THE INTERNATIONAL JOURNAL OF HEALTH PLANNING AND MANAGEMENT
Int J Health Plann Mgmt (2013)
Published online in Wiley Online Library
(wileyonlinelibrary.com) **DOI**: 10.1002/hpm.2197

Healthcare priority setting in Kenya: a gap analysis applying the accountability for reasonableness framework

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SUMMARY

In resource-poor settings, the accountability for reasonableness (A4R) has been identified as an important advance in priority setting that helps to operationalize fair priority setting in specific contexts. The four conditions of A4R are backed by theory, not evidence, that conformance with them improves the priority setting decisions. This paper describes the healthcare priority setting processes in Malindi district, Kenya, prior to the implementation of A4R in 2008 and evaluates the process for its conformance with the conditions for A4R. In-depth interviews and focus group discussions with key players in the Malindi district health system and a review of key policy documents and national guidelines show that the priority setting process in the district relies heavily on guidelines from the national level, making it more of a vertical, top-down orientation. Multilateral and donor agencies, national government, budgetary requirements, traditions and local culture influence the process. The four conditions of A4R are present within the priority setting process, albeit to varying degrees and referred to by different terms. There exists an opportunity for A4R to provide a guiding approach within which its four conditions can be strengthened and assessed to establish whether conformance helps improve on the priority setting process. Copyright © 2013 John Wiley & Sons, Ltd.

KEY WORDS: priority setting; accountability for reasonableness; healthcare; Kenya

INTRODUCTION

Priority setting, the distribution of resources among competing programmes or people, is an important planning tool for dealing with limited resources (Mckneally *et al.*, 1997;

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Baltussen and Niessen, 2006). The health sector in developing countries has implemented reforms in the face of high demands on the healthcare systems and limited budgets (Kapiriri and Martin, 2006; MOH, 2007). As a result, decision makers in health must set priorities among competing interests because demand for healthcare exceeds available resources (Gibson *et al*., 2004). In theory, priority setting is a more or less systematic approach to distributing the limited resources to fashion the best healthcare system possible. In practice, however, priority setting in healthcare often takes place implicitly.

Priority setting in resource-poor settings often tries to apply technical approaches using information derived from burden of disease statistics, cost-effectiveness analysis and published clinical trials and thus may not address other relevant values such as trust, equity, accountability and fairness, which are equally of concern (Martin *et al*., 2002; Kapiriri *et al*., 2003). Priority setting in developing countries is therefore fraught with uncertainty due to lack of credible information, unclear processes, the legitimacy of those who set priorities, the values and criteria used in the process and the capacity of the institutions that should set priorities (Kapiriri and Martin, 2007; Maluka *et al*., 2010). Addressing priority setting and ensuring legitimacy in the processes are thus necessary to developing fairer methods of allocation for scarce healthcare resources (Fleck, 2001; Alexander *et al*., 2004). This requires optimal tools and processes that draw on the best local evidence and guide policymakers and governments to identify, prioritize and implement evidence-based health interventions for scale-up and delivery. Such approaches should embrace ethical, sociological and political considerations, while acknowledging that setting priorities involves value choices of the stakeholders (Martin *et al*., 2002; Rudan *et al*., 2010; McDonald and Ollerenshaw, 2011). One such tool, a leading framework for priority setting in healthcare institutions, is the accountability for reasonableness (A4R).

Accountability for reasonableness

The A4R is an approach that can be used as an analytical lens to facilitate social learning about priority setting and connect priority setting to broader, more fundamental democratic, deliberative processes that have an impact on social justice (Martin and Singer, 2003) and to improve priority setting processes in healthcare organizations (Daniels, 2000). The A4R framework was developed in the context of real-world priority setting processes and is therefore able to give practical guidance to decision makers (Daniels and Sabin, 1997). It has been used to evaluate priority setting in healthcare settings in both resource-endowed and resource-constrained health systems (Martin *et al*., 2003a, Kapiriri and Martin, 2006; WHO, 2006; Kapiriri and Martin, 2007; Kapiriri *et al*., 2007; Valdebenito *et al*., 2009; Maluka *et al*., 2010; 2003b) and helps to operationalize fair priority setting in specific priority setting contexts, enhancing democratic deliberation (Singer *et al*., 2000). The framework provides guidance to decision makers who must identify and consider the full range of relevant values for legitimate and fair priority setting (Daniels, 2008; Daniels and Sabin, 2008).

The A4R framework identifies four conditions that operationalize the concept of fairness, a common priority setting goal in every healthcare organization.

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These are relevance, publicity, appeal and enforcement/leadership (Table 1), which are themselves grounded in the theories of justice (Daniels and Sabin, 2008). According to theory, conformance to these four conditions improves the priority setting process and may lead to sustainable health action and improved outcomes as a result of the priorities having a better chance of gaining acceptance.

The Response to Accountable Priority Setting for Trust in Health Systems to Accountability project, a European Union-funded initiative that takes an ethics-focused approach to improving service quality and outcomes of health systems, was launched in three countries in Africa in 2006: Kenya, Tanzania and Zambia (Byskov *et al*., 2009). The project aimed at strengthening fairness and accountability in priority setting for improving equity, quality and trust in healthcare at the district level using the A4R framework. In Kenya, the project was undertaken in Malindi District. This paper evaluates the Malindi district process' conformance with the A4R conditions, which is a precondition for seeing whether conformance with them improves decision making. Few studies (Kapiriri and Martin 2006, 2007; Kapiriri *et al*., 2007; Maluka *et al*., 2010) applying A4R in evaluation of the priority setting process have been carried out in developing countries. None so far has been carried out in Kenya.

Methodology

The study setting. The Malindi district in Kilifi County, Kenya, covers an area of 7605 km^2 and is divided into four administrative divisions, Malindi, Marafa, Magarini and Langobaya, with Malindi town as the headquarters. The divisions are divided into 16 locations and 56 sublocations. The district has a population of 249 355 of whom 49% are less than 15 years and 5% are 60 years and above (GOK, 2010). The population is served by government health facilities, namely, one district hospital, three health centres and 16 dispensaries, and are complimented by up to 60 privately/religious-based health facilities, which are distributed throughout the district, but with a higher concentration in urban centres. Malaria, respiratory tract

Table 1. The four conditions for accountability for reasonableness (Daniels and Sabin, 2002)

Conditions	Definition
Relevance	Priority setting decisions must rest on reasons that stakeholders can agree are relevant to the context. On the basis of criteria, information and evidence, the priorities can be identified and decisions made for more sustainable solutions
Publicity	Priority setting decisions and their rationales must be publicly accessible
Revisions/appeals	There must be a mechanism for challenge, including the opportunity for revising decisions in light of new information and arguments that stakeholders may raise
Leadership/enforcement	Leaders in the priority setting context must be responsible for ensuring that the first three conditions are met

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infections, skin infections, diarrheal diseases and intestinal worms remain the top causes of outpatient morbidity.

The health system and decision-making structures in Kenya. The current health system comprises of all groups and institutions that provide healthcare services and regulate and finance health actions, right from the household to the national levels (MOH, 2005). The activities within the health system are set primarily to promote, maintain and restore health responsiveness and fairness in health resources distribution. The Ministry of Health's commitment to address inherent constraints in the health sector has included deliberate decentralization efforts aimed at strengthening the effective implementation of activities at the district level and fostering closer coordination and collaboration amongst the line ministries, donors, organizations and other stakeholders (Ndavi *et al*., 2009). As a result of health sector reforms that have decentralized health services, services are integrated from the national level going downstream to the community level (MOH, 2006, 2007; Maina and Kibua, 2008; Ndavi *et al*., 2009). Figure 1 summarizes the hierarchical relationship of authority and decision making in each level.

Study design. A qualitative case study approach was considered the most appropriate method because priority setting in healthcare institutions is complex, is context dependent and involves social processes (Byskov *et al*., 2009). Thus, using a qualitative case study approach enabled the team to investigate priority setting within its real-life context (Yin, 1994).

Sampling procedures. Members of relevant institutions and stakeholders at the district level were included in the study. Purposive sampling was employed at the district level targeting key players and stakeholders involved in decision making and planning over health issues (Table 2).

Data collection techniques. In-depth interviews (IDIs) and focus group discussions (FGD) were conducted between January and August 2007 at the informants' workplace or other convenient venues and lasted for between 1 and 2 h. Semistructured interview guides were used to conduct the interviews and discussion. These were recorded using a digital sound recorder and notes taken as backup and also to record nonverbal expressions. Themes covered included aspects related to the process of priority setting in the district, stakeholders involvement in the process, criteria and values for priority setting and an understanding and inclusion of the key condition of A4R in the priority setting process. Information from the IDIs and the FGD was triangulated with that obtained from document reviews. Relevant documents including national guidelines in the health sector, district annual operating plans and health strategic plans among others were collected and reviewed to give an understanding of the health system and the priority setting context and process in Kenya.

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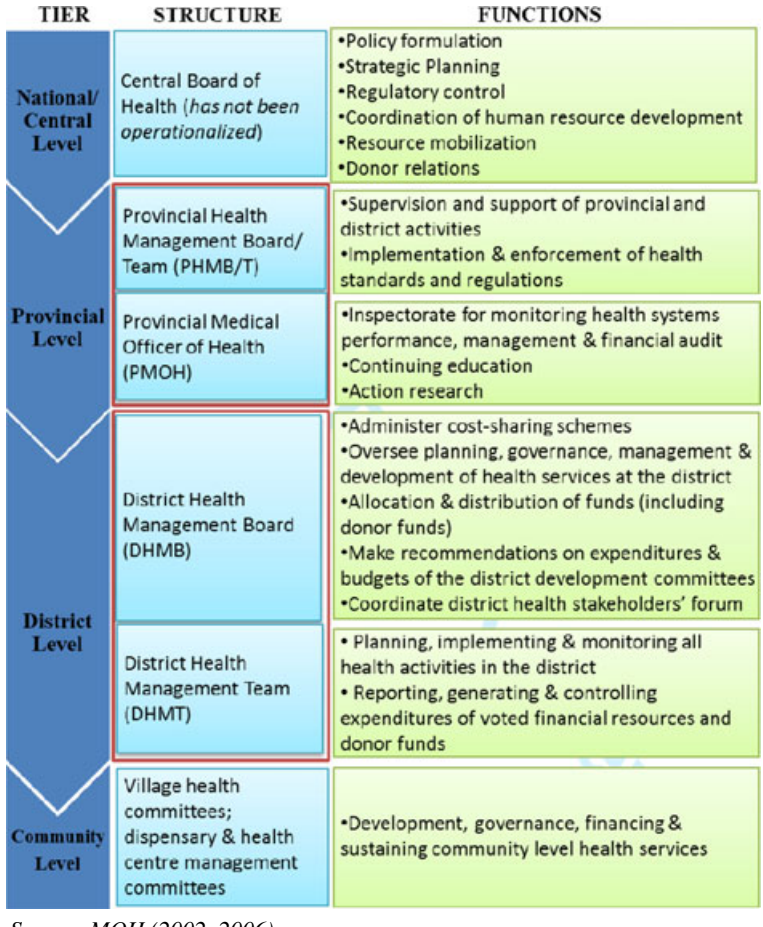

Source: MOH (2002, 2006)

Figure 1. Levels of authority and decision making in the health system.

Data analysis. Data from IDIs and the FGD were transcribed and entered into a database using the QSR NVIVO 8 software for management of files, coding and further analysis. Open coding was undertaken to segment data in relation to concepts or ideas. Related concepts were organized into themes derived from the data. Text analysis was undertaken to interpret the data and findings by relating codes and data to create common concepts. Detailed coding of the data was performed according to the A4R conditions of relevance, publicity, appeal and enforcement/leadership to identify common themes related to elements of the priority setting process, criteria and factors for priority setting, guidelines for priority setting and the people involved in the priority setting process. Codes were used to find specific occurrences of common responses in the data. They were also used to classify different levels of summaries that fell under different variables, for purposes of comparison between categories of informants, as well as between IDIs and the FGD.

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Table 2. Methods of data collection

Method (number interviewed)	Informants/discussants
In-depth interviews (30)	District health management team members (8) District health management board member (1) Other health personnel (10) Government representatives in decision-making bodies (4) Representatives of other health-related stakeholders, for example, nongovernment organizations (4) Representatives from voluntary agencies (3)
One focus group discussion	District health management team members (6 participants)
Documentary review (9)	National guidelines Policy document Planning documents

The trustworthiness of our findings was enhanced by rereading the transcripts, having three investigators coding the raw data to ensure the authenticity of the coding scheme. Two investigators (SAB and JMS) initially coded the transcripts, while a third investigator (WOO) harmonized the coded work of the two investigators. Documents were also used to validate the findings and provide information on the context, including the national policies within which priority setting in Kenya occurs.

Ethical aspects. The study protocol was approved by the ethical committee of the Kenya Medical Research Institute. Permission to conduct the study was obtained from the Ministry of Health at the national, provincial and district levels. Participation was voluntary after being taken through informed consent, and participants were allowed to refuse to participate in the study without any consequences.

RESULTS

Priority setting process at the district

A documentary review showed that the process of priority setting follows some key steps. It starts with preparation of district health profiles summarizing all key health indicators as also reported by a key informant from the hospital,

> '*My duty entails putting together health data from all our health facilities and condensing them into information that can be used by the district for preparing annual work plans*' (district health management team [DHMT] member)

These are then used to identify the major health problems using coverage, incidence and mortality rates as a guide. The third step involves choosing the most cost-effective public healthcare intervention for the different health problems identified and prioritized. This is followed by setting of 1-year targets for each major health problem. The core team (DHMT) then prepares the final district plan and budget, taking into consideration cost-saving measures. The finalized plans are then submitted for

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approval to the district health management board (DHMB) who after thorough discussions forwards it to the national level through the province. However, an informant had a contrary view of the process as illustrated in this statement,

> '*it* [*Priority setting*] *involves not just the district, it involves the whole nation. It starts all the way from the headquarters. So when they send facilities here they have already started priority setting because they know this is a district hospital and they know it has to have certain facilities that are required in a district hospital. So it is a chain from the national headquarters to the province and then here. At the district level, it is basically the district medical officer (DMOH) and the department heads who do a bit of fine tuning on the priorities set. Otherwise I think the whole thing starts from our headquarters*' (health personnel).

According to documentary review, the national level is meant to develop strategic plans and implementation plans for lower-level action. As much as some informants reported that guidelines for priority setting exist, *'We are also guided by guidelines on what we are supposed to do'* (health personnel), most of the informants were not very clear on the existence of formal guidelines for priority setting. Hence, some reported that priorities were set on the basis of what the district team thought was important as depicted in this statement,

> '*What I know . . . we have a five-year strategic plan and from each we remove objectives or task that we can achieve within a year. But then a formal plan of prioritising . . . no. We sit and discuss and say this is priority and this is not priority. But then a guideline that is written and followed we don't have*' (DHMT member).

For those who reported that a plan exists, they revealed that they normally modify the national guideline to suit their needs:

> '*We are given a plan by the ministry and we also look at our situation and decide on what we can do to make the situation better. What the national level brings may not be our priority because of the district specific needs and problems*' (health personnel).

Key players in the priority setting process

Priority setting in the Malindi district involves two major management teams concerned with district health services, the DHMT and the DHMB. This was clearly expressed by a health personnel as follows:

> '*In Malindi district there are two organs. The one at the top is the DHMT and then at the various facilities there are hospital management teams. Apart from the hospital level, we also have the DHMB that according to me, is a regulatory body. The DHMT sits to discuss all matters pertaining to health, sets policies and ensures that they are implemented*'.

The DHMT includes the main players in priority setting at the district level, whereas the DHMB plays the oversight role—approves the key decisions and advises the DHMT. The DHMT is responsible for planning and coordinating health activities in the district and works closely with the DHMB to ensure that health

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policies are implemented, resources are well utilized, quality standards are upheld and performance is monitored and evaluated for better results. It prepares annual work plans including the cost sharing and spending plans, which are scrutinized and approved by the DHMB. The core function of the DHMB is to oversee all health sector activities with functions not limited to the management of cost-sharing funds and approval and submission of district plans and budgets to the provincial level.

The DHMB has its membership drawn from expertise within the district, who also represent the community. This was corroborated by a member of the DHMB who said,

> '*DHMB has got members from all over. The District Commissioner (DC) is a member of the board, we have a board chairman, we have somebody with experience in finance, a religious representative, and representatives from the* [*County*] *Council. They bring inputs from what the community wants and expects. Because they are representing the community in that district—they know their problems*' (DHMB member).

Other players in the process include the hospital management teams and the health centre management teams who carry out similar duties as the DHMT but at the hospital and health centre levels, respectively. They forward their plans to the district, which are then reviewed and collated by the DHMT into the district annual work plans and budgets.

Stakeholders' contributions were also sought in the planning process as reported by a member of the DHMT, '*The DHMT members plus stakeholders are involved in the process of priority setting. The DHMT sits down and does the priority setting. We then present it to our DHMB and share it with our stakeholders. We have a stakeholders' forum*' (DHMT member). This view was also supported in the following excerpt, '*We also call in the stakeholders because in the ministry you cannot work alone. We involve the NGOs, Community based organisations (CBOs) and the private sector because each individual and organization has a role in the priority setting process*' (*DHMT member*). The community views are represented from the health centre level and also by the DHMB.

Criteria guiding current priority setting at the district level. Priority setting requires that one takes into consideration various factors when determining the issues to give a higher priority. According to a documentary review, the importance of the health problem, availability of additional funds, cost-effectiveness, cost-sharing measures and core activities were the criteria that should be taken into consideration to guide the priority setting process. The study shows that in the Malindi district, two broad categories of factors, health indicators and resources, play an important role in determining the priorities that are set.

Health indicators included morbidity and mortality patterns, disease burden, disease incidence and prevalence and seasonal variation. One of the factors was described as follows, '*We set priorities mainly according to . . .*, [*indicators*] *like the mortality rates*' (health personnel). Morbidity, severity and impact of disease were considered equally important as shown in the following excerpt,

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> '*actually they* [*all disease areas*] *are all critical, but we need to break down these issues into the specific intervention areas that need more priority, like malaria . . . is it the drugs? Is it the prevention? We therefore have to go down and break down the activities so we see which of them are more important in that section so that we allocate funds to the activity that is going to make a bigger impact than the other one*' (DHMT member).

The informants and FGD participants were all in agreement that the danger a disease poses, in addition to it being part of the bigger global initiatives such as the Millennium Development Goals (MDGs), were also factors that they used in deciding the priorities of the district.

Human and financial resources were also considered important in priority setting. '*Money is very important, but if you look at human resources, you look at the* [*type of training*] *and deploy them in the right places, because a nurse trained in emergency care should be deployed in the right places. So for human resources we basically use training*" (medical personnel). The amount of funds available is sometimes used to prioritize where activities will be implemented as explained in this statement, '*the funds are little, we need to give them priority. And we neglect the other areas. Somebody might even judge us wrongly and say we have neglected the rural areas. That's true. But when we get adequate funds we will get there*' (DHMB member).

In some situations, experience and historical trends are used to help set priorities, '*Sometimes during resource allocation we use work load, that is data, sometimes we use past trends. If fuel was KSh. 250,000 and it was enough we budget for the same amount*' (DHMB member). However, sometimes, these criteria are not considered at all due to political influence as reported,

> '*we politicians also sometimes play a big part in relevance because without guiding your people, you may set up a facility somewhere which is not relevant. We have had a place in this municipal council whereby the councillor constructs a market, but you find that the population is very small and that facility will not serve because they don't have things to sell in the market. So we are putting a facility where they don't need one . . . and somewhere else, that facility is needed and maybe the council would have gotten some revenue. So relevance is important but sometimes we don't put this into consideration when we are setting priorities. We get into political ambition*' (local government representative).

PRIORITY SETTING IN THE MALINDI DISTRICT THROUGH THE ACCOUNTABILITY FOR REASONABLENESS LENS

Relevance criteria

Stakeholder involvement. The relevance criterion requires that rationales for priority setting decisions must rest on reasons that stakeholders can agree are relevant. Only participation by the full range of stakeholders can ensure that all relevant reasons are brought to the deliberations. The importance of relevance was captured in the following quotes from a DHMB member, '*If it is not relevant to that community,*

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how do they value it? If it is relevant then they will value, appreciate and honour whatever has been done' (DHMB member). In line with this, informants at the district reported that they normally involve communities and other stakeholders in the priority setting process. The community views are passed on through their representatives in the dispensary, health centre and facility committees as stated,

> '*we have involved the facilities whereby we have the in-charge of each facility having members of facility committees drawn from each and every village in the facility catchment area. A facility committee member is like a representative of that village. So all the facilities prepare their plans and bring them here for the final district plan. So I would say they have been involved and their values are reflected in the current priorities*' (DHMT member).

The national guidelines through the Kenya National Health Sector Strategic Plan (KNHSSP) II clearly spells out the importance of involving the communities from the grassroots in the priority setting process. Varying methods of involving stakeholders have been used, but some of the methods may not be conducive to obtaining community views owing to problems of reaching a consensus in a big group.

Other stakeholders, such as nongovernment organizations (NGOs), community-based organizations and private sectors, who are not in the Ministry of Health are also involved in the district priority setting process. They are supposed to have occasional consultation meetings together with the Ministry of Health as reported, '*Practically we should have them* [*consultations*] *quarterly and if we cannot then we should have bi-annual meetings*' (NGO representative). However, their involvement is limited as stated: '*it is a bit of vertical . . . we can't sit with the ministry . . . we have whatever is pre-planned . . . so it is just incorporating*' (NGO representative).

The DHMT expressed difficulties in involving all stakeholders because some stakeholders have more say than others. Interference from the national and donor agenda in priority setting was illustrated in the following statement from a DHMT member,

> '*the tetanus campaign we had last week was not in our plan. Donors came and said that we need to protect our young children and girls from getting exposed to tetanus and then we included them in our work plan since they were to fund the campaign. The Ministry of Health also influences the planning process regardless of whether you have already planned activities in your district. They influence them by including activities they feel need to be included yet you had already made your work plan and had it endorsed by the same Ministry of Health*' (DHMT member).

In addition, an informant from a local NGO also reported interference from the national level in setting the priorities.

> '*I think what is interfering with the leadership at the district is . . . the MOH has decided, because there is money from* [*a donor*] *to have polio mass campaign, polio immunisation* [*will take place*] *which interferes with the programmes and the priorities set out by the districts. So there is almost continuous interference and we see that at the provincial level as well, from interventions which come from the top, from vertical programmes, which interfere with our leadership*' (NGO representative).

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Values

Priority setting needs to be based on some values. Analysis of data at the district level indicated that various values were considered important in the priority setting process, although in practice, they were not always easy to uphold. Quality was considered as the number one value, '*there is no point to give a service that is substandard. We plan in order to improve the quality of the services and try as much as possible to have quality service with the limited resources that we have*' (DHMT member). In addition, honesty, patients' dignity, openness, respect for each other, teamwork and comfort were also reported as values taken into consideration. Not discriminating was also another value mentioned as stated, '*that you should not discriminate the poor the rich, by gender, tribe and race. We give services regardless of who you are*' (health personnel). A health personnel reiterating the importance of these values in priority setting said, '*it is important not to discriminate . . . in fact there are ethics that we have sworn. . .they bind you and they become part of you*' (health personnel). Similarly, accountability was also reported, '*we are open. We keep account of what we are doing and we put it on paper for everybody to see. So we give accountability of what we are doing*' (district government official).

Most decisions made at the district level were considered fair, but those from the national level were termed as unfair as shown in this extract, '*They* [*district decisions*] *are fair. But those ones for promotions (at the national level) are not fair. Training opportunities here at the hospital are fairly distributed since, we give everyone a chance. Every department is represented. But from the ministry, they are not fair. Its only people from headquarters who get to be selected to go for international conferences*' (DHMT member). However, sometimes because of limitations of funds, the management teams are forced to make decisions that may seem unfair at the expense of others as reported by a DHMB member, '*The current priority setting process is not fair in certain aspects but we have no alternative, because . . . the funds are so few*' (DHMB member). Cultural contexts were also considered as shown in this statement, '*we also look at specific health problems in a given area. For example if there is a lack of pit latrines in a specific area due to cultural beliefs that a daughter and a father cannot share the same toilet, we design programs together with the people to ensure that the programs are relevant and acceptable to them. So we rely on data and reports from the people*' (DHMT member).

Publicity

The publicity condition requires that priority setting decisions and their rationales must be publicly accessible. In line with this, a government official reported, '*If we have made a decision today, it's my responsibility to go back and give feedback. You can also write a memo. It's important to go back and sit with the people and tell them this is what we decided*' (district government official). While a DHMB member added, '*Whatever we have decided and made as a priority at the district, we give the coordinator for rural health facilities and he goes throughout the district and informs the respective health centres and dispensaries*' (DHMB member). A health personnel gave the picture of access to decisions in the hospital as being quite good, '*I think information flow is quite good, we have good feedback. I meet the in charges*

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from the district hospital and other health facilities every fortnight. So feedback is there through meetings, through memos, letters' (health personnel).

The national health guidelines require that each facility should have a service charter publicly displayed in a strategic place within the compound of the hospital. The service charter describes the rights of the patients, the various services offered and the costs of these services among others. Although feedback is considered important, this seems to be relevant only for the dissemination of final decisions and not for the rationale behind the decisions.

However, when asked whether health workers can discuss specific decisions touching on them with the committee, it was reported that '*You* [*health worker*] *are called by that committee, this one asks you a question, the other one also asks . . . and normally a solution is generated there in your presence and you are told why they arrived at the particular decision concerning you*' (DHMT member).

Appeal/revision

The appeal condition requires that opportunities are made for people to challenge and revise decisions in light of the considerations all stakeholders may raise. In the Malindi district, client/exit interviews were reported by some members of the DHMT as a tool that has been used to get client views about the services offered and, in some situations, have been used to revise the way the services have been offered. This is depicted in this statement from a health personnel, '*At times we conduct client exit interviews and we honour them. For example, there is a time they told us that they do not want a male nurse in the maternity. We removed all the male nurses and now the maternity scores the highest in customer satisfaction*'. The way some services are planned and handled by health staff has also led to appeals from community, '*we have had cases where members of the public have complained on particular services and we have made some corrections . . . either the staff involved has been counselled . . . has been informed and he or she has had to change*' (health personnel).

The discussants in the FGD mentioned that a suggestion box is in place within the hospital for people to air their views and give their suggestions or comments on issues affecting them as reported by a health personnel, '*We even have a suggestion box. You know some information is very sensitive and they write and put in that box*' (discussant, FGD). This suggestion box is also a requirement that all public offices must have. However, whether it is used or how it is used was not clearly spelt out during the interviews.

Appeals especially at the provincial and national levels were reported not to work well as reported by a district health personnel who has not been promoted while others are being promoted:

> '*I have told my provincial boss. I have talked to them personally, I have written formally. However, I was told there are no slots. You find people in Nairobi are promoted. Even scholarships we are not given. You have to use money from your pocket. But when you go to Nairobi you hear people have been paid for their education. So you get so de-motivated. They only concentrate on Nairobi and the surrounding*' (health personnel).

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An NGO representative candidly stated that appeal has not been given the attention it deserves. He stated thus:

> '*I think it is very difficult for patients to appeal . . . and am not talking about the educated patients who can go through the civil procedure if they think they were not treated in the right way, but I am thinking about the villager who was not treated in the right way or was abused or treated rudely. I think it is very difficult. So the third pillar in democratisation is not yet there. I think it is far more on the first two aspects* [*executive-health workers from the MOH downwards and the legislation or the policy setting-civil society through their representation*], *even if you look at the national health strategy, its far more on how the executive and the policy work together*' (NGO representative).

Enforcement

Enforcement as a condition in A4R requires organizational leadership and public or voluntary regulation to ensure that the other three conditions are met. In the Malindi district, the leadership ability to manage the whole process of priority setting was reported as present but limited to some extent, '*given the right resources they* [*leaders*] *are able to implement. And even with the limited resources they have*, *they have struggled*, *they have tried their best to implement up to a certain level*' (DHMB member).

Leadership is seen as key in getting things done although the leaders may not always be up to task of enforcing the three conditions of A4R. Sometimes, they themselves stand in the way of enforcing these conditions, and some were reported to feel offended when someone appeals against a decision they have made as illustrated in the following:

> '*there is a possibility, in some dispensaries, some of the leaders might get offended if you make an appeal. They feel as if they have been accused. They feel irritated. But we advise them and tell them look . . . this is for your own good, try and correct and make amendments*' (DHMB member).

A member of the DHMB reported that leadership skills in decision making involving tricky/complex situations was present but weak among some of the district leaders as illustrated in the following excerpt:Interviewer: '*Do you think that the leaders you have, have skills in making decisions? If they are faced with a situation for example you have one vehicle, a lady is in labour in Gongoni, supplies have to be picked from the PMO, or the DMOH has a meeting with the PMO. You are the transport officer. Do you think the leaders here can make that decision which has to take into consideration fairness, accountability? Do they have the skills to make that decision?*'

> Informant: '*Again to be frank the answer would be no. They might not neglect that lady*, *but because it is the DMOH who wants to go to the PMO*, *they will give her a vehicle to go then later try to look for other means to get the lady to hospital and in the meantime there will be some delays*' (DHMB member).

The leadership at the district faced problems of making fair decisions in the face of limited finances. In addition, the leaders can improve and implement the priorities set as summed up by a representative from the local government who was asked if he

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thought the leaders in the district were capable of implementing the priorities they set, '*Yes, if they remove unfairness, sectarianism then they will be capable*' (local government representative).

DISCUSSION

Gaps identified using the four conditions of A4R (relevance, publicity, appeals and enforcement), provide the basis for recommendations for improvement in the Malindi district priority setting process. The process of priority setting in Malindi is multilayered and complex. It is influenced by the agendas of multilateral agencies, donor agencies and national governments and by budgetary requirements, tradition and local cultures. For example, some decisions made at the national level cause the district to deviate from their set priorities, by influencing the inclusion of new activities into the already approved work plans. As a result, the process of deciding what is important in the district may not always be consistent. The priority setting in the district relies heavily on guidelines from the national levels, making it more of a vertical, top-down orientation. In theory, the lower levels are required to come up with their priorities that are meant to be fed into the higher levels (MOH, 2006); however, in practice, the top-down approach from the national level has more weight and influence on what is carried out at the lower levels. Strict guidelines that accompany some policies and funding make local input to decision making almost impossible and may distort local priority setting.

Global agendas such as the MDGs also influence the priority setting at the district level. Diseases considered part of the MDGs are given priority over other diseases. This description aligns well with other studies from similar contexts. For instance, a study on strengthening health management in Gambia revealed that although health teams had better management skills and systems, their effectiveness was often limited by the extent to which donor-supported programmes were still based on standardized models, which did not allow for varying and complex environments at the district level (Conn *et al*., 1996).

District priority setting in the context of accountability for reasonableness

Relevance. Relevance was the condition that seemed widely understood and applied in the priority setting process. This could be driven by the spirit of the KNHSSP II, which recognizes that reducing health inequalities can only be achieved effectively by involving the population itself in decisions on priority setting and consequently in the allocation of resources (Muga *et al*., 2005). Relevance was closely tied with ownership and was reported to lead one to appreciate, honour and value decisions or plans that have been made with relevance taken into consideration.

Involvement of communities and other relevant stakeholders featured prominently in the priority setting process. This is in recognition by the government that reversing the trends in the health sector and moving towards the goal of equity, effectiveness and efficiency cannot be achieved by the government health sector alone but through active involvement and partnership with other stakeholders in the provision of care (Muga *et al*., 2005).

DOI: 10.1002/hpm

Participation of members of the public can contribute to important aspects of priority setting, thus improving the legitimacy and fairness of the process. Community engagement in health is consistent with notions of democracy and can empower communities to take responsibility for their own healthcare. Rural communities, health services and other community organizations need skills in working together to develop effective partnerships that transfer power from health systems (Kilpatrick, 2010). The engagement of communities through committees influenced priority setting, but emphasis on the agendas of multilateral donor agencies and on national governments left many local priorities unaddressed by the final work plans. O'meara *et al*. (2011) observed similar findings in a study on community engagement in Kenya.

In theory, the Ministry of Health takes cognizance of the importance of incorporating the views and priorities of all relevant stakeholders in decision making by involving them in making policy decisions right from the planning process to the end. However, in practice, the effective involvement of all relevant stakeholders seems to be a challenge as a result of group dynamics and inadequate funding. Martin *et al*. (2002) also identified a gap in participation in priority setting that related to techniques for obtaining public input into priority setting. This, as stated in Muga *et al*. (2005), calls for empowerment of the committees in the mobilization and allocation of resources, thereby promoting community ownership and control in the context in which they live their lives. This paradigm shift requires a fundamental change in the way things are governed and managed, as well as in the way services are delivered. Decision makers in health services may find the A4R framework useful for developing fair and publicly accountable priority setting processes and for engaging their communities more constructively around the challenges of resource scarcity (Gibson *et al*., 2005).

In terms of the guiding factors in the district priority setting process, there were no clear cut guidelines on how to undertake the priority setting process, and this led to conflicting information from the informants in terms of who is involved, the nature and level of their involvement and the factors influencing the process. Demographic and epidemiological indices were key in the process. However, studies (Olowu, 2003; Kapiriri and Martin, 2007; McDonald and Ollerrenshaw, 2011) state that using epidemiological measures as the sole factor in priority setting is especially problematic in developing countries where often it is difficult to obtain good epidemiological data. Much as it illustrates the problems and points quite clearly to the priorities that need to be addressed, it often fails to consider the cost or feasibility of the suggested interventions and does not take social, ethical or political concerns into consideration (Reichenbach, 2001). As Martin *et al*. (2002) and Kapiriri and Martin (2007) opined, technical criteria provide information but are not embedded in a fair priority setting process, consequently enhancing the perception of legitimacy in the process without actually improving legitimacy itself.

Priority setting in health services organizations needs to go beyond evidence-based medicine and economic to ensure fairness in allocating limited resources (Gibson *et al*., 2005). Priority setting decisions increasingly involve social value judgments—that is, judgments made on the basis of the moral or ethical values of any particular society. Fairness, quality, nondiscrimination, honesty, openness, respect, teamwork, comfort, patients' dignity, accountability and respect for cultural beliefs were values that were mentioned in this study. This is in line with some values such

DOI: 10.1002/hpm

as justice, equity, dignity, nondiscrimination, autonomy and solidarity, which have featured prominently in debates about priority setting (Gibson *et al*., 2004). Some values were reported to drive the decisions made at Malindi, but there was no consistent and explicit way of integrating them into the priority setting process. According to Clark (2011), the way in which values are weighed in decision making varies widely between different countries, but policymakers the world over increasingly must grapple with the problem of how to strike a balance between the values in a way that is socially and ethically justifiable.

Publicity. This condition did not come out clearly in the description of the priority setting process and was often confused with publication of patient rights, managerial transparency towards staff and health promotion campaigns. In some instances, the decision makers indicated that they normally give feedback to the rural health facilities through their coordinator, but whether information about the process and reasons for these decisions were also given was not clear. This is in line with observations made by Martin *et al*. (2003a) whereby decisions made were posted in the relevant departments, but the deliberate processes through which these decisions were made and the reasons for the decisions were not made public and hence not accessible by anyone outside the committee. The aspects of publicity gleaned from the interviews indicate that the publicity undertaken misses the important element of publicizing how the decisions publicized were arrived at. Similar findings have been documented in Tanzania by Maluka *et al*. (2010), indicating that the district had ineffective formal mechanisms of disseminating priority setting decisions. In addition, publicity is not taken as a key element in the priority setting process but more of an informative tool to passive clients, yet according to Gisbson *et al*. (2005), transparent priority setting is not just about the transmission of information but also about keeping people engaged and invested constructively in the priority setting process. In tandem with one of the intended impacts of the KNHSSP II (MOH, 2006), there is need to empower the communities to demand their rights and seek accountability from the formal system for the efficiency and effectiveness of health and other services. Thus, the public should be ensured a higher level of information on which decisions are made at which levels and which reasons there are for the individual decisions (Sabik and Lie, 2008)

Appeal/revision. The appeal/revision condition was reported minimally by the informants. Client exit interview seemed to be the success story under this condition. As much as the suggestion box was a prominent feature in health facilities, its usage is very limited. This could be because people do not believe that the institution would give the issues present therein the due attention they deserve. Staff at the health institutions were also reported to have made various complaints to the provincial and national levels yet did not receive any proper explanations for the decisions taken concerning their complaints. The reasons for the community's reluctance to appeal could be because they do not think it is their right to do so. Maluka *et al*. (2010) have shown that knowledge, skills and experience are needed for one to be effective in their appeals. As Muga *et al*. (2005) rightly observed, building the capacity of households not only to demand services from all providers but also to know and progressively

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realize their rights to equitable, good-quality healthcare is essential and can only be undertaken if community members are aware about their rights. Openness is therefore crucial to ensuring that individual decisions can be subjected to criticisms and possibly changed on the basis of the public debate (Sabik and Lie, 2008).

Enforcement/leadership. Strong leadership is a key factor in facilitating explicit priority setting (Mitton and Donaldson, 2004), yet it was reported as present but limited to some extent. Sometimes, the unwillingness of the leaders to accept criticisms of their decisions hampered the enforcement of the appeal/revision condition. The authority of health leadership did not seem absolute, and hence, there were decisions that could not be made at the district level and were left to the higher national level. This renders the leadership at the district level powerless to enforce the other conditions of the A4R. Much as the district leaders may be knowledgeable about their roles, some were reported to lack adequate skills to make core decisions when faced with a scenario that went against their core function, to save lives. Room for improvement was noted by some informants, and this required the leaders to be fair and indiscriminate. This relates to some of the important values that not only have featured prominently in debates about priority setting (Gibson *et al*., 2004) but are also part of the A4R process (Singer, 2000).

Study limitations

Our study was conducted at the district setting with the aim of understanding how priorities are set at that level. It, therefore, does not give us an opportunity to discuss priority setting at other levels beyond the district. However, it provides us with critical lessons on how such a process might influence priority setting at higher levels. The Constitution of Kenya 2010 lays emphasis on strengthening lower levels of governance as a basis of strengthening the national government. Thus, the shift is towards a bottom-up approach, embracing the spirit of decentralization of decision making to the lower levels in conducting government operations.

CONCLUSION

This study highlights the feasibility of engaging the district in priority setting using the A4R framework as the process in the Malindi district hospital already involves the elements of the A4R conditions, albeit in varying degrees. The existence of the shortcomings identified does not imply that the current process should be abandoned. Instead, improvement needs to be done to enhance them in addition to operationalizing and highlighting the similar conditions to A4R that are already present within the national health strategic plans. Ham and Coulter (2003) stated that there is a universal need to strengthen institutional processes in which decisions are taken. In light of this, the district should be encouraged to implement the intervention aspect of the A4R within their priority setting and planning process. This could help bring to the forefront and strengthen the conditions of A4R already in existence as well as operationalize any that may not have been optimally used. The leadership/

DOI: 10.1002/hpm

enforcement condition needs revisiting and a strategy on how it can be focused in the priority setting process developed. This is important because as Daniels and Sabin (2008) stated, enforcement is needed to ensure that the other three conditions of the A4R framework are met.

To change the status quo of communities as passive participants to active participants in the priority setting process, there is need for them to be empowered to demand for publicity, appeal, relevance and strong leadership in the priority setting process. Thus, redefining the appeals mechanism and expanding the opportunities for the communities to contribute relevant considerations to each decision and specifying the ground for appeal will help improve the quality of the decision-making process (Martin and Singer, 2003). Working within a priority setting framework such as A4R according to theory is expected to strengthen and improve fairness and accountability and subsequently lead to improved quality, equity and trust in the delivery of health services and interventions. Nonetheless, local priority setting at the district level will need to have an in-build flexibility mechanism because competing national priorities may take precedence over local upward-driven priorities. Conformance to the A4R conditions exists to some extent at the district level, but a further assessment could be undertaken to establish whether full conformance and compliance to the A4R conditions in the priority setting process yields better decisions about priorities.

ACKNOWLEDGEMENTS

This paper is part of a larger study of the European Union-funded REACT project, grant no. PL517709, testing the applicability of the accountability for reasonableness approach to priority setting in the Malindi district in Kenya. We are also grateful to all the informants who participated in the study and the reviewers who gave constructive critiques that helped improve this paper. The views expressed herein are those of the authors and do not necessarily represent those of the supporting institutions.

The authors have declared that there is no conflict of interest.

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