

Building Trust in Kenyan Rural Public Health Facilities

by

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Abstract

Most Kenyans seem to have lost trust in government institutions as impartial public service providers. For instance, many of them would be astonished to learn that one has obtained a passport or a driver's license without 'knowing someone' or 'paying something small.' However, despite this being the perception of the majority of the people, it is not always the case. There are numerous examples of exemplary public servants as well as institutions. This paper is as a case study concerned with the issue of a lack of trust in public institutions in rural health facilities in Kenya. The purpose of this paper is to explore factors that engender this practice and thus erode the requisite stocks of social capital that is required for good governance to take root at these facilities. A field study was undertaken in western Kenya where four institutions were used as research sites. A questionnaire was administered to both the community of health service providers and users to determine the level of trust that exists in these institutions, and how they impact on service delivery. The study found that ethnicity, amongst other prejudices, was a major hindrance to the realization of quality health care service delivery in these facilities.

Keywords:

Rural Health Facilities, Social Capital, Good Governance, Health Policy, Health Systems.

Introduction

Most Kenyans seem to have lost trust in government institutions as impartial public service providers. For instance, many of them would be astonished to learn that one has obtained a passport or a driver's license without 'knowing someone' or 'paying something small.' However, despite this being the perception of the majority of the people, it is not always the case. There are numerous examples of exemplary public servants as well as institutions. This paper is concerned with this issue of lack of trust in public institutions and uses Kenyan rural health facilities as a case study. The purpose of this paper is to explore factors that engender this practice and thus erode the requisite stocks of social capital that is required for good governance to take root at these facilities. A field study was undertaken in western Kenya where four institutions were used as research sites. A questionnaire was administered to both the community of health service providers and users to determine the level of trust that exists in these institutions, and how they impact on service delivery. The study found that ethnicity, amongst other prejudices, was a major hindrance to the realization of quality health care service delivery in these facilities.

Purpose of the Research

On-going research trends correlate social capital in the form of social trust and associational networks, with a multiplicity of desirable policy outcomes such as low crime rates, lower transactional costs and less corrupt and more effective government. The purpose of this research is to observe closely, at macro and micro levels, the manifestations of social capital amongst service providers and community of users at selected rural health facilities. This kind of observation provides a detailed description of what transpires at the inter-phase of service delivery when the existing social capital amongst the community of users interacts with the norms and attitudes of public servants charged with service delivery.

Research Objectives

The study was largely motivated by evidence in the literature dealing with social capital that suggests that the concept has large untapped economic payoffs. For example, Fukuyama (1999) cites the success of the Japanese Economic Planning Ministry (MITI) in delivering credit allocation over the years to particular industries, which was deemed vital to the overall performance of the Japanese economy. Fukuyama attributes this success to the prevalence of a unique form of social capital amongst the Japanese bureaucrats and citizens.

The notion of social capital is especially pertinent to service delivery in the social sectors, such as the health sector, where the ordinary rules of perfectly competitive markets do not apply. The relationship between the doctor and patient is not quite similar to that between, for example, those exchanging vegetables or a house for money.

It is generally assumed, and it is quite possible, that the majority of the buyers of the latter are rational and familiar with the items they are purchasing and are thus better able to discriminate while conducting the purchase. In as much as an ordinary patient may be engaged in exchange of his money for medical services, he/she, however, would not have as much knowledge as the licensed service provider, whether nurse, doctor or pharmacist, about the medicine. The latter categories of consumers are relatively less able to discriminate.

Because of the existing information asymmetry in the market for healthcare services, patients are forced by circumstances to depend more on trust. Thus, they are left to 'trust' that the professional will offer quality service to them. In the absence of this trust, clients would only be prepared to pay for the services at the value of the poorest quality of service available. The concern here is about the perceived bottlenecks amongst the community of service users as well as service providers to effective public service delivery that are pertinent to the concept of social capital.

In this study, the concept of social capital is depicted as a unit of analysis in an attempt to explore the failures of rural health facilities regarding service delivery. The debate on social capital (see, for instance, Grootaert and van Baastelar, 2002; Isham, Kelly and Ramaswany, 2002) presents an exciting new paradigm in development theory. The norms that constitute social capital generally range from friendship reciprocities all the way to the more complex norms that bind together huge organizations such as trade unions and churches (Fukuyama, 1999). Put simply, social capital refers to the informal and unwritten understandings that enable members of society to relate to each other in mutually beneficial ways.

In the pursuit of individual goals, society members are, in line with the positive tenets of social capital, expected to be mindful of other people's welfare. Henceforth, norms of reciprocations and obligations are created that are ideally self-perpetuating. I am of course referring here to 'positive' social capital to distinguish the phenomenon from the type of associations that are formed by cartels, criminal gangs, and ethnic groupings against outsiders.

Research Questions

In many rural areas of Kenya, the quality of health care facilities and service delivery systems has been less than satisfactory. Over the years, several attempts have been made to reform these services to improve on delivery. Mostly, the emphasis has been on enhancing health infrastructure and logistics, remuneration and capacity building of the employees. These endeavours have yielded mixed results, to say the least.

The core assumption of this research is that the concept of social capital influences to a great degree the quality of public provisioning in Kenya. It delimits the agency of the current public service reform drivers as characterized by the good governance discourse. To ascertain the impact of social capital on these management practices and ethos of those managing rural health facilities, the research seeks to address the following questions:

- How does the concept of social capital impact on health care service delivery?
- What erodes trust in rural health facilities?
- How do the associational norms of both the community of users as well as the service providers affect health care service delivery?

Research Design

This study employs both a survey and qualitative research methods in order to understand and describe how the phenomenon of social capital manifests itself in institutional settings. This is achieved by the use of in-depth interviews, focus group discussions as well as a questionnaire to arrive at understandings and interpretations of how service providers and community of users at rural health facilities build and exploit social capital as they interact. This is because, as Leedy and Ormrod (2001) demonstrate, the gathering of accurate information about the phenomena being investigated is crucial given that this is an interpretive study.

The institutions chosen for this study are severely resource-constrained and many people who patronize them do so for lack of a better alternative. In Kenya, it is generally conceived that only those who lack the means to access private health care opt for rural health facilities (ee, Kimelu *et al.*, 2004). Nevertheless, as the majority of Kenyans are poor, they have no alternative but to visit these much-maligned centres. Since the overriding complaint of staff in these institutions is overwork, relatives of in-patients in many instances take it upon themselves to feed, wash and change the patients.

In-Depth Interviews

Purposive sampling was used to select information-rich cases for in-depth study. This type of sampling involves selection of sites and informants based on important characteristics under study. In the course of this study, the researcher carried out fourteen in-depth interviews with various medical personnel and hospital administrators.

The researcher also carried out seven focus-group interviews over the same period. The hospitals were largely chosen for ease of access and convenience. The hospitals used in this survey included Pap-Onditi Health Centre in Nyando District, St Joseph's Nyabondo Mission Hospital, Rachuonyo District Hospital, and Oboch Rural Health facility in Nyando District.

The researcher chose as key informants mostly the medics who also served as administrators such as the medical superintendents, matrons, and public health officers. As for the patients, the researcher relied on the ward sisters and doctors to identify those who were in a position to grant an interview in passable English or Kiswahili. The researcher also carried out unstructured interviews with relatives of the patients and other staff members.

Interviews were carried out on special selected respondents in order to gather information on procedures and processes. In Kenya, the Medical Superintendent is the chief executive officer of a government provincial or district hospital. The researcher was able to interview the Medical Superintendents, the Chief Nursing Officers, Clinical Officers, the Public Health Officers and the Head Matrons. The researcher used face-to-face interviews with these officers as the method has the distinctive advantage of enabling the interviewer to establish rapport with potential participants and therefore gain their cooperation. Personal interviews also allow the researcher to clarify ambiguous answers and, when appropriate, seek follow-up information (for elaboration, see Burns, 1999; Silverman, 1993).

Focus-group Interviews

Focus group interviews with patients, nurses and relatives of patients were limited to 6 to 10 patients as recommended in many research textbooks (see, for instance, Leedy and Ormrod, 2001; De Vos and Strydom, 2001). Each informant in the study was informed of the purpose of the study and assured of confidentiality and anonymity. The interviews were conducted much like a dialogue between informant and interviewer. The questions were open-ended and conscious effort was made to build rapport with informants. The researcher proceeded to probe further into relevant topics whenever informants mentioned them during the tape recorded interview.

Open-ended questions allow the interviewee to explore different aspects of the subject so that a more complete and valid picture emerges, without any sense of the respondent trying to guess what the interviewer wishes to hear. Some of the tape-recorded interviews were over an hour long as the approach at times made respondents delve into long narratives. As Mishler (1986) points out, narratives move interviews beyond question and answer formats by bringing out the more deep-seated problems and insights of the informants. By allowing informants to elaborate and encouraging them to extend their responses, they are empowered to put forth their own views. Riesman (1993) also recommends the use of open-ended questions and less structured questions in eliciting narratives.

Burns (1999 p. 131) argues that the open-ended types of questions are especially valuable where the aim is to explore informants' 'perceptions, beliefs or opinions and to provide opportunities for unforeseen responses or for those which are richer and more detailed than responses obtainable through fixed choice questioning.' The open-ended questions also allowed respondents to offer unrestricted spontaneous expressions to help 'gather authentic understanding' of the experiences and viewpoints of the participants (Silverman, 1993 p. 10).

The researcher visited each of the four hospitals at least for six days throughout December 2004 and January 2005. Interviews were conducted during these visits. During the interviews, the researcher managed to elicit much more pertinent information regarding the operations of these institutions than I would ever have had, had straightforward objective questions been prepared in advance. This was achieved by embedding story prompts while probing into what would otherwise have been politically sensitive topics. It is my considered opinion that these helped to create awareness of responsibility in the informants as well as letting them know that what they had to say about their experience and personal history was valuable and important.

At various times during the fieldwork, the researcher did arrive at the selected hospitals before the opening times and joined the often-long queues of patients waiting for attention. It is through the casual conversations with the patients that I was able at times to steer conversations to enable me to gain some insights into the operations of the hospitals and the expectations of patients. During these conversations, the researcher would often begin with the topical issues of the day before turning to issues and events around the hospital. While this kind of data capture was not originally envisioned for my research, the tit-bits of information captured was truly useful in many instances when the researcher later had to interview medical officers as well as nurses.

Survey Questions on Trust

Let the reader keep in mind that in this paper, we are presuming established cognitive categories of ethnicity, which influence people's conduct in a deliberate manner. As theories of multiculturalism show, the existence of diverse ethno-cultural groupings need not undermine efforts in public reasoning, i.e. Kant's precursor to good governance. To begin with, how do we ensure that Kenyans see bureaucrats purely as civil servants and not as, prejudicially, Kikuyu or Luo. It may be amusing but the fact of the matter is that whenever any of the local notables refer to their personal physicians, it often turns out that such people are from their home regions (read ethnic community) or an expatriate. How then do such mind-sets interact with the good governance discourse? We are concerned with this question here because the underlying assumption of good governance is what Rawls (1987) calls an overlapping consensus based on a purely political conception of social justice and development, leaving aside comprehensive worldviews (moral, philosophical, religious views and so on) of the particular ethno-cultural groupings involved in such public reasoning/deliberation. These and other pertinent questions will be discussed in this section and in the rest of the paper especially about the respondents' answers as summarized in Table 1-1.

While the task is for the government to address the serious challenge of increasing access to health care and improving the quality of care Kenyans receive, it should be borne in mind that whatever interventions are put in place will be impacted on by the undercurrents of ethnicity and distrust as introduced above. Thus, the challenge must be broadened to include the development and training of culturally competent providers just like, say, the United States of America government has tried to do especially regarding minority access to health care (see, for instance, Kennedy, 2005).

The researcher formulated nine questions regarding trust that respondents were expected to answer one way or the other. The most common question that one frequently meets in the literature and instruments designed to elicit the level of trust in a community was included in the questionnaire as question number ten. The question is often expressed as: *Do you feel that most people can be trusted?* This question is often predicated in the widely accepted belief that, as human beings, we normally tend to trust only the people we believe trust us in return. This lack of trust or the presence thereof is what gives rise to the agency problems tackled in game theories. For this reason, the researcher felt compelled to include the question here.

This question was further followed by additional eight others that sought to confirm that the presence or absence of trust was not just a desire or a feeling but a deep-rooted conviction that could affect the quality of services delivered substantially. Thus, when question numbers two and three ask whether respondents do trust their neighbours with children and whether they do visit their neighbours regularly, it is all in a bid to know whether the particular neighbourhoods where these respondents come from have a sufficient sense of community. The sense of community is needed in order to enable collective action and deliberation on any range of issues including public governance, which is the concern of this study.

When the survey asks whether teachers are good proxy parents or whether most of the respondents' friends are from their own ethnic community, it is in a bid to determine how far the sense of trust affects service delivery. My position here is that in a community where most people do not see teachers as good 'proxy' parents, they are also not likely to trust the doctors just as much. While in Kenya the issue of trust (or lack of trust) has not led to many court cases on negligence and professional misconduct, it is my belief that one of the reasons that leads a number of Kenyans away from public hospitals whenever they can afford alternatives is lack of trust.

For instance, some patients confided in me that they feared to be tested for HIV/Aids because they suspected the nurses would tell their relatives and friends about their status without consulting them. For those who believed in witchcraft and traditional medicine, they at times felt that the doctors and nurses using modern medicine did not quite understand the nature of their ailment.

Again, given that the Ministry of Health (MOH) does not ordinarily consider one's ethnic background prior to posting, it became apparent to me that some patients felt short-changed, especially if they do not speak fluent Kiswahili or English, that a medic from a different part of the country should offer them service.

The lack of trust and perception of poor quality services resulting from this kind of arrangement was captured by one elderly lady who had visited the hospital and had just been seen by one of the nurses. She had this to say:

That young woman comes from this area and now because she is in that white uniform she even refuses to greet me in Dholuo. What are those of us who never went to school supposed to do? I spoke to her in my broken Kiswahili and she started writing things even before I finished explaining the nature of my illness to her. They have now given me only painkillers. Why is the government not employing people who have the time to talk and listen to us? (Interview, 17 January 2005).

As can be seen from the remarks above, the issue may not be about ethnicity *per se* but could be stretched to include an uncaring attitude or just pure communication. For this reason, the question about interethnic marriages was included to gauge the depths of ethnic chauvinism within the communities surveyed. Question numbers sixteen and eighteen deal with the same angle in different circumstances. I sought to find out whether the respondents are likely to once in a while give away some of their private physical space for the greater good of the community. My argument regarding holding group meetings in a private residence revolve around the estrangement of the people from the government or otherwise as well as the interpersonal relations within the communities. For instance, one might be willing to host group meetings in her house, but this can only take place if she can also trust the people she is inviting to her home. Question eighteen deals with the same issue but more at a personal level by asking about a relative. Again, with some limits, one would hope that a community that takes care of its weaker members until they are able to stand on their own feet has a higher chance of progressing together and thus helping reduce inequalities.

Question seventeen deals with a pertinent question to the MOH and many other people in Kenya. Kenya inherited a unitary civil service from the British and yet we have eight Provinces and forty-two ethnic communities with distinct cultural practices. There is need to explore and articulate officially whether this situation has any bearing on the performance of officers who might be posted to head an institution in an area where she is perceived to be an outsider. While official government records do not refer to these kinds of conflicts, it is my considered opinion that a lot of policy estrangement witnessed during implementation of government projects is in part fuelled by this practice. Whenever I talked to any of the officers in a similar situation to that described here during my field interviews, there were lots of 'these people,' 'they think,' 'we will do it for them' and so on.

On the other hand, those officers working in their own home regions tended to use words like 'we will do,' 'we need,' 'we are neglected by the government' and so on. For these reasons, question number seventeen sought to establish whether the MOH's practice is in tandem with the feelings on the ground. A summary of the questions and findings is presented in table 1-1.

Validity and Reliability

Validity relates to whether the results of the research are consistent with the data collected from the study. It also considers the likelihood of a given measurement procedure to give the same results if the exercise is repeated (Merriam, 1998). To ensure reliability, the researcher, who plays a central role in the study as a key tool, was rigorously trained and the acquired techniques applied throughout the research process as a reliable instrument. The researcher also used multiple methods to collect data. Rapport was built between the interviewer and interviewees. Interviews were conducted at their places of work. A tape recorder was used and together with the interview notes taken during the interviews, the recorded discussions were supplemented to make the presentation of the research findings concrete and reliable. It is thus the researcher's conviction that there is a very low possibility of significant errors that could have been made to affect the reliability of this research study.

An audit trail has been kept by giving an account of how the results were arrived at. Different sections in this report show how the data was collected and how decisions taken were made throughout the inquiry. According to Bulmer (1990) validity refers to the extent to which an empirical measure sufficiently reflects the actual meaning of the concept under consideration. It is further suggested that by validity, it implies that one measures what they intend to measure and nothing else.

Merriam (2002) further observes that there are several and changing realities and individuals have their own perceptions of reality. The researcher acknowledged this during the study and tried to understand the perspectives of different interviewees. This was achieved by using a triangulation strategy which involves application of multiple methods of collecting data. Thus, interviews and direct observations were complemented by related existing literature. The researcher linked the interview responses to the observations made of what was actually happening on the ground. The researcher also carried out several member checks by asking some interview respondents to comment on the interpretations of the data. This was after making tentative findings so that members could check if their experiences came through in the interpretations.

Ethical Considerations

Before embarking on the field trip to Kenya, I obtained appropriate letters introducing myself to the various institutions. I explained the purpose of my research as fully as possible to the various people in charge as well as to the people interviewed and ensured that I had written permission to proceed. I also explained to the respondents that they were free not to participate in the study or to withdraw at any stage without adverse consequences to themselves or their associates. Ethical issues are of particular relevance in qualitative research during data collection as well as when publishing the findings (Merriam, 1998). Ethics is about what is right or wrong in human conduct. There is a possible risk of the researcher being too involved in the case. To the extent possible, I ensured participants of confidentiality and anonymity. As far as I could tell, there were no group interests in the research which might have influenced the results.

Discussion of Results

As a first step, we need to acknowledge the historical inevitability of ethnic groupings without imputing to them some negative stereotypical ideologies that may be associated with ethnicity. Regarding the perceived injustices of ethnicity in health services provision and facilities, it is possible that favoritism is simply based on who is familiar to whom at these institutions without necessarily saying, for example, that one nurse will dogmatically operate in a conceived ethnic mode and ignore patients from other ethnic groups. The issue is further complicated by the fact that it is impossible to measure what we may call here, for want of a better term, ethnic attitudes, even though we can see their manifestations in practical reality without falling into the trap of anthropological determinism. Like in many other developing countries, the Kenyan national health system is inadequate given the demands placed upon it. Whether it is the equitable distribution of physical health facilities or the appointment to senior posts in the Ministry of Health (MOH), just like in other Government Ministries, Kenyans analyse these issues through an ethnic lens. It is common knowledge that these senior managers are able to unfairly sway government resources to their home areas. One of the patients in a hospital the researcher visited had this to say:

Now they have brought this Kisii man here because they want Luos to suffer. How come we cannot have a Luo Medical Superintendent in Kisii homeland yet they are always posting foreigners here? It is because they do not care about services here and want this man to take even the little we have here away (Interview, 7 December 2005).

The sentiments expressed here are widely shared by the other patients in this hospital. What this demonstrates is that ethnic sentiments may at times overshadow obvious issues of delivery failures. The patients here were basically laying the blame of system failures on the qualified doctor who had been appointed the medical superintendent. Yet, as far as the research could establish, failures such as lack of drugs and equipments could not be easily pinned on him. His major “failure” seemed to be the fact that he was from the Kisii community and was now posted by the government to serve among the Luo community.

The GoK (1997) report on policy and organization review raises questions with regard to the equitable distribution of physical facilities. The report shows, for instance, those constituencies that are represented in Parliament by perceived political heavyweights such as cabinet ministers have disproportionately more hospitals and clinics per square kilometre than other demographically comparable areas of the country. Similarly, Mwanzia, Omeri and Onga’yo (1993) decry the lack of policy measures to direct the spatial location of health facilities throughout the country. To counter urban bias as well as inter-district and intra-district disparities, both studies cited above recommend clear national policies on appropriate and affordable targets for physical planning and implementation to counteract local political interests and pressures. Indeed, the central government is best placed to ensure equity by subsidizing poorer districts yet this crucial role is not clearly spelt out.

Most of the respondents; 54% amongst the users and 57% amongst the professionals felt that locals, that is, people from the same area, should manage local institutions such as hospitals, schools and so on. This means that there is a need to diversify the health care workforce and collect better ethnic health data if we are to achieve a responsive civil administration as demanded by the dictates of good governance. Yet this is not likely to happen because the government’s stance is that ethnic issues, given the task of nation building, should not divide people. Actually, no official Kenyan government document records a person’s ethnic community, in an effort to curb ethnic privileges/ethnicity. Thus, a major tension exists between the official orchestration of nation building and the feelings on the ground.

In essence, the researcher argues that this very stance is an affront to good governance. This is because, in the economically advanced countries of the North where the paradigm of good governance emanates, consumer satisfaction, evaluation and cultural competency are considered high priorities in the discourse. Indeed, in these countries, standardized tools for measuring consumer satisfaction are readily available even in government offices. Actually, the pretence to the priority of national unity in Kenya is amazing. Considering that this study was carried out both in the city and in rural settings where communities are quite homogeneous ethnically, it was surprising to find most respondents indicating that most of their friends are from different ethnic communities (73% for nurses and 81% for patients). Again, 87% of patients interviewed and 80% of nurses interviewed claimed that interethnic marriages are not always trouble.

What the findings indicate is that 'ethnic privileges' have often been so much maligned and demonized that it is impossible to know what to make of it anymore yet it is the most often cited complaint against many public institutions in Kenya, probably second only to corruption in my reckoning (see, Korwa and Munyae, 2001). While this is the case in Kenya, the developed countries tend to deal with the issue much more practically. In these countries, researchers interested in the issue are perennially trying to develop instruments for cultural sensitivity and the like (see, for instance, Arthur and others, 2005).

One other remarkable finding from the field survey was the low levels of trust that exist within both the community of users as well as the service providers. Only 16% of both groups interviewed agreed that people can generally be trusted. On the other hand, 85% of all the people interviewed stated that they would not mind accommodating relatives in their houses while 59% would not mind holding group meetings in their homes. What this shows is the fact that trusts have been reduced to a very small network of relatives and close associates to the extent that one would argue it might impact negatively on service delivery. A common problem that came up again and again during the focus group interviews as well as during open discussions with the hospital administrators centred on this issue of trust and was quite intriguing as narrated below.

The fact of the matter is that many people have come to accept petty corruption as the normal way of life in public places. In the case of a public hospital for instance, it would be very difficult for an ordinary person to know whether there are medicines or not as the standard response will be negative. At the same time, the patients suspect that there is medicine but the nurse or doctor is merely posturing in order to extort a bribe.

Therefore, in a normal scenario where both parties 'trust' each other, the patient would straight away pay 'something small' in order to obtain the drugs or whatever it is he or she wanted. Ordinarily, this would work without a problem. However, if the lack of drugs is genuine or if the corrupt service provider does not trust the new 'customer', then there is real tension and an acute dissatisfaction with 'the service.' A circle of distrust is thus created that is extremely difficult to solve in the formal organizational sense.

The above scenario is often abetted by invoking ethnic loyalties. For instance, if we are Luo, and the doctor or nurse is Luo as well, then we would be seen as disloyal or foolish to tell on a fellow Luo and so on. It is as if the corrupt person were stealing on behalf of the community. It is thus my contention that serious public service delivery reforms must come to grips with these issues and not merely sweep them under the carpet. These issues must be addressed right from the community leadership level. It is not an impossible task to minimize the effects of ethnic privileges in the public service.

Table 1-1: Survey Findings on Trust

Quest10	I feel that most people can be trusted	Respondent	Positive	Negative
		Patients	16	84
		Nurses	16	84
		Combined	16	84
Quest11	I would trust my neighbour with a child	Respondent	Positive	Negative
		Patients	31	69
		Nurses	22	78
		Combined	28	72
Quest12	I visit some of my neighbours at least once in a week	Respondent	Positive	Negative
		Patients	62	38
		Nurses	45	55
		Combined	55	45

Table 1-1: Survey Findings on Trust Continued

Quest13	Teachers are good proxy parents	Respondent	Positive	Negative
		Patients	87	13
		Nurses	90	10
		Combined	88	18
Quest14	Most of my friends are from my ethnic community	Respondent	Positive	Negative
		Patients	19	81
		Nurses	27	73
		Combined	22	78
Quest15	Inter-ethnic marriages are always trouble	Respondent	Positive	Negative
		Patients	13	87
		Nurses	20	80
		Combined	16	84
Quest16	I have no objections to holding group meetings in my house	Respondent	Positive	Negative
		Patients	60	40
		Nurses	56	44
		Combined	59	41
Quest17	Local public institutions should always be managed by locals	Respondent	Positive	Negative
		Patients	54	46
		Nurses	57	43
		Combined	55	45
Quest18	I would not mind a relative staying in my house for some time	Respondent	Positive	Negative
		Patients	88	11
		Nurses	79	21
		Combined	85	15

From the preceding discussions, we can see that ethnic considerations often influences local policymakers and citizens far more than they are often willing to admit openly. Yet, the good governance paradigm, and understandably so because of its origins in countries where ‘ethnic community’ is not an issue, is practically silent on the issue. There is thus a need to frame the problem of ethnic privileges for deployment in academic research concerned with public administration. This is necessary because social problems have to be construed in such a manner as to arouse citizens and compel policymakers to respond.

Given the interactions between good governance and social capital, it would seem to demand that an appropriate good governance code could only be developed after a thorough analysis of historical backgrounds and political and economic developments. As it is now, reformers in developing countries will only cherry pick from the reform package and in some cases amend them unconsciously in the light of factors such as ethnicity, political culture, party dominance, and so on.

The researcher is of the view that the management of ethnic and cultural diversity in the Kenyan civil service including rural health facilities must be made much more overt. As it stands currently, the management of these tensions is undertaken covertly resulting in unproductive tensions that severely undermine confidence and morale among public service providers and the society. It is understood that these tensions impact negatively on levels of job satisfaction, the quality of the work environment and, ultimately, on performance and output.

Some of the older patients we interviewed recollected that in the early days after independence, they would often bump onto the glass doors of two of the major hospitals we visited because the doors would be so clean they would not notice the glass barrier. Today, everything seems to be falling apart in these hospitals. In one hospital, we found wooden door shutters being used as mattresses, patients sharing beds, unkempt corridors, paints peeling off walls and so on, thus further compounding patients’ misery and discomfort.

Conclusion

The paper has looked at issues of management of health facilities as well as the management of common resources in an effort to show how public service reforms (the search for good governance) interacts with existing stocks of social capital to produce sometimes very unwelcome results. Social isolation and extreme selfishness are learnt behaviours. As such, they can also be unlearnt especially for young people. The researcher thus argues that we need leaders who will endeavour to ensure that trust in public institutions is built into modern communities. Equity issues must also be considered in public provisioning as excluded groups tend to be more distrustful of public institutions and this further erodes legitimacy.

It is clear from all this is that civic education to inculcate civic engagement underpinned by effective government communication is key to an acceptable and capable public bureaucracy that is trusted by the people. The overall argument here is that the dominant model of good governance as espoused by strategic international development partners and picked up by the government and major NGO's has not had the desired effect. This is partly because of the fact that local public service reformers have not factored in the nature of social capital required to sustain these initiatives.

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