

Stakeholder engagement in practice: experiences from neonatal care research in Kenya

HIGH-Q RESEARCH BRIEF 7, AUGUST 2025



Embu feedback meeting, December 2023. Photo courtesy of KEMRI-Wellcome Trust Research Programme

About this brief

This brief is the seventh in a series based on the HIGH-Q (Harnessing Innovation in Global Health for Quality Care) project and related research on neonatal care in Kenyan hospitals. This work was carried out by the KEMRI-Wellcome Trust Research Programme and the Kenya Paediatric Research Consortium (KEPRECON), with support from the University of Oxford.

HIGH-Q is a multi-disciplinary study evaluating how the introduction of new technologies and workforce innovations influences the quality of care in newborn units (NBUs). Ethnographic and observational research has also explored the everyday experiences of nurses, the physical environment of NBUs, and mothers' experiences within these settings. Each brief focuses on a different aspect of this work.

The brief was written by members of the HIGH-Q research team.

Introduction

Stakeholder engagement throughout the research cycle is increasingly recognised as critical to the design, implementation, and uptake of health systems research. Yet, there remains limited practical guidance on how to plan and carry out meaningful engagement in real-world settings.

In embedded research, conducted within routine health service environments and often requiring long-term involvement in those systems, engagement is central to ensuring ethical practice, relevance, and the potential for impact.

This brief summarises how stakeholder engagement was carried out as part of the HIGH-Q research programme in Kenya – an intervention that sought to examine the consequences of low nurse staffing and the effects of adding nurses and ward assistants to neonatal units over a period of 15 months and 7 months, respectively (see HIGH-Q Brief 3).

It outlines how engagement was planned and implemented across a range of stakeholders and how these activities connected with the broader stakeholder engagement strategy of the KEMRI-Wellcome Trust Research Programme (KEMRI-Wellcome).

Stakeholder engagement in HIGH-Q

A complex intervention requiring multi-level engagement

The HIGH-Q intervention was implemented across eight county hospitals and involved a wide range of stakeholders, including patients and their families, hospital frontline staff and managers, county and national policymakers, and professional communities. The scale and nature of the intervention required a structured approach to engagement from the outset.

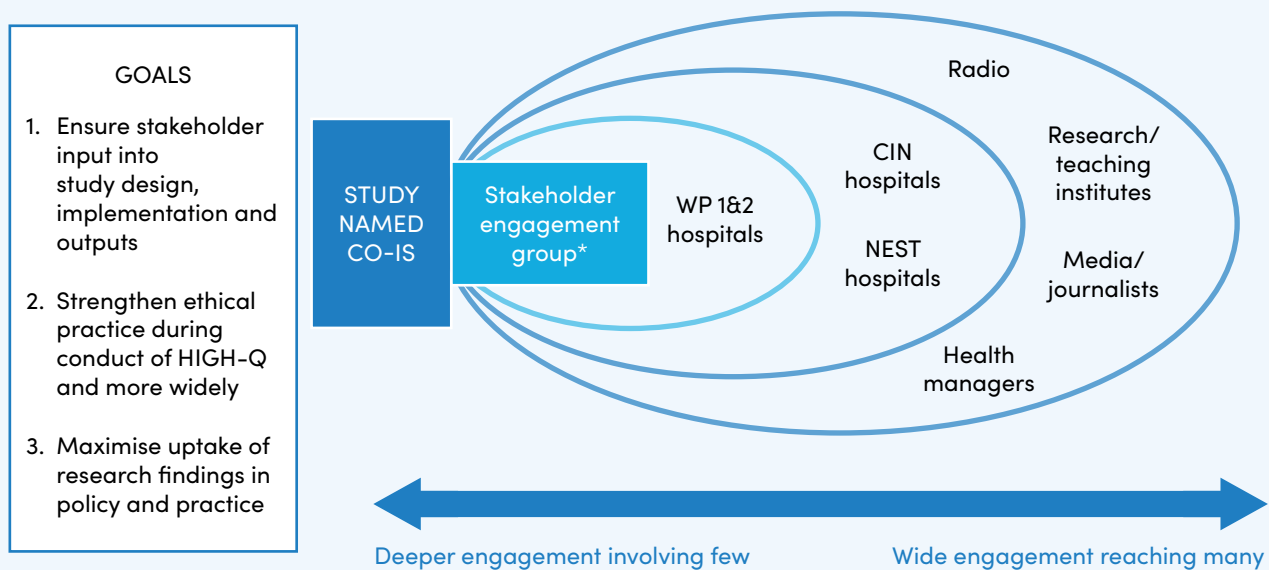
Planning and team structure

The HIGH-Q research questions and programme design were based on decades of involvement in the Kenyan health system. A stakeholder engagement group—comprising principal investigators and researchers with long-standing experience in the Kenyan health system—was established early in the programme to oversee and coordinate engagement. A project manager led day-to-day coordination.

An initial engagement framework was developed during the proposal and set-up phases (Figure 1).

Stakeholders were identified in concentric layers, depending on their influence and interest. Groups included national and county policymakers, professional associations and regulators, hospital managers, frontline healthcare workers, patients, and families. The engagement framework defined engagement objectives in relation to stakeholders and specified the content and format of engagement activities. Detailed plans were shared internally, outlining engagement targets, tools, frequency, timelines, and responsibilities.

Figure 1: HIGH-Q stakeholder engagement plan



Activities across the research cycle

Figure 2 provides a timeline of the HIGH-Q intervention and stakeholder engagement activities.

Pre-intervention phase

Engagement activities focused on securing approvals, building relationships, and collaboratively shaping aspects of the research design.

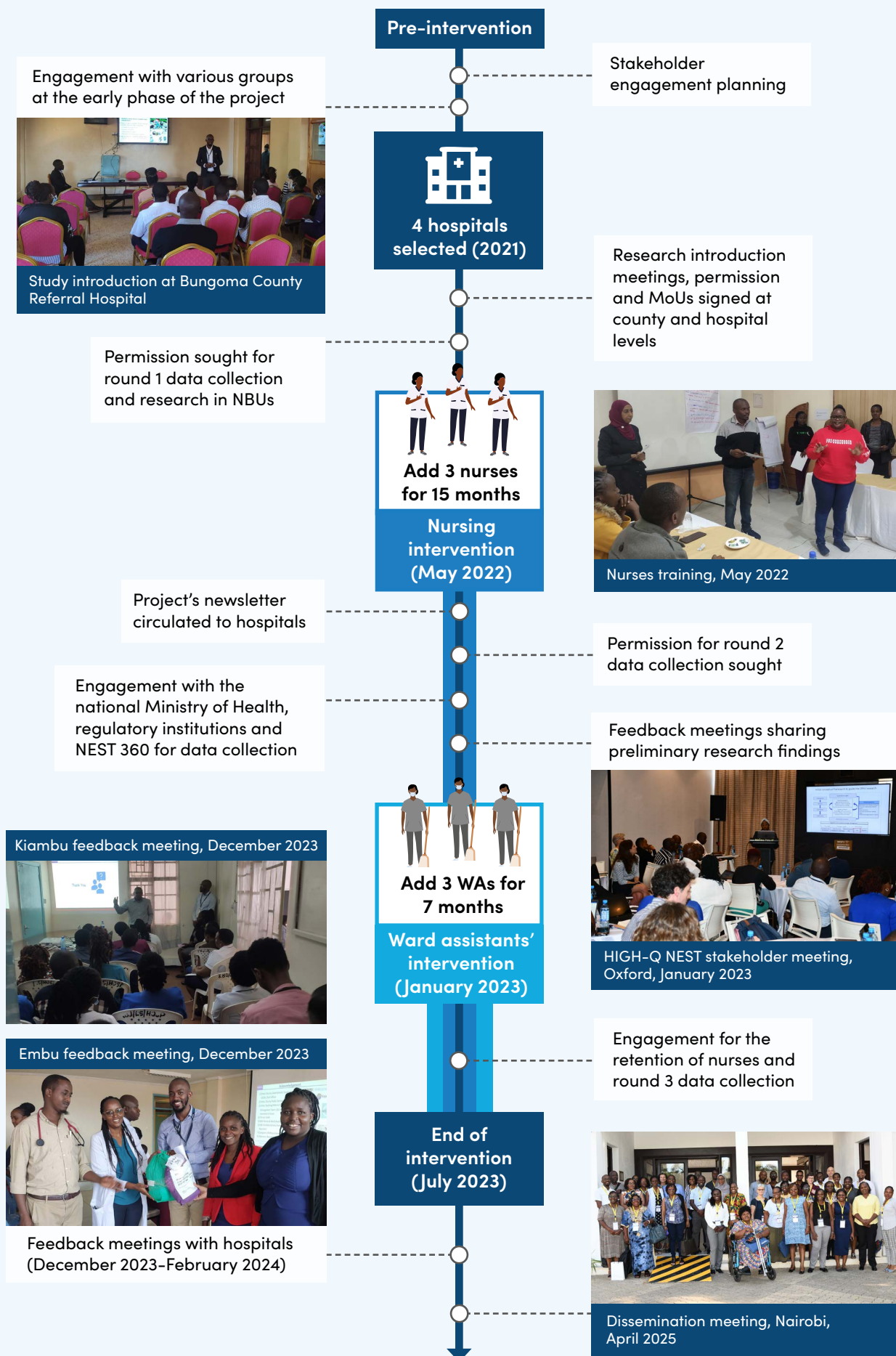
- County-level entry involved introducing the programme to county health departments, sharing documentation, and securing approvals. Memoranda of Understanding (MoUs) with each county clarified roles, expectations, and ethical commitments.
- At the facility level, engagement was cascaded to hospital managers and NBU staff. Stakeholder meetings helped align operational plans.
- Stakeholders also contributed to research design in consultative meetings that informed both the stakeholder engagement plan and broader research implementation.

During the research

As implementation progressed, ongoing engagement activities were used to navigate emerging issues. These activities helped ensure responsiveness to stakeholder concerns in real time.

- The introduction of new staff roles prompted questions about responsibilities and consent processes, which were addressed through a series of follow-up conversations and clarification with hospital teams.
- Regular site visits provided ongoing opportunities to maintain relationships and monitor implementation. Informal interactions during these visits helped surface concerns early and build trust.
- Internally, the research team held regular debrief sessions to review issues raised in the field (See Box 2, page 5). These discussions informed decisions on whether concerns needed further action and shaped communication strategies to ensure stakeholders received timely, relevant feedback.

Figure 2: HIGH-Q intervention and stakeholder engagement timeline



Research feedback and ending the study

The final phase of the programme included planned and responsive engagement activities to share findings, gather reactions, and discuss the future of programme components with key stakeholders.

- Structured feedback meetings were held with hospital teams, county officials, and national-level actors to share study findings and discuss their implications. The format and timing of these meetings were adapted in response to stakeholder availability and preferences.
- A further set of targeted engagements was held with county departments of health in all four counties. These meetings specifically explored the potential for retaining and absorbing intervention staff (ward assistants) into the county workforce beyond the research period.

Key observations

1. Stakeholder engagement is essential but complex in practice

Although the team had extensive prior experience in the Kenyan health system, engagement in HIGH-Q required continuous adaptation. The inclusion of a workforce component—introducing new staff employed through county governments—added complexity. These roles raised ethical and operational questions and required negotiation with various county-level actors, including chief officers, legal departments, and public service boards. Approval processes and implementation pathways differed across counties, illustrating how local structures and dynamics can shape engagement.

2. Stakeholder engagement requires responsiveness and flexibility

While a detailed stakeholder engagement framework was in place from the outset, actual implementation demanded frequent adjustments. Questions from the field led to many informal, unplanned follow-up interactions and the revision of communication materials in response to stakeholder feedback.

3. Some stakeholder groups are harder to reach and achieve sustained involvement than others

While many stakeholders were engaged throughout the programme, some groups were more difficult to reach. For instance, engagement with parents primarily occurred through interviews and observations, following consent. Leadership transitions, such as changes in County Directors of Health or hospital administrators, also created disruptions, requiring the team to reintroduce the study and re-establish relationships with incoming officials.

Box 1: Stakeholder engagement at KEMRI-Wellcome: a broader institutional commitment

The HIGH-Q project benefitted from wider stakeholder engagement embedded across KEMRI-Wellcome's research programmes. A dedicated engagement team coordinates both programme-wide and study-specific activities across three domains: community, public, and policy engagement.

The institutional goals of stakeholder engagement are to:



Build, sustain and deepen **respectful relations and mutual understanding** between communities/public and researchers/research institutions



Sustain and deepen values, policies and practices for engagement at KWTRP to support **responsive and mutually beneficial and ethical research**



Contribute to strengthening regional and global engagement policy and practice through **collaborative initiatives**



Strengthen the translation of research **findings into health policy**

A spectrum of engagement approaches is employed from broad outreach (e.g. media or school programmes) to deeper, participatory dialogue with community representatives or advisory groups. This layered model supports both reach and meaningful consultation.

Frontline staff play a key role. To support them, KEMRI-Wellcome prioritises training, regular debriefs, and supervision, all of which were built into HIGH-Q. Career pathways have also been developed for data collectors and engagement staff, with associated training aimed at improving both ethics and research quality.

Box 2: Team debriefs as spaces for ethical reflection

Our research team held regular debrief sessions throughout the fieldwork as an important opportunity to bring everybody together to review issues raised in the field. Debriefs can form an important component of qualitative data sets. Holding systematic debriefs can help build research team capacity, support data quality, enable the study to evolve in line with contextual issues and emerging insights, and – importantly for this brief – support discussion about the need for further engagement with wider stakeholders. We incorporated specific discussion in our debriefs on any ethical dilemmas experienced – that is, situations where team members were not sure what the right thing to do was, where they felt they knew what should be done but could not do it, or simply felt emotionally uncomfortable.

Numerous practical and ethical dilemmas were shared by research staff in our debrief meetings. Ethical dilemmas could be broadly grouped into:

1. ‘Bystander’ issues faced by others and not caused or exacerbated by our research activities,
2. Issues that were ‘research-imposed’, and
3. Issues related to the comfort and well-being of research team members.

Discussions of these dilemmas, and how to best handle them, often led to plans for engagement and feedback activities with stakeholders. In these ways, our regular debrief sessions were central to our wider engagement activities.

Conclusion

Stakeholder engagement was a foundational component of HIGH-Q, integrated from study design through planning and implementation to study close. Engagement required an experienced team, a detailed framework, and sustained flexibility, responsiveness, and effort.

The workforce component demanded more intensive engagement than observational studies. Informal and unplanned engagement proved just as critical as formal plans—emphasising the need for adaptability.

These experiences align with institutional learning at KEMRI-Wellcome, where engagement spans from broad awareness-raising to deep consultation. Across all levels, successful engagement depends on adequate resources, long-term relationships, careful attention to differing interests and levels of influence, and an embedded culture of responsiveness.

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Sources

This brief draws on both published research, case studies and research briefs.

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