Scientific Research Publishing

Open Journal of Social Sciences, 2026, 14(6), 450-473
https://www.scirp.org/journal/jss
ISSN Online: 2327-5960
ISSN Print: 2327-5952

Citizen Voice and Accountability in County Health Systems in Kenya—Are Local Governments More Responsive to Community Health Needs?

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How to cite this paper: Ponge, A., & Ochieng, A. A. (2026). Citizen Voice and Accountability in County Health Systems in Kenya—Are Local Governments More Responsive to Community Health Needs?. *Open Journal of Social Sciences, 14,* 450-473.
https://doi.org/10.4236/jss.2026.146026

Received: May 19, 2026
Accepted: June 26, 2026
Published: June 29, 2026

Abstract

Kenya's devolution of health services to 47 county governments, anchored in the 2010 Constitution, was premised on the expectation that geographic proximity would enhance citizen voice and improve accountability in the delivery of health services. This paper critically examines whether county-level governance structures have translated this promise into practice, with particular attention to the tension between public participation and elite capture. Drawing on theoretical frameworks of deliberative democracy, principal-agent theory, and elite capture theory, the paper argues that while devolution has opened formal spaces for citizen engagement in health governance, these spaces are routinely colonised by local political elites, health bureaucrats, and interest networks whose priorities diverge from community health needs. The paper maps the mechanisms through which elite capture undermines participatory health governance in Kenya's counties, and proposes pathways—through social accountability tools, civil society engagement, and institutional reform—through which genuine citizen voice may be reclaimed. The analysis contributes to broader debates on decentralisation, health systems governance, and the political economy of local accountability in sub-Saharan Africa.

Keywords

Citizen Voice, Accountability, Elite Capture, Public Participation, County Health Systems, Devolution, Kenya, Health Governance

1. Introduction

Over the past three decades, decentralisation has emerged as a dominant governance reform across sub-Saharan Africa, driven by the pursuit of democratisation and more responsive public service delivery (Smoke, 2003; Muriu, 2013). In the health sector, proximity between governance and communities is expected to reduce information asymmetries, align health priorities with local needs, and strengthen citizen accountability over service providers (Bossert & Beauvais, 2002; Saltman et al., 2007). Kenya's 2010 Constitution represented one of the region's most ambitious decentralisation experiments, establishing 47 semi-autonomous counties with elected governors, county assemblies, and devolved mandates over primary and secondary health services—a transformative break from a historically centralised and inequitable health system (Barasa et al., 2017). Kenya's concurrent pursuit of Universal Health Coverage by 2030, anchored in the "Big Four Agenda" and operationalised through the Kenya Primary Healthcare Strategic Framework (2019-2024) and the Kenya Community Health Policy (2020-2030), has added urgency to questions of governance responsiveness (Ponge & Ochieng, 2025; Republic of Kenya, 2020).

More than a decade on, the evidence is mixed. Devolution has generated real gains in some counties—including infrastructure investment, staff recruitment, and expanded community health programming—but has simultaneously reproduced, and in some cases deepened, the exclusion, misallocation, and unaccountability that characterised the system it replaced (Tsofa et al., 2017). Mixed-method analysis across Kenyan counties confirms that inefficiency in county health systems is systemic, driven by funding shortages, procurement delays, lack of facility-level autonomy, and weak community engagement, all of which undermine responsiveness to local health needs (Zeng et al., 2022). Where improvements have occurred, they have not consistently translated into responsiveness to community priorities. A persistent disconnect remains between formally identified community health needs and actual resource allocation, with health investments frequently misaligned with locally expressed priorities. Projects are initiated, funded, and publicly launched, yet their implementation is often incomplete, poorly targeted, or fails to deliver sustained community benefit—resources intended to strengthen service delivery are instead diverted, diluted, or absorbed within administrative and political processes that do not prioritise community health outcomes.

The central question this paper addresses is why, despite the existence of formal public participation mechanisms, community health needs so consistently fail to shape county health governance decisions. Health responsiveness, as used in this paper, refers to the degree to which county health governance decisions—including budget allocation, service planning, and resource deployment—reflect and prioritise the expressed health needs of communities, as evidenced by budget alignment with community priorities, equitable staffing and commodity distribution, and the measurable uptake of community-identified needs into county health plans. The paper argues that the answer lies in the tension between two

competing forces: public participation as a formal institutional commitment, and elite capture as a structural and political reality. Where participation frameworks open spaces for citizen voice, elite capture—operating through political patronage, bureaucratic discretion, and the colonisation of participatory spaces—systematically redirects health governance decisions toward narrow, powerful interests. The paper develops this argument across six sections, encompassing theoretical frameworks, Kenya's devolution architecture, participation mechanisms, elite capture dynamics, and pathways toward genuine accountability.

This paper is a conceptual and policy-analytical review grounded in systematic engagement with published literature on decentralisation, health governance, citizen participation, and elite capture in Kenya and sub-Saharan Africa. The literature was identified through searches of electronic databases including Google Scholar, PubMed, and the World Bank Open Knowledge Repository, using search terms including "devolution Kenya health", "citizen voice accountability Kenya", "elite capture community-driven development", "community health promoters Kenya", and "public participation county health Kenya". Sources were selected for relevance, empirical grounding, and recency, with preference given to peer-reviewed journal articles, official government publications, and grey literature from credible policy institutions. The synthesis draws on both Kenya-specific evidence and comparative material from sub-Saharan African and global contexts where directly relevant. The paper does not present primary empirical data; rather, it synthesises existing evidence to develop a conceptual argument about the structural conditions shaping health responsiveness in Kenya's county health systems.

2. Conceptual and Theoretical Framework

2.1. Citizen Voice and Accountability

The concept of citizen voice refers to the capacity of individuals and communities to express preferences, articulate needs, and influence the decisions of public institutions (World Bank, 2004). In the context of health systems, citizen voice encompasses formal mechanisms—such as public hearings, community health committees, and participatory planning processes—as well as informal channels including community mobilisation, media advocacy, and civil society engagement (Lodenstein et al., 2017).

Accountability captures the relationship in which actors are obligated to explain and justify their conduct to others, and in which sanctions or rewards follow from this process (Schedler, 1999). Fox (2015) distinguishes between "thin" accountability—the formal obligation to report—and "thick" accountability, which requires the capacity to enforce consequences. In health systems, accountability operates across financial, performance, and democratic dimensions (Brinkerhoff, 2004). The relationship between citizen voice and accountability is theorised as mutually constitutive: meaningful citizen voice creates pressure for accountability, while accountable institutions incentivise citizen engagement (Gaventa & McGee, 2013). This positive relationship, however, is contingent on structural

conditions—including the openness of political systems and the organisation of civil society—that are frequently absent in low- and middle-income country contexts (Lodenstein et al., 2017).

2.2. Public Participation Theories

The normative case for public participation draws on deliberative democracy, which holds that legitimate political decisions must emerge from inclusive, reasoned public deliberation rather than from the aggregation of pre-given preferences (Habermas, 1996; Dryzek, 2000). Arnstein's (1969) ladder of citizen participation remains the most widely cited typology, distinguishing eight rungs from manipulation at the bottom through tokenism to genuine citizen power at the top. Cornwall (2008) builds on this to distinguish between "invited spaces"—participation forums created and moderated by the very institutions whose decisions are meant to be scrutinised—and "claimed spaces" created and controlled by citizens. This distinction is analytically central to the Kenyan case, where formal participation channels are almost entirely of the "invited" variety.

2.3. Principal-Agent Theory and Health Governance

Principal-agent theory provides a useful framework for understanding accountability gaps in health governance (Preker & Harding, 2003). Citizens are the ultimate principals—the party whose interests the state is meant to serve—while government officials and health workers are agents delegated to act on their behalf. Accountability problems arise from information asymmetries: agents typically know more about their own efforts than principals do, creating conditions for moral hazard and adverse selection (Stiglitz, 2002). In devolved health systems, the principal-agent chain is extended and complex. Devolution, in theory, shortens this chain by bringing agents geographically closer to principals. In practice, the critical variable is not geographic proximity but the quality of information flows, the organisation of citizens, and the capacity of intermediary institutions to act as effective accountability mechanisms (World Bank, 2004; Brinkerhoff, 2004).

2.4. Elite Capture Theory

Elite capture refers to the process through which local elites—individuals or groups with disproportionate social, economic, or political power—appropriate the benefits, spaces, and processes of governance programmes designed to serve broader community interests (Platteau, 2004; Mansuri & Rao, 2013). Bardhan and Mookherjee (2000) demonstrate that decentralisation increases the risk of elite capture when local political accountability is weak, civil society organisation is limited, and local power inequalities are acute. Platteau (2004) identifies three principal mechanisms: capture of decision-making positions; manipulation of information and agenda-setting; and the use of patronage and social authority to demobilise potential opposition. The literature distinguishes between elite con-

trol and elite capture. While elites routinely dominate Community-Driven Development (CDD) processes, this need not mean project benefits are appropriated at the community's expense (Mansuri & Rao, 2004). Empirical evidence from Indonesia confirms that elite-controlled projects can still reach the poor (Dasgupta & Beard, 2007; Fritzen, 2007), making accountability structures—rather than elite exclusion—the more policy-relevant concern. There is also the distinction between "benevolent" capture—where elites appropriate governance but deliver some community benefits to maintain legitimacy—and "predatory" capture, where elites systematically extract resources at the community's expense, a distinction with direct implications for policy design (Mansuri & Rao, 2004; 2013).

Figure 1 below synthesises the four theoretical lenses informing this study—deliberative democracy, principal-agent theory, elite capture theory, and citizen voice and accountability—and their interrelationships as a unified analytical framework.

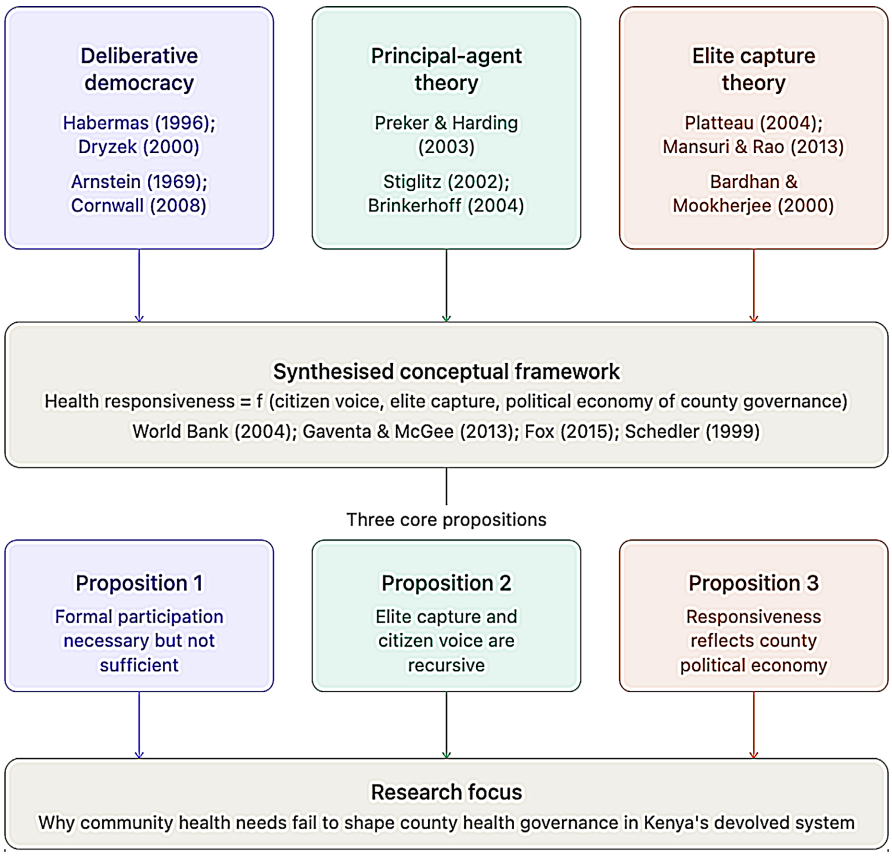

Figure 1. Theoretical framework underpinning the study (Authors, 2026).

2.5. Conceptual Framework

Synthesising these theoretical strands, this paper advances a framework in which health responsiveness—defined as the alignment between community health needs and county health governance decisions—is the outcome of a dynamic ten-

sion between citizen voice and elite capture. Three core propositions follow. First, formal public participation mechanisms are necessary but not sufficient conditions for health responsiveness; without accessible information, independent facilitators, and sanctions for non-compliance, formal participation creates invited spaces that are structurally prone to capture. Second, elite capture and citizen voice are not independent variables: elite capture actively suppresses citizen voice by colonising participatory spaces, controlling information flows, and demobilising non-elite participation—a recursive relationship in which weak citizen voice facilitates elite capture, and elite capture further weakens citizen voice. Third, the degree of health responsiveness in any given county reflects the political economy of that county—the distribution of power, the organisation of civil society, and the degree to which health governance is embedded in competitive political dynamics. Counties with more plural political environments and stronger civil society organisations are expected to exhibit less severe elite capture and greater health responsiveness.

Figure 2 below illustrates this conceptual framework, mapping the recursive relationship between citizen voice and elite capture and their joint effect on health responsiveness across Kenya's 47 county health systems.

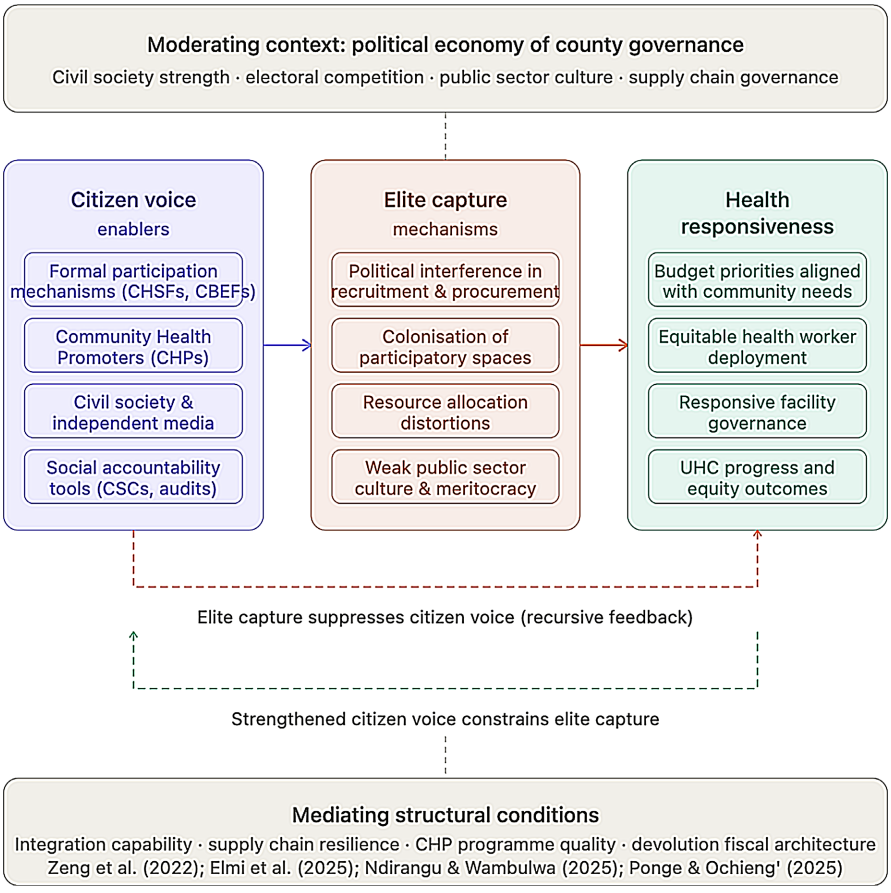

Figure 2. Conceptual framework—Citizen voice, elite capture, and health responsiveness in Kenya's devolved county health systems (Authors, 2026).

3. Devolution, County Health Systems, and the Promise of Local Responsiveness

3.1. Kenya's Devolution Architecture and Legal Framework

Kenya's 2010 Constitution established a two-tier governance system comprising the national government and 47 county governments (Republic of Kenya, 2010). This constitutional settlement represented a fundamental restructuring of the state, driven by recognition that Kenya's highly centralised political system had reproduced historical inequalities in access to public services (Cheeseman et al., 2016). Schedule Four assigns health services—including county health facilities, pharmacies, and ambulance services—to county governments, while national government retains responsibility for national referral hospitals and health policy. The County Governments Act (Republic of Kenya, 2012a), the Public Finance Management Act (Republic of Kenya, 2012b), and the Health Act (Republic of Kenya, 2017) provide the legislative framework for county health governance, including provisions for public participation and community health service delivery. Fiscally, devolution is underpinned by an equitable share formula allocating at least 15% of national revenue to counties (Commission on Revenue Allocation, 2022), with health absorbing on average 25% - 35% of county budgets (KHSSP, 2018).

3.2. Implementation Realities and Performance Gaps

The transfer of more than 60,000 health workers and approximately 4600 lower-level health facilities to county management was completed in 2013 (Barasa et al., 2017). The scale and speed of this transition created significant administrative challenges, including unclear lines of accountability, disrupted supply chains, and labour disputes (Tsofa et al., 2017). While some counties moved quickly to increase health budgets and expand community health programming, the evidence on health outcomes remains mixed, with significant inter-county disparities persisting and some counties experiencing deterioration in service quality and coverage (Kenya National Bureau of Statistics (KNBS), 2022; Tsofa et al., 2017).

Mixed-method research across five Kenyan counties with varying performance levels identifies a consistent set of systemic inefficiency drivers: shortage of funding, delays in disbursement from the national treasury, lack of facility-level autonomy in procurement and human resource management, and political interference in resource allocation (Zeng et al., 2022). Critically, the two factors most reliably distinguishing high-performing from low-performing counties are commitment to health—reflected in the share of the county budget allocated to the health sector—and community engagement, particularly the establishment and resourcing of Community Health Units (Zeng et al., 2022).

Research in Garissa, Mandera, and Wajir counties—among the most underserved in Kenya—further confirms that service delivery challenges are compounded by inadequate staffing, low empathy among health personnel, poor supply chains, and weak integration between formal health systems and communities

(Elmi et al., 2025; Moses et al., 2020). Public sector culture, including the degree of meritocracy, formalism, and accountability in civil service conduct, significantly moderates service delivery outcomes in these counties, with weak cultural norms undermining the potential of even well-designed integration strategies (Elmi et al., 2025).

Devolution has also created new vulnerabilities at the supply chain level. Kenya's COVID-19 response revealed that excessive dependence on imported medical supplies—with 94% of medications sourced externally—exposed the country to health insecurity during global supply chain disruptions, while local financial mismanagement within county health systems compounded these vulnerabilities (Ndirangu & Wambulwa, 2025). These findings underscore that the promise of devolution is mediated not by proximity alone but by political will, institutional culture, governance quality, and supply chain resilience.

3.3. Gaps between Policy and Practice

The gap between formal commitment to public participation and its implementation is consistently documented. Muriu (2013) identifies structural and institutional barriers including inadequate civic education, lack of awareness of participation rights, logistical challenges in reaching dispersed rural populations, and the absence of effective accountability mechanisms to enforce participation requirements. These barriers disproportionately affect marginalised groups—including women, youth, persons with disabilities, and low-income households—whose voices are most likely to diverge from elite preferences. The institutional design of participation mechanisms also creates vulnerability to capture: County Health Stakeholder Forums are convened and facilitated by county health departments—the very entities whose decisions are meant to be scrutinised—with agendas set by county officials, participants often selectively invited, and outcomes not legally binding on county decision-makers (Tsofa et al., 2017). Evidence from nationally representative surveys further confirms that facility-level governance structures, including health facility management committees, frequently lack the capacity, mandate, and financial management skills required to exercise genuine oversight (Waweru et al., 2013).

4. Public Participation Mechanisms in County Health Governance

4.1. Formal Participation Channels and Their Limitations

Kenya's county health governance system provides for participation through multiple formal channels. The County Health Stakeholder Forum, the County Budget and Economic Forum (CBEF) under the Public Finance Management Act (2012), and the County Integrated Development Plan (CIDP) preparation process all provide windows for community input. In practice, however, these forums are irregularly convened, inconsistently attended, and frequently dominated by institutional stakeholders with greater access to information and decision-makers than

ordinary citizens (Barasa et al., 2017; Karuga et al., 2023). CIDP preparation is frequently a technocratic exercise driven by county planning departments, with public consultations that are poorly facilitated, inadequately documented, and weakly linked to actual budget allocations. Nationally representative survey evidence confirms that health facility management committees—a key formal governance structure intended to anchor community voice at facility level—consistently lack the financial management capacity and institutional mandate to translate community input into accountability outcomes (Waweru et al., 2013). The Controller of Budget has noted persistent non-compliance with participation requirements, with many counties conducting cursory or poorly advertised forums that do not constitute meaningful engagement (Controller of Budget, 2021).

4.2. Community Health Promoters: Grassroots Interface and Structural Constraints

Community Health Units (CHUs) constitute Kenya's primary institutional mechanism for integrating community voice into health service delivery. Each CHU serves a catchment population of approximately 5,000 people, supported by Community Health Promoters (CHPs)—formally known as Community Health Volunteers (CHVs)—who conduct household visits, collect health data, and provide basic preventive and promotive services (Republic of Kenya, 2017). CHPs operate at the intersection of the formal healthcare system and the community, functioning as what Ponge and Ochieng (2025) describe as "nyamrerwa"—eyes on the ground—whose privileged position of understanding local context makes them indispensable agents of change in Kenya's UHC journey. Their multifaceted responsibilities encompass health education, preventive interventions, and facilitating access to health services, with the 2023 revamped CHP Programme committing the government to providing stipends, kits, and the Electronic Community Health Information System (eCHIS) to all 100,000 CHPs across 47 counties (Ponge & Ochieng, 2025; Akumu, 2023).

In principle, CHPs provide a grassroots platform through which community health needs can be systematically identified, documented, and escalated to facility and county levels. In practice, their effectiveness as accountability mechanisms is severely constrained. CHPs frequently lack adequate commodities—a CHP covering 800 people may receive only 10 doses of antimalarial treatment to last an entire month—and many struggle with digitalisation requirements of the eCHIS platform (Ponge & Ochieng, 2025). Structural weaknesses including inadequate remuneration, insufficient training, weak supervisory structures, and the absence of clearly defined accountability roles limit their transformative potential (Nzinga et al., 2018). Community Health Committees, where they are active, are often captured by local political networks or dominated by educated community members whose health priorities may not represent those of the broader community (Abramowitz et al., 2015). Nationally representative survey evidence shows that the formal governance structures intended to anchor community voice at facility

level—including health facility management committees—are frequently not ready to exercise the financial management and oversight functions assigned to them, limiting their effectiveness as accountability actors (Waweru et al., 2013). Zeng et al. (2022) confirm that attrition of CHPs is particularly high in urban counties, where volunteers leave for paid employment, jeopardising the sustainability of community health programming.

Evidence from comparable settings reinforces these structural observations. Nally et al. (2024, 2025), drawing on CHW programs implemented during the Sierra Leone Ebola epidemic and post-Hurricane Dorian in the Bahamas, demonstrate that CHW effectiveness depends fundamentally on structured supervision, clear communication pathways, continuous quality improvement mechanisms, and genuine community ownership of the selection process. Their findings show that CHWs selected from and by their communities, adequately compensated, and equipped with structured feedback loops generated a 32% increase in referrals to formal health services in Sierra Leone—a measurable accountability outcome achieved through bottom-up pressure rather than top-down mandate (Nally et al., 2025). The 2020 Community Health Policy and the CHP programme represented a significant policy response (Ministry of Health, 2020), but the evidence shows that implementation has been uneven across counties, with stipend payment irregularities limiting its transformative potential (Karuga et al., 2023; Ponge & Ochieng, 2025). Peer-reviewed Kenyan research further confirms these structural constraints. Karuga et al. (2010) demonstrate that Community Health Extension Workers in Kenya face critical shortages of supervision, supplies, and transport that systematically undermine their ability to serve as effective health system interfaces, findings that remain relevant to the contemporary CHP programme. Munga and Mæstad (2009) provide evidence from the Kenyan public health sector of how inadequate remuneration and career path uncertainties drive health worker attrition and reduce motivation—dynamics directly applicable to CHP retention challenges. This paper argues that these converging lines of evidence confirm a structurally consistent pattern: the transformative accountability potential of community health workers in Kenya is repeatedly constrained by the same governance failures—inadequate resourcing, weak supervision, and limited institutional recognition—that characterise county health systems more broadly.

4.3. Barriers to Meaningful Participation

Multiple intersecting barriers constrain the quality and inclusiveness of public participation. Lodenstein et al. (2017) identify three categories particularly relevant to the Kenyan context. Supply-side barriers include inadequate notice of participation opportunities, inaccessible meeting locations, technical language that excludes lay citizens, and the absence of meaningful feedback mechanisms. Demand-side barriers include limited civic awareness of rights and participation opportunities, constrained time and resources for participation among low-income and rural households, and social norms discouraging marginalised groups—par-

ticularly women—from speaking in public forums (Gaventa & McGee, 2013). Power-related barriers are perhaps the most analytically significant: the use of social authority, political patronage, and community hierarchies to silence dissenting voices and shape the content of participatory deliberations. Cooke and Kothari (2001) describe these dynamics as the "tyranny of participation"—the ways in which participatory processes reproduce rather than disrupt existing power relations, legitimising elite preferences through a veneer of community endorsement.

4.4. Tokenism versus Substantive Participation

Evidence from Kenya's counties consistently suggests that public participation in health governance is predominantly tokenistic. Participation forums frequently function as procedural requirements rather than genuine spaces for influencing decision-making. Tsofa et al. (2017) document patterns across multiple counties where forums are used to explain and legitimise budget decisions already made by county health departments, rather than to solicit and incorporate community priorities. Karuga et al. (2023) find that even where participation forums produce documented community health priorities, there is weak or no traceable link between these priorities and actual county health budget allocations—particularly regarding maternal and child health, community health worker support, and facility supplies. This tokenism is not merely a design failure; it reflects deliberate choices by county health administrators and political elites to maintain discretionary control over resource allocation while fulfilling the formal letter of participation requirements (Cornwall, 2008).

In practice, community members may be invited to attend meetings but are often presented with pre-determined plans, technical documents that are difficult to interpret, and limited opportunities for meaningful contribution. Priorities raised—such as essential drug stock-outs, staffing shortfalls, or support for community health services—are frequently not reflected in subsequent budgets or implementation plans. The following examples are illustrative composites drawn from patterns documented across multiple Kenyan counties in the published literature (Tsofa et al., 2017; Karuga et al., 2023; Barasa et al., 2017), and are presented as analytically representative rather than as documented case studies of specific named counties. In one western Kenya county type, community members who raised concerns about drug stock-outs and peripheral facility staffing found the final approved budget instead prioritising construction of a new facility in a relatively well-served area, with no feedback on how their inputs were considered. In a semi-arid county type, forums convened at headquarters with limited notice produced low rural turnout, with discussions dominated by local leaders and technical staff; resulting plans emphasised visible infrastructure while community-level concerns remained underfunded.

Over time, this persistent disconnect erodes trust in participation processes and reduces incentives for continued community engagement, reinforcing participation as a compliance mechanism rather than a substantive accountability tool.

5. Elite Capture in County Health Systems

5.1. Political Elites and Health Decision-Making

The most visible form of elite capture in county health governance involves the direct influence of elected officials over health system decisions that are nominally the domain of professional administrators. Kenya's county health systems are formally governed by a hybrid structure in which the Governor and the Executive Committee Member (ECM) for Health set overall policy direction, while technical management is delegated to the County Director of Health and County Health Management Teams (Barasa et al., 2017). In practice, this demarcation is frequently violated. Governors and ECMs intervene in operational health decisions—including health worker recruitment, procurement, and facility investments—motivated by political considerations rather than technical or community health criteria (Barasa et al., 2016; Tsofa et al., 2017). Health worker recruitment has been consistently identified as a site of political interference, with appointments to senior positions determined by political affiliation, ethnic networks, or financial payments rather than merit (Tsofa et al., 2017). The politicisation of health infrastructure investment represents another significant manifestation: decisions about the location of new health facilities and the allocation of medical equipment are frequently shaped by electoral geography—directing investment toward political strongholds—rather than by epidemiological need (Nyangau, 2009).

The role of public sector culture in shaping these dynamics warrants emphasis. Research in North Eastern Kenya finds that operational decisions within county health systems are heavily centralised within top management, limiting the involvement of lower-level staff in decision-making and constraining opportunities for innovation and responsive service delivery (Elmi et al., 2025). Where meritocracy is weak, individual initiative goes unrewarded, and monitoring of civil servants' conduct is inconsistent, public sector culture becomes a permissive environment for elite capture rather than a counterforce to it (Kiiru, 2015, as cited in Elmi et al., 2025).

5.2. Capture of Participatory Spaces

The colonisation of formal participatory spaces by local power brokers represents a subtle but significant form of elite capture. Elites consistently dominate community-level governance structures—including community health committees, facility management boards, and public participation forums—not through direct coercion, but through superior access to information, social networks, and the time and resources necessary for participation (Platteau, 2004). Community Health Committees are particularly vulnerable to capture by teachers, pastors, business people, and local officials who view membership as a source of status, access to health resources, or political leverage. Abramowitz et al. (2015) document similar dynamics across community health governance structures in East Africa, noting

that the social capital and communication skills required for committee effectiveness are concentrated among educated community members who may not represent the poorest and most marginalised. Evidence from Sierra Leone's Ebola response corroborates these dynamics at scale: community health programming that bypassed established governance structures was systematically less effective than programming working through trusted, community-selected actors with genuine local legitimacy (Cancedda et al., 2016).

Political influence over health system decisions is further reflected in facility-level investment patterns. In several counties, the siting of new health facilities has been observed to align more closely with areas of strong political support than with population need or geographic access gaps, leaving peripheral communities reliant on under-resourced facilities while newly constructed ones in more central locations remain underutilised. Health worker recruitment has similarly been reported to prioritise political and social connections over technical qualifications, producing uneven distribution of skilled personnel and reduced service quality—outcomes that undermine both efficiency and equity in health service delivery.

5.3. Resource Allocation Distortions

Resource allocation distortion—both fiscal and human—represents the most consequential form of elite capture in county health systems. Mansuri and Rao (2013) identify this as the primary mechanism through which elite capture causes development harm, noting that even where non-elite community members are not entirely excluded from governance, resources are systematically redirected toward elite-serving projects and services. The evidence from Kenya's health sector shows that these distortions are wide-ranging. Procurement irregularities—including inflated contracts, phantom deliveries, and awards to politically connected suppliers—siphon health budgets away from service delivery (Controller of Budget, 2021). The deployment of specialised health workers similarly favours county headquarters and politically influential facilities over peripheral, low-income, and rural communities, while conditional grants and equipment donations nominally targeting underserved facilities are routinely captured by better-connected ones (Barasa et al., 2017).

Zeng et al. (2022) quantify the governance dimension of these distortions across five Kenyan counties, finding that political consideration in budget allocation is a pervasive concern, and that lack of implementation autonomy—particularly at the facility level—constitutes a systemic constraint. The irony is sharp: devolution, designed to move decisions closer to communities, has produced what Barasa et al. (2017) describe as "recentralisation within decentralisation", concentrating power at the county tier while further removing it from the facility and community levels where service delivery actually occurs. The COVID-19 pandemic exposed these vulnerabilities further, with procurement irregularities—including irregular PPE acquisition and senior management interference in supply chains—directly endangering frontline health workers and undermining the national response (Ndirangu &

Wambulwa, 2025). The Controller of Budget's annual reports consistently flag health sector procurement as among the highest-risk areas for financial mismanagement, with recurring findings of irregular expenditure, pending bills, and non-compliance with procurement regulations (Controller of Budget, 2021).

In practice, resource allocation distortions are observable beyond formal audit findings, in the everyday functioning of county health systems. The following county-level illustrations are analytically representative composites drawn from patterns documented in the published literature (Barasa et al., 2017; Tsofa et al., 2017; Zeng et al., 2022; Controller of Budget, 2021), and should not be read as accounts of specific named counties. Facilities may be constructed without corresponding staffing or operational capacity; equipment is procured without trained personnel to operate it; programmes are launched without continuity beyond initial phases. In one county type, substantial investment in medical equipment for a sub-county facility was accompanied by a high-profile public launch, yet the equipment remained underutilised due to staffing gaps, while basic shortages of essential drugs persisted. In another, multiple small-scale health projects were initiated across wards in a single financial year, reportedly to ensure political visibility, yet many experienced delays, cost overruns, or remained non-functional—leaving communities reliant on under-resourced facilities despite significant expenditure. These patterns reinforce the argument that elite capture operates not only through overt political interference, but through subtler processes of resource diversion, misalignment, and weak accountability that persistently undermine health system responsiveness to community needs.

5.4. Empirical Evidence of Elite Capture

Empirical evidence on elite capture in Kenya's county health systems is accumulating across multiple research traditions. Tsofa et al. (2017) document patterns of political interference in health workforce management, procurement, and planning consistent with elite capture dynamics. Barasa et al. (2017) identify political patronage and bureaucratic capture as primary drivers of accountability failures. Karuga et al. (2023) evaluate the Community Score Card process across multiple counties and find consistent divergence between community-expressed health priorities and actual county health budget priorities. The evidence shows that counties with more competitive political environments and stronger civil society presence exhibit better alignment between community health priorities and resource allocation decisions.

Elmi et al. (2025) add to this evidence base, demonstrating that county health service delivery in marginalised counties is characterised by "considerable uncertainty" regarding accessibility, staffing adequacy, and promptness of services—uncertainty that reflects not resource absence alone but governance failures rooted in weak integration capability and inadequate public sector culture. Zeng et al. (2022) demonstrate that counties with the highest share of budgets committed to health and the strongest community engagement consistently outperform com-

parable counties on health outcomes, confirming that political commitment and community governance quality are the primary mediating variables.

5.5. Conditions under Which Participation Has Worked Better

The evidence reviewed in this paper emphasises structural constraints on citizen voice, but the evidence also points to a set of identifiable conditions under which county participation mechanisms have performed relatively better—offering important comparative lessons for both research and reform. Zeng et al. (2022) find that counties demonstrating stronger alignment between community health priorities and resource allocation consistently share two characteristics: a higher share of the county budget committed to health, and more active investment in Community Health Units. This paper argues that these two factors do not operate independently of governance quality: they reflect a prior political commitment to health responsiveness that is, in turn, associated with more plural competitive political environments and more active civil society presence.

Evidence from Kenya's Community Score Card initiatives indicates that successful improvements in health service responsiveness are associated with effective community facilitation, regular interface meetings between citizens and service providers, systematic follow-up of agreed actions, and incorporation of community feedback into health planning and management processes (Abuga et al., 2022; Ministry of Health, 2022; Muriithi, 2024; Council of Governors, 2025). These cases demonstrate that participation mechanisms are not inherently incapable of generating accountability; rather, their effectiveness is contingent on facilitation independence, consequence mechanisms, and political competition that creates incentives for responsiveness. Similarly, evidence from counties that have achieved more representative Community Health Unit governance suggests that CHU performance improves where committee members are selected through genuinely community-driven processes, are given regular access to facility performance data, and where women and marginalised groups are included through affirmative procedural commitments rather than tokenistic representation (Nzinga et al., 2018; Ministry of Health, 2020). These enabling conditions are neither automatic nor self-sustaining; they require deliberate institutional design, sustained civil society engagement, and, critically, county-level political will—the dimension most resistant to technical intervention and most dependent on the political economy of individual counties.

6. Toward Accountability—Pathways for Strengthening Citizen Voice

6.1. Social Accountability Tools

While a range of social accountability tools and institutional reforms have been proposed to strengthen citizen voice, their effectiveness depends critically on the political and administrative realities within which county health systems operate. In contexts where decision-making is highly centralised within county executive

structures, and where incentives for responsiveness to community priorities are weak, technical solutions alone are unlikely to produce meaningful change. Strengthening accountability therefore requires not only the introduction of new tools, but also deliberate efforts to align incentives, increase transparency, and create consequences for non-responsiveness.

Social accountability—encompassing citizen-led mechanisms through which communities directly demand accountability from public officials and service providers—offers a practical toolkit for strengthening citizen voice in county health governance (Ringold et al., 2012). Unlike formal accountability mechanisms, which depend on institutional willingness to enforce standards, social accountability tools generate bottom-up pressure that complements and reinforces official oversight. Community Score Cards (CSCs), implemented in several Kenyan counties through civil society support, involve communities assessing health facility performance against agreed standards, presenting findings to county officials in joint interface meetings, and tracking follow-up improvements (Lodenstein et al., 2017). Evidence from Kenya indicates that CSCs can improve facility responsiveness, health worker conduct, and service quality—though their influence on higher-level resource allocation decisions remains limited (Karuga et al., 2023). Citizen Report Cards, public expenditure tracking surveys, and social audits further enable citizens to verify government expenditure claims and create accountability pressure through civil society, media, and opposition politicians (Kremer & Holla, 2009). The effectiveness of all these tools depends critically on the presence of capable, independent civil society organisations and the genuine willingness of county health officials to engage with findings.

6.2. Civil Society and Media

Civil society organisations and independent media play indispensable roles in strengthening citizen voice and accountability in county health systems. As intermediary institutions between citizens and the state, civil society organisations can reduce information asymmetries by translating technical health budgets into accessible formats, organise collective action, and sustain accountability pressure over time (Gaventa & McGee, 2013). Kenya's civil society sector has a significant, if uneven, presence in county health governance. National organisations such as SHUJAAZ, the Institute for Social Accountability (TISA), and Haki Jamii have developed significant expertise in budget tracking, community mobilisation, and social accountability facilitation (Karuga et al., 2023). However, civil society presence is heavily concentrated in Nairobi and a small number of urban counties, leaving health governance in many counties—particularly marginalised pastoral and arid counties—without effective civil society oversight. Independent media, including county-level radio which remains the primary information source for rural populations, can create accountability pressure by publicising health budget decisions, investigating procurement irregularities, and amplifying community voices.

6.3. Strengthening Community Health Promoters as Accountability Actors

The Community Health Promoter (CHP) system holds genuine potential as an institutional anchor for community accountability, but realising this potential requires structural reforms that go beyond the current model. As presently configured, CHPs function primarily as delivery platforms, lacking the mandate, capacity, and independence to scrutinise county health governance decisions. Ponge and Ochieng (2025) argue that the transformation from Community Health Volunteers to CHPs—backed by government stipends, digital tools, and formal engagement contracts—represents a paradigm shift in community health governance in Kenya. However, they caution that realising this transformative potential requires sustained investment in training, strengthened commodity supply chains, sustainable incentive mechanisms, and the legislative anchoring of CHP recognition and financing. Critically, they recommend an integrated approach in which CHPs are not only institutionally recognised but also genuinely community-owned—relying on both communities and the formal health system for supplies, communications, and referrals—directly addressing the structural vulnerability that allows elite capture to neutralise community health infrastructure (Ponge & Ochieng, 2025).

Three complementary reforms are required to transform CHPs into accountability actors. First, Community Health Committees must be constituted through genuinely representative processes—with specific provisions for the inclusion of women, youth, and persons with disabilities—and given meaningful access to information about county health budgets and facility performance. Second, CHPs must receive adequate remuneration, training, and logistical support—including consistent commodity supply and functional eCHIS access—to sustain community engagement and reduce vulnerability to political patronage. Third, CHPs must be connected to higher-level accountability mechanisms so that community-level findings can be escalated into county-level decision-making (Nzinga et al., 2018; Ministry of Health, 2020).

Evidence from humanitarian settings confirms that these enabling conditions are achievable: structured, community-selected, and well-supervised community health worker programmes in Sierra Leone and the Bahamas generated measurable improvements in health system responsiveness and community-facility trust (Nally et al., 2021, 2024, 2025). In Kenya, counties where CHPs have been better supported—through consistent remuneration, training, and linkage to facility management structures—demonstrate improved responsiveness to community needs, particularly in maternal and child health. However, such cases remain uneven across counties, underscoring the importance of consistent policy implementation and sustained political commitment.

6.4. Institutional Reforms for Inclusive Participation

Strengthening the quality and inclusiveness of formal public participation in

county health governance requires targeted institutional reforms. Five reform priorities are identified. First, participation forums must be decentralised from county headquarters to sub-county and ward levels, where community members are more likely to attend and where distance from county health administration creates greater space for authentic expression of community priorities. Second, the timing, notice, and format of participation events must be reformed to maximise accessibility—including adequate advance notice in multiple languages, events at times convenient for working adults and smallholder farmers, and facilitation approaches that do not require literacy or formal education. Third, the outcomes of participatory processes must be formally recorded, publicly reported, and linked to accountability mechanisms, with county governments required to publish responses explaining which community priorities have been incorporated and why others have not. Fourth, independent facilitation of participation forums—by civil society organisations or academic institutions rather than county health officials—should be piloted and evaluated as a mechanism for reducing the capture of participation spaces by administrative elites. Fifth, meaningful sanctions for non-compliance with participation requirements must be introduced and enforced; linking county government performance evaluations and fiscal transfers to participation quality indicators would create institutional incentives for genuine engagement.

Addressing public sector culture as a governance variable is equally important. Elmi et al. (2025) recommend that county governments cultivate a robust public sector culture that prioritises meritocracy, rewards individual initiative, ensures strict compliance with rules and procedures in decision-making, enforces stringent control measures, and regularly monitors the actions of civil servants and the efficient utilisation of public resources. Without this cultural transformation, even well-designed integration strategies and participation mechanisms will be captured or nullified by informal power dynamics (Elmi et al., 2025).

6.5. Supply Chain Resilience as an Accountability Concern

A dimension of accountability that is insufficiently addressed in existing frameworks is health supply chain governance. Ndirangu and Wambulwa (2025) demonstrate that Kenya's excessive dependence on imported medical supplies—combined with financial mismanagement at KEMSA and inadequate cold chain infrastructure in remote counties—constitutes a national security risk as much as a public health one. From a citizen accountability perspective, supply chain failures have a direct and disproportionate impact on communities with the least political power: rural, pastoralist, and marginalised populations who cannot access alternative supply channels when county health facilities run out of essential medicines and equipment. Building accountability into health supply chain management—through open tender processes, real-time expenditure tracking, artificial intelligence-driven demand forecasting, and community-level monitoring of commodity availability—is therefore an integral component of a comprehensive

citizen voice strategy (Ndirangu & Wambulwa, 2025). The digitisation of the CHP system through eCHIS, which enables real-time performance dashboards and automated reporting, offers an entry point for community-level supply chain monitoring that can feed into broader accountability frameworks (Ponge & Ochieng, 2025; Akumu, 2023).

6.6. Policy Recommendations

At the national level, the Ministry of Health and the Ministry of Devolution should jointly develop a Health Sector Citizen Participation Framework establishing minimum standards for public participation quality across all county health systems, with technical and financial support for compliance and effective monitoring and enforcement mechanisms. The Commission on Revenue Allocation should consider incorporating participation quality indicators into the criteria for conditional health grants, creating fiscal incentives for counties to improve the depth and inclusiveness of community engagement. The Controller of Budget and the Auditor General should systematically incorporate community participation findings into their oversight processes, linking resource allocation anomalies to the quality of participatory governance.

At the county level, governors and county executives for health should publicly commit to specific participation quality targets—including the regularity of participation forums, their geographic reach, the diversity of participants, and the demonstrable incorporation of community priorities into health plans and budgets. County assemblies, which have largely been passive in oversight of the executive in health matters, should be supported to develop the technical capacity to scrutinise health budgets and hold the executive to account for participation compliance. Critically, counties should invest in harmonising and coordinating the multiple stakeholders supporting CHP development and health service delivery, ensuring that the CHP programme is not only institutionally anchored but genuinely community-owned and sustained through both national and county matching mechanisms (Ponge & Ochieng, 2025).

7. Conclusion

This paper has examined the tension between the promise of citizen voice in Kenya's devolved county health systems and the reality of elite capture that systematically undermines it. Drawing on deliberative democracy, principal-agent theory, and elite capture theory, and synthesising empirical evidence from Kenya's devolved health sector, the analysis demonstrates that devolution has created formal participatory spaces that are, in practice, predominantly tokenistic—captured by county political elites, health bureaucrats, and local power brokers whose interests frequently diverge from community health needs.

Elite capture has been traced through four interconnected mechanisms: direct political interference in health system decisions; the colonisation of formal participatory spaces by institutional stakeholders and community elites; the distortion

of resource allocation toward politically preferred constituencies; and the structural design of participation mechanisms that places citizens in information-poor, power-asymmetric settings where authentic influence is structurally constrained. Mixed-method evidence from Kenyan counties confirms these distortions are systemic, with political commitment to health and the quality of community engagement most reliably distinguishing high-performing from low-performing counties (Zeng et al., 2022). Research in marginalised counties further confirms that public sector culture—meritocracy, accountability, and integration in civil service conduct—significantly shapes whether governance structures enable or undermine health system responsiveness (Elmi et al., 2025).

Genuine pathways for strengthening citizen voice exist. Social accountability tools, civil society organisations, and independent media can generate bottom-up accountability pressure. Community Health Promoters, if reformed with adequate resourcing, representative governance, structured feedback mechanisms, and genuine community ownership, hold potential as institutional anchors for community accountability—supported by evidence from comparable settings demonstrating how community-selected, well-supervised, and adequately compensated community health workers measurably improve health system responsiveness (Nally et al., 2021, 2024, 2025). The transformation of Community Health Volunteers into salaried CHPs, backed by digital tools and formal government commitment, represents a structural shift with genuine accountability implications (Ponge & Ochieng, 2025). Targeted institutional reforms—including decentralised participation, independent facilitation, mandatory public reporting, fiscal incentives for participation quality, and health supply chain governance—can further improve structural conditions for genuine engagement (Ndirangu & Wambulwa, 2025).

The broader implication extends beyond Kenya: across sub-Saharan Africa, geographic proximity is not, by itself, a sufficient condition for responsiveness. Addressing elite capture is ultimately a political challenge requiring the deliberate construction of countervailing community power—without which the promise of devolved, community-centred health systems will remain only partially realised.

Authors' Contributions

The two authors are responsible for all facets of this work.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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