the county to mandate the continued funding of PBF (beyond donor timelines) as part of the county's health financing arrangements. A summary of the key themes of findings are shown through the lens of the adapted Shiffman and Smith [1] framework in Table 5. These themes are discussed in more detail in the text below this Table.

Table 5: Summary of the key themes through the lens of the adapted Shiffman and Smith ^[1] framework

Framework category	Findings
Intersection between the political context, intervention design and actor power	<p>1. The introduction of a devolved system of governance (change in political context) resulted in contestation about the HSSF direct transfer of funds mechanism which had been adopted by the initial/pre-devolution PBF model, leading to: roughly over an year's delay in implementing PBF, and changes to the PBF model ('intervention design' as an issue characteristic).</p> <p>2. Devolution (change in political context) affected the MoH's ability to lead and be an effective guiding organisation.</p> <p>3. Devolution (change in political context) introduced new county level non-health sector bureaucrats (i.e. county treasury and legal team) and politicians (specifically, county governor) who despite having key roles to play in PBF's implementation at the county level, were not involved in PBF's earlier stages of inception, piloting and design and, the subsequent PBF sensitization, training and decision-making spaces. This reduced their understanding and buy-in of PBF. In Kilifi specifically, the county non-health sector bureaucrats (i.e. county treasury and legal team) saw PBF as a threat to the newly acquired county level functions, bureaucratic powers and interests (such as controlling all county public funds and retaining county political regime) due to its design features ('intervention design' as an issue characteristic).</p>
Issue characteristics	<p>In the newly devolved context of Kilifi county, the underlying features of the problem which PBF was addressing (such as severity and/or credibility of the MCH indicators and health workers motivation) were rarely discussed outside the health sector, and were uncontested. However, the intervention design (the solution) was contested.</p>
Ideas	<p>There were issues with the internal framing of PBF which may have affected the public positioning of PBF and whether/how it attracted the attention of the county political elites. Specifically:</p> <p>1. Perceptions that the idea of 'pay for performance' was contradictory to the PFM law's planning and budgeting processes and timelines.</p> <p>2. Perception that PBF was a donor-funded program providing much-needed 'additional funding' for healthcare providers created the impression that it would be an 'additional expense' if funded by the government in the long-term following the end of World Bank PBF funding.</p>
Actor power	<p>The failure to mobilise some key county politicians (specifically, Members of County Assembly) who have high political power at the county was a problem since their support was essential in determining whether any county legislative actions and/or financial allocation for PBF would take place at the county level, and beyond the World Bank's funding and timelines.</p>
Outcome	<p>PBF was not sustained as a high priority issue in Kilifi county. On the one hand, there was: donor funding; development of some PBF policy documents (specifically, operational manuals and guidelines) and; PBF sensitisations and training. On the other hand, there was: substantial delay (almost three years) in signing of the performance agreement between Kilifi and MoH thereby limiting its implementation in the county; no domestic funding (i.e. separate from the standalone project funding from donor) and; no county legislative actions to mandate continued local funding of PBF beyond donor timelines. As a result, PBF implementation stopped once donor funding ended.</p>

2.3.2 Key factors influencing the nuanced political prioritisation of PBF at the sub-national level

Our analysis of this experience highlights the following three key interacting sets of factors that explain the shortcomings in political prioritisation of PBF within Kilifi county.

2.3.2.1 Intersection between the political context, actor power and 'intervention' design as an issue characteristic

The findings reveal that global health agendas such as the 'shift in health financing from inputs to results' and the MDGs four and five, helped frame an agenda for PBF's introduction in Kenya. Thus, between October 2011 and 2013, the MoH, with financial and technical support from the World Bank, set up a pilot project in one of the arid and semi-arid land (ASAL) regions known as Samburu district (later became a county). An ASAL pilot district was selected as their performance in MCH indicators was reportedly worse than other regions in the country. Following its end line evaluation, the PBF pilot was considered a 'success' by the MoH and the World Bank due to the improvements seen in facility management (e.g. availability of infrastructure, staff trainings and regular meetings) and in some service utilisation indicators (e.g. under-five child welfare clinics attendance). Therefore, it was agreed that it should be implemented in other ASAL regions (including Kilifi) due to their similar socio-demographic and geographic characteristics to the pilot county and therefore, the potential, for success. In addition, a non-ASAL region referred as Migori was also included as one of the PBF implementing counties because its MCH indicators were also performing poorly, perhaps also allowing PBF's effectiveness to be tested in a different setting in the country.

However, towards the end of the PBF pilot in Samburu, the national political context changed due to the June 2013 adoption of the devolved system of governance. In the newly devolved context of Kilifi, the underlying features of the problem (*issue characteristics*) which PBF was addressing (such as severity and/or credibility of the MCH indicators or health workers motivation) were rarely discussed outside the health sector, and were uncontested. However, as will be discussed, there were significant concerns and contestation related to the design features of PBF (*intervention design*) given the new political context and actor power. Devolution had three significant effects on the PBF policy process in Kilifi.

First, the changing governance context reportedly delayed the implementation of PBF in Kilifi and other PBF implementing counties for over a year. The first reported PBF related communication to Kilifi was only in early 2015. The delay resulted from the newly formed county governments contesting the HSSF mechanism of direct transfer of funds to facilities, as adopted within the initial PBF model that had been piloted in Samburu pre-devolution (*intervention design*). As a result, the MoH, national treasury and World Bank agreed to some changes to the design features of the PBF model before it

was introduced to Kilifi. For example, as illustrated in Figure I below, post-devolution, the county treasury was assigned the role of fundholder, rather than funds being sent through the MoH direct to facility bank accounts. In addition, the funds had to be transferred to a ring-fenced county health special purpose account that would be jointly managed by the CDoH and county treasury. From the special purpose account, the PHC facilities would then be paid based on their verified performance in the incentivised indicators. In addition to Figure I shown here, Appendix VIII provides the full details of the initial PBF model (based on the HSSF mechanism/ pre-devolution policy design) and final PBF model (i.e. post-devolution policy design).

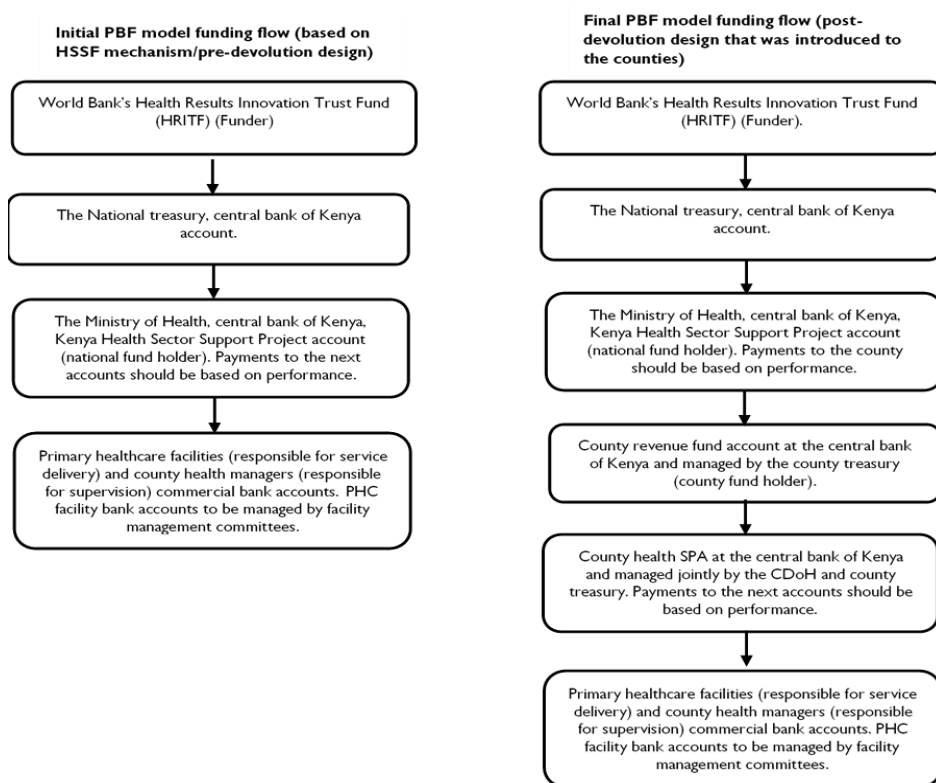


Figure I: Changes in the PBF funding flow arrangements pre and post devolution

Second, devolution impacted on actor power dynamics, undermining the national MoH's ability to lead and be an **effective guiding organisation for PBF** by reducing its influence at the county level. Pre-devolution, the MoH in consultation with the World Bank had taken the lead role in the design, piloting and implementation of PBF in the country (see Figure 2). After devolution, however, responsibility for service delivery, including the management of human resources and PHC facilities, was assigned to county governments. Neither the county government nor governor were answerable to the MoH and both had very **high "political power"** at the county level [37, p. 614].

Third, devolution introduced new county level bureaucrats outside the health sector (i.e. county treasury and legal team) and politicians (specifically the county governor) into the PBF policy process. These actors had key roles to play in PBF's implementation but had not been adequately involved in

the earlier stages of inception, piloting and design or the subsequent sensitisation and trainings. The latter were directed at the county health managers, health workers and health facility management committees. In addition, the implementation of PBF was experienced as a ‘top-down’ process as the national MoH provided instructions on its implementation through the CDoH. All these limited the understanding of and buy-in for PBF by the county non-health sector bureaucrats and governor, and the treasury and legal team, in particular, saw PBF as a threat to their newly acquired county level functions and “bureaucratic powers” [37, p. 614]. They were particularly suspicious of its design features, especially the opening of the special purpose account and the governor needing to sign an already established performance agreement (*intervention design*). For example, the county treasury, responsible for the control and management of all public funds held in the county revenue fund (*actor interest*), contested the need to set up a separate ring-fenced county health special purpose account for PBF, and jointly manage it with the CDoH. Both design features challenged their newly acquired “bureaucratic power” in relation to the control of county public funds [37, p. 614]. Similarly, the county legal team, responsible for advising the county government and governor on all legal matters including those related to their relations with the national government (*actor interest*), contested the need for the county governor to sign the already established performance agreement. As this agreement had been developed without their involvement, this again appeared to undermine their “bureaucratic power” [37, p. 614].

SBM003, 2020: *“the challenge was between the legal team not accepting the fact that there are funds that have been brought and they came with a contract, the performance contract. And it was to be signed by the governor for us to be able to implement. Also, for finance, being not able to understand how this program was being implemented. You see, because RBF [PBF] implementation was a bit different. And as much as money was supposed to come through the county revenue fund, still this money was supposed to end up in what we call a special purpose account (jointly managed by county department of health and county treasury) which was to be opened.”*

Two county participants suggested two other reasons for the contestation around PBF design features. They noted that : 1) county level actors did not have established, historical working relations and trust with those making the key decisions on PBF’s introduction and implementation, donors, the national treasury and MoH (*historical dimension*), and 2) county level attempts to *claim space* [38] in the decision-making process for PBF, through suggesting some alterations to the performance agreement (in August 2016), were rejected by the KHSSP unit on the grounds that the national actors had already finalised the agreement.

SBM002, 2020: *“The fact that maybe they [national treasury/MoH] have been able to deal with these donor funds many times made it easier for them; you know it was not the first time... But for us [at the county] it now became a challenge because the new people that we had [as part of*

devolution structures] you don't know from which background that these people were coming from; maybe they were in private institutions, then you come to government and you have to learn again."

SBM003, 2020: *"But now for the Ministry of Health, this [i.e. performance agreement] was a document that they had developed for all the [PBF] counties. So, they did not see any reason for them to change it."*

These county actors outside the health sector also interpreted the timing of PBF's introduction in the **newly devolved context** as a political tactic. They felt that the incumbent Jubilee national government sought to use an "innovative" health sector funding scheme to win political votes for the upcoming 2017 national and county elections, given that Kilifi's elected county governor was a key member of the main opposition political party [ODM party].

SBM004, 2020: *"now the legal advisor [Because]at the back of her mind she knew that health is devolved. so, she said now, why is the national government coming in with these innovations this time? then that is when now somehow the Jubilee and ODM issues came in because you know our governor is from ODM and the president is in Jubilee party. So, you see now people started associating these things politically which was not right. yeah."*

Together these factors contributed to the three-year (2015-2018) delay in the signing of the performance agreement by the Kilifi county governor (see Figure 2). The governor's eventual decision to sign was perceived to have been motivated by the fact that the county was informed that it had to either sign and use the PBF funds (about USD \$ 660,000) that had initially been sent to the county to foster PBF's implementation by the end of the KHSSP, or return the funds. Following the signing, PBF was implemented over a span of about four months between September and December. This required verification of facilities' performance in the previous quarter, and the payment of performance bonuses to the facilities, health workers and health managers. There was reportedly no subsequent progression of PBF related activities in Kilifi and PBF was not taken up by the county and country beyond the World Bank's KHSSP funding timelines.

SBM002, 2020: *"it really did not go according to plan because it was to be implemented in that financial year 16/17 but it didn't, it didn't take off. It was implemented in financial year 18/19.. then it was more of compliance because we had gotten to a point where these monies had to go to the facilities or the county government refunds the money to World Bank. ..it was done in about a quarter, so four, three months."*

2.3.2.2 Issues with the understanding and framing of PBF

Key actor groups involved in PBF included the World Bank, MoH and National Treasury at the national level and, CDoH, county treasury, county legal team and county governor at the county level. Amongst these actor groups, the national level actors and the CDoH supported PBF, whereas the county

treasury, legal team and governor had reservations about PBF, as discussed. However, even amongst the ‘domestic’ actor groups supporting PBF, two key issues in the understanding and framing of PBF (i.e. issues with the internal frame) may have affected the public positioning of PBF to attract the attention of the political elites (affecting its external frame). First, the idea of ‘pay for performance’ was perceived to be contradictory to the PFM law’s planning and budgeting processes and timelines. According to the law, the amount of funds that could be sent to a county was not supposed to exceed those that had been pre-estimated in the County Allocation of Revenue Act (CARA) that guides government resource allocation to counties. However, PBF funding was intended to be linked to performance and was likely to exceed the estimated CARA annual allocation to Kilifi. In practice, therefore, the amount of PBF funds sent to Kilifi was reportedly not based on actual quarterly performance but rather on the MoH ‘estimates’ determined before the financial year began. This approach defied the internal logic of PBF (i.e. payments linked to efforts/performance) and perhaps also underlay the contestation around the design of PBF (**intervention design**).

NM001, 2020: *“So the challenge was this PBF money because you know if it is based on performance you cannot be absolutely sure in advance how much county A is going to make, isn’t it? Because it will depend on the deliveries, the children immunized and all that. So basically when ministry [of health] is submitting the estimates for a given year that this particular money let’s say it’s under PBF for county A or B, so chances are that eventually what is disbursed to the county is more or less than what is captured in the CARA. But if it is more then how do you account for that difference? Does it mean that the estimates had to be revised or what exactly? They [at the National Treasury] would not just approve that money to be channelled to the counties. So, I think those are the issues just around the PFM Act and I think they were quite complicated.”*

Second, most of the health sector actors (MoH and CDoH) understood and framed PBF as a donor-funded program providing much-needed ‘additional funding’ for healthcare providers (health managers, health workers and PHC facilities) for a defined time period, after which it would end like other programs. This understanding and framing of PBF was heavily influenced by the perception that the PHC facilities had been underfunded post-devolution due to the centralisation of financial management at the county treasury and the abolition of user fees (which occurred in 2013, at around the same time as devolution). However, this framing of PBF did not appear to be ‘politically attractive’ at the county level. Instead, PBF was seen at county level as a potential future ‘additional expense’, to be carried by the county government once the World Bank’s funding came to an end. One participant noted this might be due to a lack of understanding of the ‘problem’ and ‘solution’ that PBF offered, as shown here:

NM001, 2020: *“it would be difficult for PBF initiatives to really take off and to be funded [by the government]. The question is, if I have paid the health worker, I have provided the infrastructure, I*

have provided the essential medicines, why am I paying extra for PBF? You know, as policy makers, that's what they would ask. So, the question is how do you convince them of the value of this because I believe that is the link, that is the gap that is missing.”

2.3.2.3 Lack of mobilisation and influence of some key county politicians (i.e. Members of County Assembly)

It was highly notable that key county politicians (i.e. Members of County Assembly) who had high “political power” at the county level [37, p. 614] were not mobilised to support PBF. Yet, their advocacy and support was essential in determining whether any legislative actions and/or financial allocation to PBF would be implemented at the county level in the long-term. Section 104 of the PFM Act stipulates that no public funds shall be appropriated outside a county's planning and budgeting framework approved by the county assembly.

CM001, 2020:...*During my time at least [as a senior bureaucrat within Kilifi CDoH] then I do not remember whether there was a Member of the County Assembly who came to say okay I heard about this [PBF] in this country so maybe why don't we start implementing, I never heard. I would probably tell them there is these kinds of funding mechanism, why don't we introduce, you know”*

Based on the narrative above, Figure 2 below shows a summary of the timeline of PBF related events and activities with a specific focus on those related to Kilifi county. It shows how the PBF policy process led by the MoH encountered contestation over key implementation features of the PBF intervention upon devolution, which subsequently delayed the signing of the PBF performance agreement and its implementation in Kilifi.

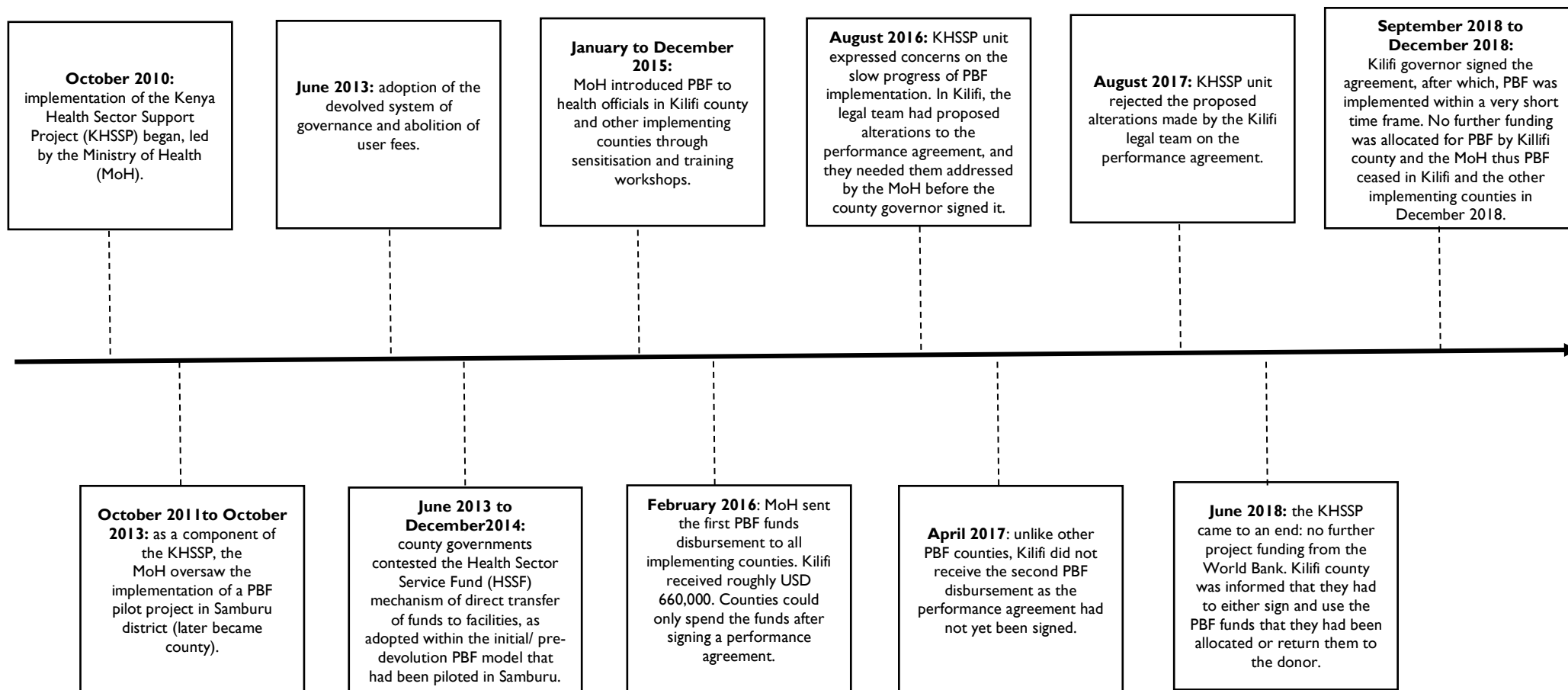


Figure 2: Timeline of PBF related events and activities with a specific focus on events affecting Kilifi County

2.4 Discussion

To the best of our knowledge this study is the first to examine the political prioritisation of PBF at a sub-national level, relevant in Kenya because of its devolved governance structure. In this work we also aimed to test, at the sub-national level, the utility of applying the Shiffman and Smith [1] political priority setting framework. Ultimately, we identified three interacting sets of factors that offered critical explanations on why PBF was not sustained as a high priority issue at the sub-national level and was not funded within Kilifi county. First, we discuss the intersection between the political context, actor power, and intervention design as an issue characteristic. Second, we discuss the challenges that decentralisation reforms pose to the implementation of health programs. Third, we discuss misalignment between the ideas/framing of PBF and the political context..

The existing literature on national level political prioritisation of health sector reforms has shown the importance of national level bureaucratic (such as national MoH) and political (such as national Ministers of Health and Presidents) actors in effectively guiding and leading the adoption of health sector reforms. For example, in Ghana [39] and Ethiopia [40], the national MoH led by their Ministers of Health played key roles in effectively managing stakeholders' interests and advancing national level health insurance policy agendas. Likewise, in both Armenia and Rwanda, "strong political and technical leadership" by the national MoH was part of the reason for PBF's evolution from a programme to a national policy [8, p. 142]. The ability of these national level actors to lead their respective countries' political prioritisation processes effectively was arguably because of their relatively more centralised systems of governance. Our findings show that in highly devolved systems, policy prioritisation and leadership by national level actors does not guarantee successful policy prioritisation and uptake by sub-national actors. In Kenya, devolution happened after PBF had been prioritised by national level actors including the MoH. However, devolution reduced the national MoH's bureaucratic power and influence over PBF's adoption at a sub-national level. It also assigned new bureaucratic powers to county actors outside the health sector who saw the design features of PBF as a challenge to their newly acquired county level functions, powers and interests (such as controlling all county public funds and retaining county political regime). As neither these county bureaucratic actors nor the local county politicians were involved in the 'decision-making spaces' [38] for PBF, this likely limited their ownership and buy-in of the scheme. Finally, the county actors may have not trusted the national MoH which was leading the PBF policy process given the lack of a historical working relationship. Given all these factors, it is perhaps not surprising that the non-health sector county actors opposed the scheme's introduction at the sub-national level, making it difficult for the MoH to effectively guide the policy process.

Decentralisation reforms usually have laudable goals (such as promoting community involvement, accountability, efficiency, and equity in resource management), which ultimately aim at improving

health service delivery and public health. However, in practice, these goals are not always achieved due to technical [24 25] and/ or political obstacles [41 42 43]. In our study, devolution resulted in a significant change in context, changing actor power relationships between the national and sub national level. Because of the new political power at the sub national level, further PBF implementation was not prioritised at the end of 2018 in Kilifi when donor funds ceased. In Brazil, decentralisation of fiscal and administrative decision-making capacities to state and municipal governments affected the performance of the national HIV/AIDS programme, formerly run by the federal MoH [41]. This was linked to the newly weakened position of the federal MoH in programme oversight, and the empowering of conservative local elites who had little interest in supporting the funding of some of the programme activities e.g. campaigns aimed at commercial sex workers [41]. In the early 1990s in Philippines, although the family planning programme was one of the main national health sector priorities, upon devolution, a provincial governor stopped the delivery of family planning services in his province due to religious convictions [42]. Upon decentralisation of health programs in 2001 in Indonesia, rather than supporting local health programs, the newly empowered local elites seemingly utilised their enhanced fiscal decision-making capacities for their own vested interests such as increasing their salaries [43].

Recently the influence of ideas, rather than only actors' interests, over the political prioritisation of policy options at the national level has been gaining increased traction [44]. For example, studies on agenda setting for community based health insurance (CBHI) policies in Ethiopia [40] and Rwanda [44] noted that these policy reforms were adopted and promoted nationally due to their alignment with the ruling political party's ideologies, centred on 'self-reliance' and 'visible' community participation. However, our findings at the sub-national level in Kilifi suggest that when the ideas underpinning a reform do not align (or are in conflict) with the political context, the reform may not garner sufficient political attention. In Kilifi for example, there seemed to be conflict between the globally advocated idea of 'pay for performance' and the pre-existing centralised and rigid approaches to public financial management in the local context. In addition, the idea that PBF could be understood as 'additional funding' was contested as county actors felt it would be an 'additional expense' to the county government once the World Bank stopped funding PBF. As a result, PBF was not sustained as a high priority issue at county level despite the initial availability of substantial amounts of donor funds (about US \$ 660, 000) for its implementation. As also more widely identified, the use of donor funds to support a policy does not necessarily imply that government has prioritised it [8]. Given that donors mostly set the priorities for how their money will be spent, the ways in which national governments allocate their domestic resources is a strong indicator of political prioritisation at the national level [2]. And in this study, at the sub-national level as well.

Beyond the explanations of PBF priority-setting in Kilifi county, this study offers insights about "issue" characteristics as a key determinant of political priority, as emphasised in the Shiffman and Smith [19]

framework. Our findings at a sub-national, however, reveal minimal concern over the characteristics of the ‘problem’ that PBF was meant to address in health facilities. This might have been because the sub-national actors became involved in PBF’s scaling up at a late stage of decision-making, given the decision to pilot and adopt PBF as a solution to the poorly performing MCH indicators had been made pre-devolution by national actors. At this late stage, there may have been less motivation for sub-national actors to examine and scrutinise the features of the problem to which a solution had already been decided. Rather, we found that the intervention design features were a key determinant of political priority within the new devolved governance context. Issue characteristics include some consideration of intervention design, but wider literature more clearly points to their importance. Grindle and Thomas [45, pp. 237-242], specifically, describe these intervention design features as “policy characteristics” influencing the acceptability of policies. Key characteristics are: the distribution of costs and benefits associated with implementation across policy actors and society; the technical and administrative complexity of the reform; and the duration needed for visible impact. Crichton [46], in another Kenyan study, meanwhile, argues that the prioritisation and implementation of a family planning policy was affected by its policy characteristics (including intense administrative and technical requirements, and opposition linked to cultural and religious sensitivity on contraceptive use). In addition, and similar to our findings at the sub-national level, concerns and contestation over intervention design (the solution) appears to be a key feature of national level political prioritisation of health financing reforms. In Ghana, there were delays in the agenda setting process due to contestation over the design of the National Health Insurance Scheme (NHIS) between the Minister of Health who wanted a single-payer social insurance and the NHIS task force members who wanted multi-payer mutual health organisations [39]. In South Africa, the introduction of an NHIS was delayed in part due to political disputes and contestation, including by provincial governments who seemingly felt that the proposed design of the NHIS threatened their roles and powers [47].

We made three final observations in applying the framework. First, we recognised the focus on national level applications adopted by Walt and Gilson [26] in their reflections on the Shiffman and Smith [19] framework. This highlights the allocation of domestic resources as evidence of an ‘outcome’ of political prioritisation at the national level. We argue, based on this study, that the allocation of domestic resources as an indicator of political priority is important in a devolved governance context as well. Second, as the framework appears to be rooted in a central/national government perspective, it does not allow for the multiple levels of political prioritisation required in devolved governance settings. Therefore, we propose that the formal and informal institutions at ‘devolved levels of governance’ should be considered as part of the governance structure element in political context to make the framework more applicable at the sub-national level. It would also be important to include the range of national and sub-national actors as part of the leadership element in actor power. Finally, we argue

that 'issues characteristics' can be usefully expanded by reference to the notion of policy characteristics, as discussed earlier.

2.5 Study limitations

We acknowledge three key limitations. One, challenges related to conducting online audio interviews. For example, lack of non-verbal cues and network connection problems. Two, the study lacked interviews with some key actors mentioned by interviewed participants, such as the county treasury, legal team and county governor whose views would have enriched our study. Efforts made during the data collection to reach some of these actors were either unanswered for unknown reasons or refused due to perceived minimal involvement in PBF. Three, some of the study participants struggled to remember the details and/or exact chronology of events as PBF was introduced in the county about five years ago and in between there have been several other policy processes. This limitation was partly addressed through triangulations with the reviewed documents.

2.6 Conclusions

This study contributes to theory building by empirically testing the Shiffman and Smith [1] political priority setting framework with adaptations by Walt and Gilson [2]. It therefore contributes to the limited but growing body of literature on the politics of policy processes. The interactions of three key factors (political context, actor power and intervention design as an issue characteristic) in the framework was helpful in understanding why PBF was not sustained as a high priority issue at the sub-national level in Kilifi between 2015 and 2018. However, the framework does not allow for the multiple levels of political prioritisation in devolved systems of governance. Hence, we suggest further adaptations to the framework as identified above.

For policymakers, advocates or researchers aiming to make health reforms a political priority in highly devolved contexts, it is important to recognise the formal and informal institutions existing at the devolved level of governance, and ensure adequate early involvement and leadership from sub-national bureaucratic and political actors, in health and beyond the health sector. In addition, the frames used for policy advocacy should be tailored to the political context in order to increase their chances of gaining political traction. Finally, the political context including political and bureaucratic power at different levels of government are crucial features that will also influence the acceptability of reform and ultimately political prioritisation.

2.7 Declarations

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2.7.3 Conflict of interests

The authors declare that they have no conflict of interests.

2.7.4 Authors contributions

All authors were involved in the conceptualisation of the study, and protocol development. DW conducted data collection, conducted analysis and drafted the original manuscript. All authors were involved in reviewing draft and final analyses and editing. All authors read and approved the final manuscript for publication.

2.7.5 Ethics approval and consent to participate

This study obtained ethical approval from the University of Cape Town Human Research Ethics Committee (Reference number: 086/2020) (Appendix VII) and the KEMRI Scientific and Ethics Review Committee (Reference number: KEMRI/SSC/2795) (Appendix IV and Appendix V) in Kenya. In addition, authorisation for data collection in the county was obtained from the Kilifi CDoH (Appendix VI) and from all the study participants.

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Appendices

Appendix I: Interview guide

Date of discussion:	Interviewer:
Venue:	Note taker:
Time start:	Interviewee's Code:
Time stop:	
Interview completed (Yes/No)	
Reason for incomplete interview	

Interviewer's remarks about the session and issues from debrief

- 1.
- 2.
- 3.

The interview will be conducted online after the participant has been taken through the consent form, signed it and has verbally agreed to participate. The interview will take place in a private location chosen by the interviewee. Before starting the interview, the student researcher will respond to any questions that the interviewee may have. See the guiding questions and prompts in the next page:

Guiding questions

- How and when did you hear that PBF would be introduced into the county?
 - Probe for key actors. For example, if heard in a workshop or meeting, probe for the actors who were there and the roles they played
 - Probe for key events. For example, what was happening in the county at the time?
- From whom did you hear the news about PBF and what information were you given? [speaks to ideas and issue characteristics]
 - For example, what information were you given on why PBF was being implemented in Kilifi?
- What was your role at the time in the county?
 - At what level of the health system? Global, national or local
 - Probe for source of power. In terms of their position, resources under their control, expertise and networks (who they work closely with)
- At the time what difference did you believe PBF would make in the county? Please explain [speaks to ideas]
 - Probe for the source of information or evidence on the beliefs
- Was this belief / disbelief shared amongst your colleagues? If yes or no, can you explain why? [speaks to shared ideas]
- Have these beliefs changed over time? please explain why you think so [examining for evolution of ideas]
 - Probe for the source of information or evidence on the change in beliefs
- Did you play any role in the introduction or implementation of PBF in the county? Please explain your role(s)
- Which actors would you say had the most influence in the introduction of PBF in Kilifi county? Why those actors? [speaks to actor power]
 - Probe for source of power. Is it due to their positions, resources, knowledge or networks/relationships?
- Which actors would you say had surprisingly low influence in the introduction of PBF in Kilifi county? Why those actors? [speaks to actor power]
 - Probe for source of power. Is it due to their positions, resources, expertise or networks/relationships?

- Did the influence of the identified actors over PBF change over time? If yes, how and why? [speaks to changes in actor power]
- Were there actors who did not want PBF or certain aspects of PBF? If yes, please explain why you say so? [speaks to any contestations]
 - Did their views towards PBF change over time? Why do you say so?
- Could you please explain where the PBF funds come from and the process through which they reach the facilities?
 - Does the national and county government contribute to the funding of PBF? If yes or no, why do you think that is the case? [speaks to outcome of political priority]
 - Who is/was meant to manage the funding for PBF?
 - Was there any specific reactions from health managers, health providers and/or politicians to the proposed funding arrangements?
 - Were there any contestations around funding?
- Apart from funds, are there any resources (human and technical) that the national and Kilifi county government allocates towards PBF? If yes, which and when? If not, why do you think they do not allocate any resources? [speaks to outcome of political priority]
- Are there any local policy documents or laws related to PBF that have been developed in Kilifi county? [speaks to outcome of political priority]
 - If yes, which ones and when were they developed? Who were involved in developing them? What processes were involved in making them?
 - If no, why do you think there are no local policy documents or laws?
- Where is the county now in relation to implementing PBF? What is currently happening?

Finally, is there anyone you would suggest that I speak to as well? [snowballing]

Thank you for your time. If it is fine with you, I will be in touch if there is need to follow-up issues for clarification. I will also share my findings with you at a later stage.

**Political prioritisation for performance-based financing at the county level in Kenya
from 2016 to 2019**

Investigator	Institution
Dennis Waithaka	1. University of Cape Town (UCT) 2. KEMRI-Wellcome Trust Research Programme (KWTRP)

Introduction

This study is being carried out by Dennis Waithaka. Dennis is a Master's of Public Health student at UCT and works at KWTRP. KWTRP is a research institution that carries out medical and public health research to find better ways of preventing and treating illness in the future for everybody's benefit. The research includes observation, and asking questions to health providers, policy makers and other health stakeholders about what they know, feel or do about policies and programmes in the country.

Before this study begins, it must have been approved by the Human Research Ethics Committees of UCT and KWTRP. These ethics committees look carefully at the planned work, and they must agree that the research is important, relevant and follows nationally and internationally agreed research guidelines. This includes ensuring that all participants' safety and rights are respected.

About the study I am asking you to participate in

Performance based financing (PBF) also referred to as Results based financing (RBF) was implemented in 20 Arid and Semi-Arid Land counties in Kenya from 2015. This study aims to find out how a range of actors mainly based at the county level in Kilifi experienced the introduction and implementation of the PBF scheme. I feel that your experiences with the PBF scheme will provide valuable information that will contribute to our understanding of how PBF evolved (or not) on Kilifi county government's agenda over time. We are seeking to contribute to a growing body of knowledge on health financing in Kenya and globally as health financing is a key part of securing health coverage for all.

Your participation in this study will take the form of an online semi-structured interview. The focus of the interview will be on your own understanding and perceptions of how the PBF scheme was introduced and implemented and, the set of factors that influenced these processes. The interview will take between 45 minutes and 60 minutes. I will ask you for your consent to interview you and ask for your consent to audio record you.

Should you give us your consent to interview you and to audio record you, the interviews will be audio-recorded. All your personal data, along with interview notes and audio-recordings will be

secured and kept private in a password protected computer. Your name will not appear in any outputs of this research, we will anonymise you in any research reports produced or in any journal publications. I will share the preliminary study findings with you before publication if you so wish. You will be asked for permission to be contacted for a follow-up. However, you can consent to the initial interview and refuse for follow-up contact.

All data collected in the project will be used to produce a masters thesis, a research report and journal publication(s).

Although you will not receive any material benefit on the basis of your participation in this research, the study findings will contribute to understanding the evolution and implementation of health financing policies in Kenya, including why some issues are prioritized by the government and others not. It is important to understand health policy processes as they represent critical moments in society that determine what health policies we will have in the county and nationally.

Ethics approval for this research has been obtained from two institutions, the ethics clearance numbers are: KEMRI/RES/7/3/1 [from KEMRI Scientific and Ethics Review Unit] and, 086/2020 [from Human Research Ethics Committee in University of Cape Town].

You are free to ask me any question about this research. Should you have any further questions or concerns about your participation in this research, you are free to contact the KEMRI Scientific and Ethics Review Unit or the University of Cape Town, Faculty of Health Sciences Human Research Ethics Committee using the contacts below:

Contact details:

Human Research Ethics Committee in Kenya:

KEMRI Scientific and Ethics Review Unit,
P. O. Box 54840-00200, Nairobi.
Telephone: +254 717 719477 or +254 776 399979
Email address: seru@kemri.org

Principal Investigator, Kenya:

Dr Edwine Barasa,
KEMRI-Wellcome Trust Research programme,
P.O. Box 43640, Nairobi.
Telephone: +254 730 162213
Email address: EBarasa@kemri-wellcome.org

Principal Investigator, South Africa:

Ms. Marsha Orgill,
University of Cape Town,
Telephone: +27 (021) 650 3859.
Email address: ms.orgill@uct.ac.za

Professor Marc Blockman,

Human Research Ethics Committee,
University of Cape Town,
Faculty of Health Sciences
E 52, Room 24, Old Main Building,
Groote Schuur Hospital,
Observatory, 7925
Telephone: +27 21 406 6492
Fax: +27 21 406 6411

Student researcher: Dennis Waitthaka

KEMRI-Wellcome Trust Research Programme,
P.O. Box 43640, Nairobi.
Cell: +254 725 792 328 or +27 655 049 871
Email address: waitthakadennis1@gmail.com

Appendix III: Consent form

**Political prioritisation for performance-based financing at the county level in Kenya
from 2016 to 2019**

Investigator	Institution
Dennis Waithaka	1. University of Cape Town (UCT) 2. KEMRI-Wellcome Trust Research Programme (KWTRP)

I, _____, have had the research explained to me and have read the information sheet. 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

Signature: _____ Date: _____

Participant Name: _____ Time: _____
(please print name)

Do you consent to being interviewed for this study (Please tick where relevant and sign):

Yes

No

Signature: _____

Do you consent to this interview being audio-recorded (Please tick where relevant and sign):

Yes

No

Signature: _____

I, _____, confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant (if any) have been answered to the best of my ability.

I confirm that the individual has not been coerced into giving consent, and that consent has been given voluntarily.

A copy of this form has been provided to the participant.

Signature: _____ Date: _____

Researcher's Name: _____ Time: _____



KENYA MEDICAL RESEARCH INSTITUTE

P.O. Box 54840-00200, NAIROBI, Kenya
Tel: (254) 2722541, 2713349, 0722-205901, 0733-400003, Fax: (254) (020) 2720030
Email: director@kemri.org, info@kemri.org, Website: www.kemri.org

KEMRI/RES/7/3/1

June 16, 2020

**TO: DR. JANE CHUMA,
PRINCIPAL INVESTIGATOR.**

**THROUGH: THE DEPUTY DIRECTOR, CGMR-C,
KILIFI.**

Dear Madam,

**RE: PROTOCOL NO. SSC 2795 (REQUEST FOR ANNUAL RENEWAL): A
CRITICAL ANALYSIS OF HEALTH CARE PURCHASING ARRANGEMENTS
IN KENYA**

Thank you for the continuing review report for the period **June 24, 2019, to May 11, 2020.**

SERU acknowledges receipt of the following documents:

1. Your Cover Letter
2. Continuing Review Report
3. The last SERU approval letter
4. The currently approved protocol.
5. Study Outputs

This is to inform you that the Expedited Review Team of the KEMRI Scientific and Ethics Review Unit (SERU) was of the informed opinion that the progress made during the reported period is satisfactory. The study has therefore been granted approval.

This approval is valid from **June 24, 2020** through to **June 23, 2021**. Please note that authorization to conduct this study will automatically expire on **June 23, 2021**. If you plan to continue with data collection or analysis beyond this date please submit an application for continuing approval to the SERU by **May 12, 2021**.

You are required to submit any amendments to this protocol and other information pertinent to human participation in this study to the SERU for review prior to initiation. You may continue with the study.

Yours faithfully,

**ENOCK KEBENEI,
THE ACTING HEAD,
KEMRI SCIENTIFIC AND ETHICS REVIEW UNIT.**

Appendix V: Letter from the Principal Investigator in Kenya



**KEMRI/ WELLCOME TRUST RESEARCH
PROGRAMME**
(Centre for Geographic Medicine Research – Coast)

wellcometrust

P.O.Box 230, 80108, Kilifi, Kenya
Tel: (+254) 417 522535/522063/525044/525453
Fax: (+254) 417 522390
Email: info@kilifi.kemri-wellcome.org

P.O.Box 43640, 00100, Nairobi, Kenya
Tel: (+254) 20 2710672/2715160
Fax: (+254) 20 2711673
Email: info@nairobi.kemri-wellcome.org

16/12/2019

To

The Ethics Review Committee
University of Cape Town

RE: Ethics approval for the study titled Political prioritisation for performance-based financing at the county level in Kenya:2016 to 2019

This is to confirm that the study in question is part of a larger study that aims to analyse purchasing arrangements in Kenya. This study has obtained ethics approval in Kenya (no KEMRI/RES/7/3/1) from the Kenya Medical Research Institute Scientific and Ethics Research Unit (SERU). Performance based financing is a type of provider payment mechanism that aims to, among others, enhance strategic purchasing in healthcare.

Yours sincerely

Dr Edwine Barasa

Director, Nairobi Programme

KEMRI-Wellcome Trust Research Programme

COUNTY GOVERNMENT OF KILIFI

DEPARTMENT OF HEALTH SERVICES

When Replying quote
Email; chmtkilifi@gmail.com
REF: DOM/KLF/SH/VOL.1/08



P. O. Box 9-80108
Kilifi

Date: 23rd July 2020

OFFICE OF THE COUNTY DIRECTOR

Mr. Dennis Walthaka
MPH student-University of Cape town
School of Public Health and Family medicine
Reg No. WTHDEN001
South Africa,

Dear Sir,


RE: DEPARTMENTAL AUTHORIZATION TO CARRY OUT RESEARCH IN KILIFI COUNTY

The Kilifi County Department of Health Services is in receipt of your request to conduct a study titled, "**Political prioritization for performance-based financing at the county level in Kenya:2016 to 2019**". The department is in receipt of the protocol and ethical and scientific approval from KEMRI Scientific and Ethics Review Unit **Ref: KEMRI/SSC/2795** and University of Cape Town Human Research Ethics Committee **Ref: HREC/086/2020**.

The Department is pleased to grant you authorization to conduct your study within **Kilifi County** in line with the approved study protocol, the county guidelines on the conduct of research in Kilifi County during COVID-19, and within the expiry date of your ERC approval **June 23, 2021**.

Upon completion of the study, you are required to share your study findings, and recommendations with the County Director, Department of Health Services, Kilifi County.

Sincerely,


Dr. David Mulewa
Director Medical Services
KILIFI COUNTY



Cc

- County Executive Committee Member
- Chief Officer Medical Services
- Directors - Administration & Public Health



UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee



Room G50- Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 406 6492
Email: hrec-enquiries@uct.ac.za
Website: www.health.uct.ac.za/fhs/research/humanethics/forms

20 March 2020

HREC REF:086/2020

Ms M Orgill
Health Systems Policy Division
1st Floor, Room 1.42
School of Public Health & Family Medicine
Falmouth Building-FHS

Dear Ms Orgill

PROJECT TITLE: POLITICAL PRIORITISATION FOR PERFORMANCE-BASED FINANCING AT THE COUNTRY LEVEL IN KENYA: 2016-2019 (Master's -Mr Dennis Waithaka)

Thank you for your response letter dated 18 March 2020, addressing the issues raised by the Faculty of Health Sciences Human Research Ethics Committee (HREC).

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

Approval is granted for one year until the 30 March 2021.

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.

(Forms can be found on our website: www.health.uct.ac.za/fhs/research/humanethics/forms)

We acknowledge that the student: Mr Dennis Waithaka will also be involved in this study

Please quote the HREC REF in all your correspondence.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please note that for all studies approved by the HREC, the principal investigator **must** obtain appropriate Institutional approval, where necessary, before the research may occur.

Yours sincerely

AP *UBurgess*

PROFESSOR M BLOCKMAN
CHAIRPERSON, FHS HUMAN RESEARCH ETHICS COMMITTEE

Federal Wide Assurance Number: FWA00001637.
Institutional Review Board (IRB) number: IRB00001938

HREC 086/2020sa

Appendix VIII: Similarities and differences between the initial PBF model (i.e. based on the HSSF mechanisms/pre-devolution policy design) and the final PBF model (i.e. post-devolution policy design)
(Text highlighted in blue colour shows the key differences over time)

Key features of Kenyan PBF	Initial PBF model (Source: 2014 PBF operational manual)	Final PBF model (source: 2017 PBF operational manual)
Funder	World Bank	World Bank
Stated goal	To improve health outcomes for women and children and thus contribute to the achievement of the Millennium Development Goals (MDGs) four and five.	To improve health outcomes for women and children and thus contribute to the achievement of the Millennium Development Goals (MDGs) four and five.
Scale of implementation	20 Arid and Semi-Arid Land (ASAL) counties (henceforth referred as the PBF counties)	20 Arid and Semi-Arid Land counties (ASAL) plus Migori county (a non-ASAL county).
Incentivised services/activities	<ul style="list-style-type: none"> -10 quantity indicators mainly drawn from maternal and child health (MCH) services. -13 broad quality assessment areas (such as general management, availability of drugs, health management information systems, hygiene and waste management). - Integrated supportive supervision by the county health management team (CHMT). 	<ul style="list-style-type: none"> -10 quantity indicators mainly drawn from maternal and child health (MCH) services. -13 broad quality assessment areas (such as general management, availability of drugs, health management information systems, hygiene and waste management). - Integrated supportive supervision by the county health management team (CHMT).
Who is incentivized and how are the incentives split	<ul style="list-style-type: none"> -Incentives for primary health care providers (60% salaries top-up, 40% facility investment). -Incentives for the CHMT. 	<ul style="list-style-type: none"> -Incentives for primary health care providers (60% salaries top-up, 40% facility investment). -Incentives for the CHMT.
Schedule of incentive disbursement	Quarterly (after every four months) performance payments.	Quarterly (after every three months) performance payments.
Assignment of PBF functions across national and county government entities:		
1. Regulator- responsible for overall policy guidance including the development of the PBF implementation guidelines and, overseeing its implementation in the counties.	MoH with the support of a PBF technical working group comprising of the World Bank, MoH, CDoH and key partners.	MoH, with the support of a PBF technical working group comprising of the World Bank, MoH, CDoH and key partners.
2. National and county fundholder- responsible for receiving the PBF funds from the donor and ensuring that the financial management regulations and reporting requirements were	National fundholder: HSSF unit within the MoH (makes quarterly performance-based payments to the bank accounts of the PHC facilities and the CHMT).	National fundholder: HSSF unit (name was changed to the KHSSP unit) within the MoH (makes quarterly performance-based transfers of PBF funds to the county fund holder).

<p>adhered to at national and county levels respectively.</p>	<p>County fundholder: None.</p>	<p>County fundholder: county treasury (makes transfer of the PBF funds to the purchaser).</p>
<p>3. Purchaser- responsible for paying the PHC facilities and CHMT for the PBF incentivised services based on their performances as indicated in the verified PBF invoices.</p>	<p>County PBF steering committee (chaired by the CEC-Health official and the Chief Officer of Health as the secretary and other members to include the county health management team, county treasury, implementing partners, health facility management committees (FMCs) and civil society) was assigned the role of the purchaser although it was not actually making the payments for the PBF incentivised services, as this was done by the national fund holder (HSSF unit). Thus, its role was mainly overseeing county PBF implementation and, approving the PBF invoices and submitting them to the national fund holder (HSSF unit) for direct payments to the bank accounts of the PHC facilities and CHMT.</p>	<p>CDoH was assigned the role of the purchaser with the ability to make payments to the PHC facilities depending on their verified performance in the quantity and quality indicators. This was because, in this model, the county treasury was to authorise the CDoH to open a ring-fenced county health special purpose account (SPA) where the PBF funds would be deposited and managed from jointly by the CDoH and county treasury.</p>
<p>4. Verifiers-responsible for verification of the accuracy of the self-reported performance indicators.</p>	<p>Internal verification- This role was assigned to a joint verification team (JVT) (comprising of a minimum of one local implementing partner and three members from the CHMT). Specifically, the JVT would: a) compare the PHC facilities PBF submitted invoices with service utilisation records in the facility registers and b) use a quality assessment tool to assess the quality of service delivery.</p> <p>External verification- This role would be done by an independent (actor from outside the public health system) verifier contracted by the MoH and their role would be to conduct periodic sample based external verification using standard protocols provided by the MoH.</p> <p>Community verification- This role would be done by a contracted community-based organisation and it would mainly involve comparing facility records with patient reports in the community.</p>	<p>Internal verification- This role was assigned to a joint verification team (JVT) (comprising of a minimum of one local implementing partner and three members from the CHMT). Specifically, the JVT would: a) compare the PBF submitted invoices with service utilisation records in the facility registers and b) use a quality assessment tool to assess the quality of service delivery.</p> <p>External verification- This role would be done by an independent (actor from outside the public health system) verifier contracted by the MoH and their role would be to conduct periodic sample based external verification using standard protocols provided by the MoH.</p> <p>Community verification- This role would be done by a contracted community-based organisation and it would mainly involve comparing facility records with patient reports in the community.</p>
<p>5. Providers- responsible for providing the incentivised services</p>	<p>Public and faith-based PHC facilities that, among other things, could deliver at least six of the ten incentivised quantity indicators.</p>	<p>Public and faith-based PHC facilities that, among other things, could deliver at least six of the ten incentivised quantity indicators.</p>

Appendix IX: Journal manuscript instructions for authors

Aims and scope

The Journal is concerned with the politics of health and healthcare, policy making and implementation for and in the health sector and of course health planning and management. Globalization, and the economic circumstances facing groups of countries worldwide, present a great challenge for health systems, planning and management, and the Journal analyses global issues. But it also examines specific issues in specific countries and regions.

Manuscript categories and requirements

- Original Papers - reports of new research findings or conceptual analyses that make a significant contribution to knowledge (7000-word limit).
- Commentaries - evidence-based opinion pieces involving areas of broad interest (3000-word limit).
- Comprehensive Reviews - critical reviews of the literature, including systematic reviews and meta-analyses (5000-word limit).
- Case Studies - a case report of particular interest (2000-word limit).
- Letters to the Editor - are welcomed (1000-word limit).
- Critiques - reviews of books or grey literature (please approach the Editor before submitting a review, 800-word limit).
- Special Issues and Special Sections - on topics of interest are also regularly published. These are usually invited.

Preparing your submission

Cover Letters

Cover letters are **not** mandatory; however, they may be supplied at the author's discretion.

Parts of the Manuscript

The manuscript should be submitted in separate files: main text file; figures.

A. Main Text File

The text file should contain the following sections:

- I. Title
- II. A short running title of less than 70 characters
- III. The full names of the authors and full contact details of the corresponding author
- IV. The author's institutional affiliations where the work was carried out, with a footnote for the author's present address if different from where the work was carried out
- V. Acknowledgments

- VI. Funding or sources of support in the form of grants, equipment, drugs etc
- VII. Conflict of interest statement for all authors
- VIII. Abstract and keywords
- IX. Main text
- X. References
- XI. Tables (each table complete with title and footnotes)
- XII. Figure legends
- XIII. Appendices (if relevant). Figures and supporting information should be supplied as separate files.

Title

The title should be short and informative, containing major keywords related to the content. The title should not contain abbreviations (see Wiley's best practice SEO tips).

Authorship

For details on eligibility for author listing, please refer to the journal's Authorship policy outlined in the Editorial Policies and Ethical Considerations section.

Acknowledgments

Contributions from individuals who do not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Funding

Include the name(s) of any sponsor(s) of the research contained in the paper, along with grant number(s).

Conflict of Interest Statement

Authors will be required to provide a conflict of interest statement during the submission process. For details on what to include in this section, see the 'Conflict of Interest' section in the Editorial Policies and Ethical Considerations section below. Authors should ensure they liaise with all co-authors to confirm agreement with the final statement.

Abstract

An abstract is a concise summary of the whole paper, not just the conclusions, and it should be understandable without reference to the rest of the paper. It should contain the major keywords and not contain citations to other published work.

Keywords

Please provide a maximum of seven keywords. When selecting keywords, Authors should consider how readers will search for their articles.

Main Text

Spelling: The journal uses British spelling; however, authors may submit using U.S. spelling.

Footnotes: to the text are not allowed and any such material should be incorporated into the text as parenthetical matter.

Abbreviations: In general, terms should not be abbreviated unless they are used repeatedly, and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.

Units of measurement: Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website for more information about SI units.

Numbers: numbers under 10 are spelt out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).

Trade Names: Chemical substances should be referred to by the generic name only. Trade names should not be used. Drugs should be referred to by their generic names. If proprietary drugs have been used in the study, refer to these by their generic name, mentioning the proprietary name and the name and location of the manufacturer in parentheses.

References

The Journal follows the AMA style. References should be numbered consecutively in order of appearance and should be as complete as possible. In text citations should cite references in consecutive order using superscript numerals. Sample references follow:

Journal article:

1. King VM, Armstrong DM, Apps R, Trott JR. Numerical aspects of pontine, lateral reticular, and inferior olivary projections to two paravermal cortical zones of the cat cerebellum. *J Comp Neurol* 1998;390:537-551.

Book:

1. Voet D, Voet JG. *Biochemistry*. New York: John Wiley & Sons; 1990. 1223 p.

Please note that journal title abbreviations should conform to the practices of Chemical Abstracts.

For more information about AMA reference style - AMA Manual of Style.

The editor and publisher recommend that citation of online published papers and other material should be done via a DOI (digital object identifier), which all reputable online published material should have - see www.doi.org for more information. If an author cites anything which does not have a DOI they run the risk of the cited material not being traceable. We recommend the use of a tool such as Reference Manager for reference management and formatting.

Tables

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figure Legends

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

Figures

Although we encourage authors to send us the highest-quality figures possible, for peer-review purposes we are happy to accept a wide variety of formats, sizes, and resolutions.

[Click here](#) for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Figures submitted in colour may be reproduced in colour online free of charge. Please note, however, that it is preferable that line figures (e.g. graphs and charts) are supplied in black and white so that they are legible if printed by a reader in black and white. If an author would prefer to have figures printed in colour in hard copies of the journal, a fee will be charged by the Publisher.

Guidelines for Cover Submissions

If you would like to send suggestions for artwork related to your manuscript to be considered to appear on the cover of the journal, please follow these general guidelines.

Additional Files

Appendices

Appendices will be published after the references. For submission they should be supplied as separate files but referred to in the text.

Supporting Information

Supporting information is information that is not essential to the article but that provides greater depth and background. It is hosted online, and appears without editing or typesetting. It may include tables, figures, videos, datasets, and checklists among other materials. Click here for Wiley's FAQs on supporting information. Note, if data, scripts or other artefacts used to generate the analyses presented in the paper are available via a publicly available data repository, authors should include a reference to the location of the material within their paper.

Manuscript Preparation Tips

Wiley has a range of resources for authors preparing manuscripts for submission available here. In particular, authors may benefit from referring to Wiley's best practice tips on Writing for Search Engine Optimization.

Article Preparation Supports

Wiley Editing Services offers expert help with English Language Editing, as well as translation, manuscript formatting, figure illustration, figure formatting, and graphical abstract design – so you can submit your manuscript with confidence. Also, check out our resources for Preparing Your Article for general guidance about writing and preparing your manuscript.